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 _____	04/06/2018

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

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F 000	INITIAL COMMENTS Additional information provided to the team which resulted in deletion of F 640, 5/4/18 BW	F 000		
F 553 SS=D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care.	F 553		5/10/18

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

Electronically Signed | 04/29/2018

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 553	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and staff and family interviews, the facility failed to allow family to participate in the development of care planning for 1 of 37 residents care plans reviewed (Resident #63). Findings included: Resident #63 was admitted to the facility on 11/12/15 with the current diagnoses of Alzheimer's dementia and anxiety. Resident #63 Minimum Data Set (MDS) dated 3/13/18 revealed the resident was rarely/never understood and had memory problems. The resident had severe impairment in cognitive skills for daily decision making. The resident's care plans were last updated in March, 2018. A care plan meeting attendance sheet, dated 1/23/18, revealed that 2 family members of resident #63 attended a care plan meeting with staff present. There were no progress note, assessment or documentation to indicate that the family participated in the development of the resident's care plan during the period of 6/9/17 through 1/23/18. Resident's #63 representative was interviewed on 04/03/18 at 3:30 PM. She stated she participated in 2 care plans in the last 2 years. She remembered she participated in a care plan in June, 2016. The facility had also not reached out	F 553	F- 553 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. It is the position of Maple Grove Health and Rehabilitation regarding the deficiency that the facility failed to allow family to participate in the development of care planning for 1 out of 37 records review was the staff failed to follow care planning policy. Resident 63 required no intervention as a care plan meeting was conducted within the quarter on January 23, 2018.Residnet # 63 with a scheduled quarterly MDS assessment May 7,2018,	

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F 553	Continued From page 2 to her about care plan meetings and she had asked about it. The social worker was interviewed on 4/5/18 at 2:48 PM. She stated they do care plan meetings quarterly with the MDS nurse, dietary manager, activities director and other staff. They had a care meeting for the family and verbally scheduled the meeting (January, 2017). The entire care plan was printed out on the care plan's meeting date and was reviewed and updated at that time and any significant changes were also updated. The social worker was interviewed on 4/5/18 at 4:44 PM. She stated there was a meeting on 9/13/17 but she would have to look for the sign in sheet. She stated that prior to 9/13/17, she was not sure what happened with the care plan meetings because she was not here. She stated that she started working at the facility in July, 2017 and the facility did not have a social worker prior to her coming here. The MDS nurse was interviewed 4/6/18 at 2:44 PM. She stated that the care plan meeting were set up by the social worker and the resident and resident's representative were invited. She stated that during the meetings, the resident's chart would be reviewed and therapy, activities and dietary staff would be there. She stated that there had been a care plan meeting for resident #63 recently. Care plan meeting were supposed to be completed every 90 or 92 days and on admission. A letter would also be sent to the resident's family reminding them of the meeting. The social worker was interviewed again on 4/6/18 at 3:45 PM. She stated that she did not see anything about the September, 2017 care	F 553	care plan meeting with responsible party held with interdisciplinary team on May 9,2018 In-service conducted by the Administrator to the Social Worker on 4/6/2018. The in service included to invite residents and responsible parties 1- 2 weeks in advance of scheduled care plan conferences with the interdisciplinary team. Follow-up by way of telephone call with resident or responsible party to ensure participation. A telephone conference is also an option for care plan interdisciplinary meetings. Documentation of notification will be in Point Click Care under Social notes of the upcoming interdisciplinary care plan meeting. An audit was performed on 100% of the occupied residents on 4/6/2018 by the Social Worker. The audit was to identify any other resident that may have been affected by this deficient practice. Any resident or responsible party identified were scheduled for a meeting within 2 weeks. In-service by the Administrator to the Social Worker, Assistant Dietary Manager, and Receptionist on allocation of task on 4/9/2018. Social Worker will print Minimum Data Set schedule for Receptionist to send out invitations to interdisciplinary care plan meetings 1-2 weeks prior to the scheduled meeting. Social Worker will call resident of responsible party to ensure invitation received and attendance expected. An alternate date and telephone conference will be offered if unable to attend at that	

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F 553	Continued From page 3 plan meeting and did not remember if it occurred or not. She stated that she kept up with the meetings based on the care plan assessments. She stated resident's #63 family had requested to have the care plan meeting with them in January, 2018. The Administrator was interviewed on 4/6/18 at 3:46 PM and stated that they went a few months without a social worker. She stated that she didn't see any other information on care plan meetings for this resident. She stated that she thought there was an invitation for a care plan meeting on 6/9/17 and that was mailed to the resident's family on 5/24/17. The Administrator was interviewed on 4/6/18 at 7:44 PM. She stated that she would expect for the resident and family to be offered to attend care plan meetings quarterly.	F 553	time. The Social Worker will then document in Point Click Care the scheduled date of the interdisciplinary care plan meeting. The Assistant Dietary Manager will monitor Point Click Care to ensure documentation present as indicated weekly X 8 weeks , then bimonthly X 2 months then month X 2 months. This in-service will be added to the orientation for any new hire social workers, assistant dietary managers, or receptionist . The Assistant Dietary Manager will monitor the care plan meetings according to the MDS schedule weekly X8 weeks, then bi- monthly X2 months, then monthly X 2 months. The monitoring tool is titled Care Plan Meeting Audit Tool Results of the monitoring will be reported to the Quality Improvement Committee for review. The Quality Improvement Committee consist of the Receptionist, Social Worker, MDS Coordinator, Dietary Manager, Assistant Dietary Manager Rehabilitation Manager. The Assistant Dietary Manager will report auditing tools to the Quality Improvement Committee for evaluation of the plan. The Administrator will be notified immediately for any identified deficient practices. The Administrator/ or Director of Nursing will report quarterly to the Executive Quality Improvement Committee X 2 quarters. The Executive Improvement Committee consist of, Medical Director, Director of Nursing,	

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F 553	Continued From page 4	F 553	Social Worker, Dietary Manager, Medical Records Supervisor, Activity Director, Pharmacy Consultant ,Dietary Manager, Assistant Dietary Manager and the Administrator. The first Executive Quality Improvement meeting was on April 25, 2018 and the care plan meeting alleged deficient practice was discussed. All recommendations to continue, alter or modify the plan will be explored at that time. Recommendations were debated to continue the current plan meeting with emphasis on the policy of notification of residents and responsible parties. Estimated completion of plan six months . The Social Worker is responsible for implementation of the acceptable plan of correction.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for	F 584		4/28/18

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F 584	Continued From page 5 the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and observation the facility failed to (1) maintain walls in resident rooms for 4 of 11 residents rooms (110N, 103E, 205S and 104N), (2) maintain the floors in residents rooms for 3 of 11 resident rooms (102E, 208S and 104N), (3) maintain a clean environment in resident rooms for 2 of 11 resident rooms (103E and 104N), (4) maintain equipment in resident rooms for 4 of 11 resident rooms (103E, 208S, 110N and 228S). Findings included: 1a: An observation of room 110N occurred on	F 584	F- 584 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	

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F 584	Continued From page 6 4-6-18 at 1:30pm. The resident's bathroom was noted to have a hole in the wall above the bathroom door. The maintenance supervisor was interviewed on 4-6-18 at 2:10pm regarding the hole in the wall. The supervisor stated he did not know it was there and that staff was responsible for placing work orders when they saw issues in the resident rooms. He also stated that he did do a walkthrough of the resident rooms but that he must have missed the hole in the wall. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 1b: Room 103E was observed on 4-3-18 at 10:33am. The walls were noted to have paint chipping off behind the resident's bed and the wall near the window. Another observation of room 103E occurred on 4-6-18 at 1:35pm which revealed that there was paint chipping from the wall behind the resident's bed and by her window. An interview with the maintenance supervisor occurred on 4-6-18 at 2:12pm who stated that the maintenance staff was working on repairing and painting the walls but that it was a slow process. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 1c: An observation of room 205S was completed on 4-4-18 at 11:07am at which time the room was noted to have chipping paint on her door and the bathroom door. Room 205S was observed again on 4-6-18 at 1:37pm. The door to the resident's room and her	F 584	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. The position of Maple Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency- of not providing a safe clean, homelike environment was staff failure to follow procedures to report a discrepancy in a safe, clean, homelike environment for needed repairs. On 4/6/2018 room 110 N bathroom was repaired for a hole in the wall, and paint chipping by the resident□s bed and the window by the Maintenance Supervisor. On 4/6/2018 room 205 S was repaired for chipped paint by the door and bathroom door by the maintenance supervisor. On 4/6/2018 room 104N hole in the wall was repaired by the maintenance supervisor. On 4/20/2018 the floor tiles were replaced in room 102E by the maintenance supervisor. On 4/24/2018 room 208 S floor tiles were replaced by the maintenance supervisor. On 4/23/2018 floor tiles were replaced by the maintenance supervisor. On 4/6/2018 the privacy curtain in room 103E was removed and cleansed by an	

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F 584	Continued From page 7 bathroom door were noted to have chipping paint. An interview with the maintenance supervisor occurred on 4-6-18 at 2:12pm who stated that the maintenance staff was working on repairing and painting the walls but that it was a slow process. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 1d: Room 104N was observed on 4-6-18 at 1:39pm. A hole was noted in the resident's wall above the bathroom door. The resident stated he did not know how it got there but that it had been there "for a long time." The maintenance supervisor was interviewed on 4-6-18 at 2:13pm and stated he had not received a work order for the hole in the wall so he was not aware it was there. He also stated he would have it repaired. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 2a: An observation of room 102E occurred on 4-3-18 at 2:39pm at which time black streaks were noted on the resident's floor by her sink. Room 102E was observed again on 4-6-18 at 1:40pm and there were black streaks on her floor from the corner of her closet to the corner of the wall leading into her bathroom. An interview with the environmental supervisor occurred on 4-6-18 at 2:14pm. He stated the marks did not come up with regular mopping because "it is the structural line and when the tile was placed the stuff used to place the tile came through." An interview with the Administrator occurred on	F 584	environmental worker. On 4/6/2018 the heating and cooling vent in room 104N was cleansed by the environmental supervisor. On 4/6/2018 in room 103 E the disposable glove holder was repaired by the maintenance supervisor. On 4/6/2018 the toilet tissue holder were replaced by the maintenance supervisor in room # 110 N and 228 S. On 4/11/2018 an in-service was initiated by the maintenance supervisor for all staff on the procedure of completing a work order for repairs identified in regards to holes in walls, missing toilet tissue holders or crooked glove receptacles. The in service was completed on 4/19/2018 by the maintenance supervisor. All new hires will be in serviced during orientation. On 4/11/2018 the environmental supervisor conducted an in service with all housekeepers on the observations and reporting of unidentified brown substances on heating and cooling vents. All new hires will be in serviced during orientation. On 4/9/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor in regards to holes in resident□s room walls. 11 resident rooms were identified and repairs initiated by the maintenance supervisor and supply clerk with completion on 4/27/2018.	

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F 584	Continued From page 8 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 2b: Room 208S was observed on 4-4-18 at 9:20am to have a brown substance in the resident's bathroom around the toilet and in front of the sink. Another observation of room 208S was made on 4-6-18 at 1:41pm at which time the brown substance remained around the toilet and in front of the residents sink. The environmental supervisor was interviewed on 4-6-18 at 2:15pm who stated he was aware of the issue and that he had a list of rooms that his staff was working on but that the process was slow. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 2c: An observation of room 104N occurred on 4-4-18 at 10:33am. The floor behind the resident's door in the corner there was a buildup of a brown substance. Room 104N was observed again on 4-6-18 at 1:39pm where it was noted that the corner of the floor behind the resident's door remained stained with a brown substance. It was also noted that the resident's floor throughout his room had patches of brownish/yellow stains. An interview with the environmental supervisor occurred on 4-6-18 at 2:13pm. He stated that the stains are due to the "tile being old" and that the stains cannot be removed but did become lighter when the floors were polished. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a	F 584	On 4/11/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor on toilet tissue holder availability. 5 resident rooms were identified and completion of tissue holders placed in bathrooms was on 4/11/2018. On 4/9/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor in regards to glove receptacle holder. There were 4 receptacles that were replaced by the maintenance supervisor on 4/10/2018. On 4/9/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor on damaged, stained floor tiles. Resident room and bathrooms resulted in 72 areas needed for replaced floor tiles. 10% of occupied rooms will be replaced weekly by the maintenance supervisor. On 4/9/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor on all heating and cooling vents. 13 heating and cooling vents were identified to have an unidentified substance present. All heating and cooling vents were removed and cleansed by the housekeeping supervisor and staff with completion on 4/11/2018. On 4/9/2018 an audit was performed by the supply clerk, maintenance supervisor and environmental supervisor privacy	

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F 584	Continued From page 9 clean and safe manner. 3a: An observation of room 103E occurred on 4-3-18 at 10:33am at which time the privacy curtain between the 2 beds were noted to have brown colored stains. Another observation of room 103E was conducted on 4-6-18 at 1:35pm. The privacy curtain separating the 2 beds was noted to have brown colored stains. The environmental supervisor was interviewed on 4-6-18 at 2:12pm. He stated that the facility was in the process of cleaning all the privacy curtains but that the process was slow. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 3b: An observation of room 104N occurred on 4-6-18 at 1:39pm. An inspection of the heating and cooling vent revealed many black round shaped areas on the vent slats. An interview with the environmental supervisor occurred on 4-6-18 at 2:13pm. He stated he was unsure what the substance was but felt that "juice" may have been spilled into the vent. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. 4a: An observation of room 103E occurred on 4-3-18 at 10:33am. The room was found to have a disposable glove holder on the wall next to the door that was detached from the wall by 2 screws and hanging crooked. Room 103E was observed again on 4-6-18 at 1:35pm and was found to have a disposable	F 584	curtain identification of brown colored stains. No identified privacy curtain with brown colored stains noted as environmental supervisor was in the process of cleaning all privacy curtains on 4/6/2018 during recertification. The supple clerk, maintenance supervisor and environmental supervisor will audit 100% of toilet tissue holders in place, glove receptacles , privacy curtain and heating and cooling vents weekly x 4 weeks then 50% weekly x 8 weeks to ensure residents have a clean safe environment. This audit will be documented on a census sheet with printed date. . The monthly QI committee will review the results of the audits from the census sheets monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The maintenance supervisor is responsible for implementing the acceptable plan of correction.	

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F 584	Continued From page 10	F 584	.	

glove holder detaching from the wall and hanging crooked.
An interview with the maintenance supervisor occurred on 4-6-18 at 2:12pm who stated he was unaware of the problem and that staff should have put in a work order to fix the problem.
An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner.

4b: Room 208S was observed on 4-6-18 at 1:41pm at which time it was noted that the resident's toilet was leaning to the left and slightly loose from the floor.
The maintenance supervisor was interviewed on 4-6-18 at 2:15pm who stated he was aware of the problem and that the issue was on the list to be fixed but "we are working from most severe issues to less severe so I am not sure when it will be completed but it is on the list."
An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner.

4c: An observation of room 110N was completed on 4-4-18 at 1:56pm at which time it was noted that the resident did not have a toilet paper holder in her bathroom.
Room 110N was observed again on 4-6-18 at 1:10pm and was found not to have a toilet paper holder in the bathroom.
The maintenance supervisor was interviewed on 4-6-18 at 2:10pm and stated that he was unaware of the issue but would make sure the issue was resolved.
An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her

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F 584	Continued From page 11 expectation was that the environment be kept in a clean and safe manner. 4d: An observation of room 228S occurred on 4-6-18 at 1:43pm. Upon observation of the bathroom, it was noted not to have a toilet paper holder present. The maintenance supervisor was interviewed on 4-6-18 at 2:20pm who stated he was unaware of the issue but that he would have it corrected. An interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated her expectation was that the environment be kept in a clean and safe manner. An interview with the maintenance supervisor occurred on 4-6-18 at 2:25pm who stated there were maintenance request slips and a box to place them in at each nurse's station. He went on to state that he checked each box every day. The environmental supervisor was interviewed on 4-6-18 at 2:26pm who stated his staff reported issues directly to him and that staff would do the same.	F 584		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		4/26/18

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F 637	Continued From page 12 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set assessment within 14 days of the hospice enrollment date for 1 of 2 residents reviewed for hospice care (Resident #4). Findings included: Resident #4 was admitted to the facility on 5/2/17 with the current diagnoses of dementia with behavioral disturbance, anxiety, and dementia. Resident #4's Minimum Data Set (MDS) dated 1/4/18 revealed the resident was rarely understand or never understood. The resident had long term and short term memory problems. The resident required extensive assistance with bed mobility and eating and total dependence with personal hygiene, toilet use, dressing and bathing. A physician's order dated 3/14/18 revealed the resident had a hospice consult. The resident was enrolled in hospice care on 3/14/18. Resident #4 had a significant change MDS dated 3/15/18 that was in progress. The MDS dated 3/15/18 had not been signed verifying the assessment completion or submitted as of 4/7/18. The MDS nurse was interviewed on 4/6/18 at 7:35 PM. She stated she was still working on a significant change assessment MDS for resident	F 637	F- 637 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. Resident #4 significant change assessment with an ARD of 3/15/2018 was not closed by the Minimum Data Set Coordinator within 14 day allotted time frame. Resident # 4 significant change assessment was completed on 4/10/2018. The completed assessment for resident # 4 was transmitted to the National Repository and accepted on 4/10/2018.	

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F 637	Continued From page 13 #4 and it was not complete. She stated the Care Area Assessment (CAA) was not completed and everyone involved in coding of the MDS had to complete their section and then she was the last person to sign off the MDS. She stated the other sections were not complete, which is why the MDS was incomplete. She stated that she typically had 14 days to complete a significant change for a resident. The administrator was interviewed on 4/6/18 at 7:44 PM. She stated that she would expect for significant change assessments to be completed within 14 days.	F 637	On 4/6/2018 a 100% audit of resident with the criteria for significant changed was completed by the Minimum Data Set Coordinator. Any residents identified to have a significant change assessment not completed within the 14 day requirement had a significant change assessment completed and accepted at the National Repository on 4/10/2018. On 4/20/2018 the Minimum Data Set Coordinator was in serviced by corporate office RAC-CT Reimbursement Auditor on significant change to be completed within 14 days of the election of Hospice services. The date of election and 13 days thereafter to conclude 14 days. All new hire Minimum Data Set nurses will be in service during orientation. On 4/10/2018 2018 the interdisciplinary team was in serviced on the communication tool in Point Click Care to alert the team of a significant change assessment and the completion date by the administrator. All members of the interdisciplinary team were reeducated on the daily morning meeting that requested information of significant change assessment were to include date of opening and completion of assessments on 4/9/2018. The interdisciplinary team consist of the Minimum Data Set Coordinator, Social Worker, Dietary Manager, Rehabilitation Manager and Activity Director. A monitoring tool titled MDS Significant Change Audit Tool was developed to	

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F 637	Continued From page 14	F 637	ensure significant change assessments were completed in 14 days according to RAI manual v.1.13. The Assistant Dietary Manager will monitor all significant change assessments to ensure that they were completed within 14 days. A Quality Improvement team was initiated consisting of the, Minimum Data Set Coordinator, Dietary Manager, Assistant Dietary Manager, Rehabilitation Manager, Activity Director and Interim Director of Nursing. The Assistant Dietary Manager will present to the Quality Improvement Committee the auditing tool for evaluation of the plan. The Administrator will be notified immediately for any identified deficient practices. The Quality Improvement team will meet weekly X 8 weeks, then bimonthly X2 month□s then, monthly X 2 months to assess the completion of significant change assessments with 14 days according to the RAI manual v.1.13. The Administrator and / or Director of Nursing will report quarterly to the executive Quality Improvement Committee X 2 quarters. The Executive Improvement Committee consist of, Medical Director, Director of Nursing, Social Worker, Dietary Manager, Medical Records Supervisor, Activity Director, Pharmacy Consultant ,and the Administrator. The first Executive Quality Improvement meeting was on April 25, 2018 and the significant change deficient practice was discussed. All recommendations to continue, alter or modify the plan will be explored at that	

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F 637	Continued From page 15	F 637	time. Recommendations were debated to continue the transmission and acceptance of significant change assessments within 14 days per RAI manual. The Minimum Data Set Coordinator is responsible for implementing the acceptable plan of correction.	
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the correct discharge status for 1 of 2 residents (Resident #123) reviewed for community discharge and the facility failed to accurately code the MDS to reflect insulin administration for 1 out of 5 residents (Resident #104) reviewed for unnecessary medications. Findings included: 1. Resident # 123 was admitted to the facility on 1/10/18 with diagnoses that included pneumonia and cognitive communication deficit. a. A review of the resident's most recent MDS dated 1/16/18 was coded as a discharge tracking assessment. The assessment had documentation of the resident being discharged to the community.	F 641	F641 The plan of correcting the specific deficiency 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	4/28/18

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F 641	Continued From page 16 b. A review of a physician order dated 1/16/18 that read: Transfer to ER for further evaluation. c. A review of a nursing note dated 1/16/18 read: Resident would not awaken for therapy. He would not wake up long enough to eat or drink anything this shift. Vitals signs within normal limits. Respirations had become shallow and rapid. This writer called residents RP (Responsible Party) and asked her what measures she wanted to take as far as sending him to hospital or making him a DNR. She wanted the hospital. MD called and resident was sent to hospital for evaluation. d. During an interview with the MDS coordinator on 4/5/18 at 11: 31 am, she indicated the resident was discharged to the hospital. She further stated the assessment was not accurate and would modify the assessment today. 2. Resident #104 was admitted to the facility on 9/22/17 with diagnoses that included unspecified dementia, Alzheimer's disease, unspecified, Chronic Obstructive Pulmonary Disease, hypertension, heart failure, Type 2 Diabetes Mellitus with unspecified complications, and low back pain. a. A review of Resident #104's most recent MDS was coded as a quarterly assessment and was dated for 3/9/18. The MDS coded the resident as cognitively impaired. Resident 104's active diagnoses included heart failure, hypertension, diabetes mellitus, Alzheimer's disease, Non Alzheimer's dementia, chronic obstructive pulmonary disease, and low back pain. The MDS coded Resident 104 as having no insulin injections in the seven day look back period.	F 641	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. The position of Maple Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to code comprehensive assessment (MDS) accurately- was staff failure to follow established policy and procedure. Resident # 123□s MDS assessment dated 1/16/18 was modified to accurately reflect residents discharge to hospital on 4/6 /2018 by Minimum Data Set Coordinator Resident # 104□s MDS assessment dated 3/9/18 was modified to accurately reflect resident□s insulin injections on 4/5/2018by Minimum Data Set Coordinator. On 4/27/2018 the administrator conducted an audited all residents to ensure comprehensive assessments are accurate for discharge location and insulin injections scheduled for the past 30 days .The audit reviewed no required adjustment for discharged residents or residents receiving insulin injections . On 4/27/2018 the MDS coordinator was in-serviced on accuracy of MDS assessments including discharge disposition and insulin injections based on the resident assessment instrument (RAI) manual by the title. Any newly hired MDS	

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F 641	Continued From page 17 b. A review of Resident 104's MAR (medication administration record) revealed the resident received Lantus injection 60 units every night from 3/2/18-3/9/18. c. An interview was conducted with the MDS coordinator on 4/6/18 at 6:29pm. She reported Resident 104's MDS was coded incorrectly for injections. She reported "he was on insulin." The MDS coordinator reported she will correct the MDS and resubmit the assessment.	F 641	coordinator will be in-serviced. The administrator, or director of nursing will audit 100% of MDS assessments complete and submitted to the national repository weekly x 4 weeks then 50% weekly x 8 weeks to ensure assessments were submitted. This audit will be documented on the MDS audit tool. The monthly QI committee will review the results of the fall and MDS audit tools monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction.	
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		4/28/18

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F 657	Continued From page 18 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to update the residents' care plans for 7 of 37 residents for which care plans were reviewed for (Resident #5, Resident #69, Resident #16, Resident #50, Resident #326, Resident #324, Resident #58). Findings included: 1. Resident #5 was admitted on 11/4/17 with the diagnoses of respiratory failure, muscle weakness, depression. The resident had care plans in place for risk for a urinary tract infection (last revised 12/11/17), potential for constipation (last revised on 12/11/17), diabetes mellitus (last revised on 7/7/17 and last reviewed on 11/1/17),	F 657	F657 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	

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F 657	Continued From page 19 Hypertension (last revised on 12/11/17), ineffective breathing pattern (last revised on 12/11/17), falls (last revised on 7/7/17 and last reviewed on 11/1/17), adverse reactions to medications (last revised on 12/11/17), pain management (last revised on 12/11/17), skin breakdown (last revised on 12/11/17). The entire care plan stated that it was last reviewed on 11/1/17. Resident #5's Quarterly Minimum Data Set (MDS) dated 3/20/18 revealed the resident was cognitively intact. The resident required extensive assistance with bed mobility and total assistance with transfers, locomotion, dressing, toilet and personal hygiene and bathing. Resident #5 was not steady with surface to surface transfers, had an ostomy and was always incontinent of urine. The social worker was interviewed on 4/5/18 at 2:48 PM. She stated that the MDS nurse would update the care plans unless other staff initiated a new section of the care plan then they would be responsible for updating that section of the care plan. She also added that any discipline could initiate a care plan. The social worker was interviewed again on 4/5/18 at 4:44 PM. The "review history" tab was the date the care plan had last been reviewed. The MDS nurse was interviewed 4/6/18 at 2:22 PM. She stated that she has been in the MDS position since mid-January, 2018. She stated she was responsible for updating the care plan as of now. She stated that if the resident had an acute change then she would update care plan and the MDS would trigger for her to review. She stated that after she reviewed the MDS then she would	F 657	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. The position of Maple Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency-failure to update care plans timely- was staff failure to follow established policy and procedure. Resident # 5, 69, 16, 50, 324, 326, and 58□s care plans were reviewed by the IDT on 4/27/2018 .This review was documented in each of the resident□s medical record. On 4/27/2018 the Assistant Dietary Manager conducted an audit on current residents to ensure care plans have been reviewed within the last 90 days. Any identified care plans during the audit were reviewed at that time. On 4/17/2018 the MDS coordinator, social worker, assistant dietary manager, and assistant activity director were in-serviced on care plan reviews by the administrator. Any newly hired MDS coordinator will be in-serviced. On 4/27/2018 the MDS Coordinator was in serviced by the administrator to open a new review of care plan with MDS assessment for all disciplines to review, or revise.	

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F 657	Continued From page 20 go in and set a new date for the care plan to be updated. She added that under the review history the completion date was when the care plan was last updated and each person of the team has to review their own section of the care plan. After each section was reviewed, then she would close the care plan, indicating that the care plan had been reviewed. She stated that Resident 5's quarterly MDS was completed on 3/20/18 and the resident's care plan had not yet been reviewed. She stated that she would open the care plan up today so that the care plan sections can be reviewed by the staff. The administrator was interviewed on 4/6/18 at 10:46 AM. She stated she was unable to say specifically who could update the care plan but that the inter-disciplinary team were responsible for updating the care plans. The administrator was interviewed again on 4/6/18 at 12:45 PM. She stated that the bottom of the care plan stated the date the care plan was last reviewed. She stated that the MDS nurse was responsible for updating the care plan for some of the nursing care areas. Other staff members have a calendar that tells them when to update the care plan. The administrator was interviewed on 4/6/18 at 7:44 PM. She stated that she would expect the care plan to be updated in a timely manner and with the quarterly MDS assessments. 2. Resident #69 was admitted to the facility on 11/7/2007 with the diagnoses of cerebral palsy, diabetes and heart failure. Resident #69's Quarterly Minimum Data Set	F 657	The administrator, or director of nursing will audit 100% of MDS assessments completed and submitted to the national repository weekly x 4 weeks then 50% weekly x 8 weeks to ensure care plans were updated. This audit will be documented on the MDS audit tool. The monthly QI committee will review the results of the fall and MDS audit tools monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction. .	

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F 657	Continued From page 21	F 657		

(MDS) dated 2/19/18 revealed the resident was cognitively intact. The resident had verbal behavioral symptoms directed toward others 1-3 days. The resident required extensive assistance with mobility and total dependence with transfers, dressing, toilet use and personal hygiene. The resident had an indwelling catheter and an ostomy.
The resident had care plans in place for recreation (last reviewed on 12/11/17), bathing (last reviewed on 12/11/17), personal hygiene (last reviewed on 12/11/17), dressing (last reviewed on 12/11/17), transfers (last reviewed on 12/11/17), toileting (last reviewed on 12/11/17), problematic manner (last reviewed on 12/11/17), decline in intellectual functioning (last reviewed on 12/11/17), risk for infection (last reviewed on 12/11/17), allergies (last reviewed on 12/11/17), (last reviewed on 12/11/17), Diabetes (last reviewed on 12/11/17), falls (last reviewed on 12/11/17), feelings of sadness (last reviewed on 12/11/17), psychotropic drugs (last reviewed on 12/11/17), impaired vision (last reviewed on 12/11/17).

Resident #69's Quarterly Minimum Data Set (MDS) dated 2/19/18 revealed the resident was cognitively intact. The resident had verbal behavioral symptoms directed toward others 1-3 days. The resident required extensive assistance with mobility and total dependence with transfers, dressing, toilet use and personal hygiene. The resident had an indwelling catheter and an ostomy.
The social worker was interviewed on 4/5/18 at 2:48 PM. She stated that the MDS nurse would update the care plans unless other staff initiated a new section of the care plan then they would be responsible for updating that section of the care

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plan. She also added that any discipline could initiate a care plan.

The social worker was interviewed again on 4/5/18 at 4:44 PM. The "review history" tab was the date the care plan had last been reviewed.

The MDS nurse was interviewed 4/6/18 at 2:22 PM. She stated that she had been in the MDS position since mid-January, 2018. She stated she was responsible for updating the care plan as of now. She stated that if the resident had an acute change then she would update care plan and the MDS would trigger for her to review. She stated that after she reviewed the MDS then she would go in and set a new date for the care plan to be updated. She added that under the review history the completion date was when the care plan was last updated and each person of the team had to review their own section of the care plan. After each section was reviewed, then she would close the care plan, indicating that the care plan had been reviewed. She stated that resident #69's care plan review needed to be opened and reviewed by the staff. She stated that she just opened the care plan to be reviewed. Resident #69's MDS was dated 2/19/17 and the care plan should have been reviewed after the quarterly MDS was complete.

The administrator was interviewed on 4/6/18 at 10:46 AM. She stated she was unable to say specifically who could update the care plan but that the inter-disciplinary team were responsible for updating the care plans.

The administrator was interviewed again on 4/6/18 at 12:45 PM. She stated that the bottom of the care plan stated the date the care plan was

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last reviewed. She stated that the MDS nurse was responsible for updating the care plan for some of the nursing care areas. Other staff members have a calendar that tells them when to update the care plan.

The administrator was interviewed on 4/6/18 at 7:44 PM. She stated that she would expect the care plan to be updated in a timely manner and with the quarterly MDS assessments.

Findings included:

3: Resident #16 was admitted to the facility on 4-28-16 with multiple diagnoses which included encephalopathy, congestive heart failure, delusional disorder and muscle weakness.
The Minimum Data Set (MDS) dated 1-12-18 revealed that resident #16 was cognitively intact and was coded as feeling down, trouble sleeping and a poor appetite for 2-6 days out of the week. The resident was also coded as independent with no assistance for bed mobility, transfers, walking in her room or corridor and locomotion on or off the unit, supervision with set up help only for dressing, toileting and personal hygiene and independent with set up help only for eating.

The care plan for resident #16 was last reviewed on 11-01-2017 with the following goals; Resident will be neat, clean and odor free, resident will express desire to be clean and have hair combed, resident will ask for and receive necessary assistance, resident will receive care in her choices and preferences, resident will be free of a urinary tract infection, resident will not

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experience a severe and/or anaphylaxis reaction, resident will be free of signs and symptoms of congestive heart failure as evidenced by normal breath sounds, heart rate and normal weight range, resident will be free from injury due to seizure activity, resident will have a reduction in seizures through medical management, resident will not develop a pressure ulcer and resident will not experience mental and psychological adjustment difficulties.

An interview with the MDS nurse occurred on 4-5-18 at 2:44pm. She stated she was the one who updated the care plans and that she did this every quarter or if there was a change in the resident. The MDS nurse also stated she did not know why the care plan for resident #16 was not updated or reviewed.

The interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated she expected care plans to be reviewed in a timely manner.

4: Resident #50 was admitted to the facility on 7-24-12 with multiple diagnoses which included cerebrovascular disease, cellulitis, neuropathy, anemia and systemic lupus.

The Minimum Data Set (MDS) dated 2-5-18 revealed that resident #50 was cognitively intact and that he had trouble concentrating for 2-6 days out of the week. Resident #50 was also coded as needing extensive assistance with 2 people for bed mobility and transfers, extensive assistance with one person for dressing, independent with one person assistance for eating and total assistance with one person for toileting and personal hygiene.

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Resident #50's care plan was last reviewed 0n 10-27-17 with the following goals; resident will participate in daily out of room activities and attend 3-5 activities without prompting per week, resident will be neat, clean and odor free, resident will maintain good hygiene, resident will be appropriately dressed, resident will receive the necessary physical assistance to transfer, contractures of the right arm will not worsen, resident will move about in bed with assistance, resident will not have any falls, resident will ask for and receive necessary assistance in toileting, resident will wait his own turn for care or assistance from staff, resident will make request of staff politely, resident will accept care, resident will exhibit sexual behavior within the privacy of his own room, resident will be free of urinary tract infection, resident will not exhibit signs and symptoms of anemia, resident will be free of signs or symptoms of bleeding, resident will maintain a normal blood pressure with medications and diet, resident will be free of injury due to seizure activity, resident will be free of falls, resident will maintain mood, resident will continue to use bed rails safely, resident will show minimal to no side effects from medications and resident will not have any skin integrity impairment without appropriate nursing interventions.

An interview with the MDS nurse occurred on 4-5-18 at 2:44pm. She stated she was the one who updated/reviewed the care plans and that she did this every quarter or if there was a change in the resident. The MDS nurse also stated she did not know why the care plan for resident #50 was not updated or reviewed.

The interview with the Administrator occurred on

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4-6-18 at 2:45pm at which time she stated she expected care plans to be reviewed in a timely manner.

5: Resident #324 was admitted to the facility on 4-6-17 with multiple diagnoses which included dorsalgia, end stage renal disease, anxiety and cerebrovascular disease.

The Minimum Data Set (MDS) dated 2-20-18 revealed that resident # 324 was cognitively intact and was coded as independent with no assistance for bed mobility, transfers and toileting, independent with set up assistance for dressing, eating and personal hygiene. Resident #324 was coded for dialysis.

The care plan for resident #324 was last reviewed on 10-27-17 with the following goals; resident will not experience complications from dialysis treatment without appropriate interventions and will have sufficient fluid balance, resident will participate in out of room activities as desired and verbalize enjoyment of one activity after participating, resident will assist staff with appropriate planning and activity provision, resident will maintain adequate nutrition, resident will receive the necessary physical assistance to transfer, resident will maintain or increase mobility function, resident will ask for and receive the necessary assistance, resident will have a decrease in frequency of hallucinations, resident will be free of signs or symptoms of hyper/hypoglycemia, resident will maintain blood pressure within normal limits, resident will be free of falls, resident will not develop a pressure ulcer, resident will show minimal to no side effects of medication, resident will not experience any mental or psychological adjustment difficulties

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and will receive care and services to assist resident in reaching or maintaining highest level of mental and psychological functioning.

An interview with the MDS nurse occurred on 4-5-18 at 2:44pm. She stated she was the one who updated the care plans and that she did this every quarter or if there was a change in the resident. The MDS nurse also stated she did not know why the care plan for resident #324 was not updated or reviewed.

The interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated she expected care plans to be reviewed in a timely manner.

6: Resident #326 was admitted to the facility on 2-3-17 with multiple diagnoses which included cellulitis, hemiplegia and hemiparesis effecting right side and dementia.

The Minimum Data Set (MDS) dated 1-30-18 revealed that resident #326 was as coded as having long and short term memory loss with severe impairment. The resident was coded as being short tempered 2-6 days out of the week and needing total care with one assistance for bed mobility, dressing and personal hygiene, total care with 2 people for transfers and extensive assistance with one person for eating. The MDS also coded resident #326 as receiving hospice services.

Resident #326's care plan was last reviewed on 10-27-17 with a revision date of 3-16-18 with the following goals; resident will not experience pain without appropriate nursing interventions, resident will participate in 1:1 visits weekly by staff,

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resident will be neat, clean and odor free, resident will be appropriately dressed, resident will maintain adequate nutrition, resident will receive necessary assistance to transfer, resident will have no falls, resident will have no skin breakdown related to splint application of left hand palm guard, resident will receive timely incontinence care, resident will feel safe and secure, resident will have a decrease in episodes of playing with feces, resident will display appropriate response to situations, resident needs will be anticipated and met by staff, resident will be free of a urinary tract infection, staff will provide appropriate oral hygiene, resident will be free from fractures, resident will not sustain serious injury, resident will have an improved mood state, resident will maintain weight, resident will be free of pain, resident will show no side effects of medication.

An interview with the MDS nurse occurred on 4-5-18 at 2:44pm. She stated she was the one who updated the care plans and that she did this every quarter or if there was a change in the resident. The MDS nurse also stated she did not know why the care plan for resident #326 was not updated or reviewed. She also stated that she could not show or remember what revisions she had made to the care plan because she had not documented the changes.

The interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated she expected care plans to be reviewed in a timely manner.

7: Resident #58 was admitted to the facility on 6-3-17 with multiple diagnoses which included dementia, delirium, muscle weakness and a

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urinary tract infection.

The Minimum Data Set (MDS) dated 2-9-18 revealed that resident #58 had long and short term memory issues with moderate impairment. Resident #58 was also coded as feeling tired with a poor appetite for 2-6 days out of the week and needing total assistance with one person for bed mobility, dressing, toileting and personal hygiene and independent with one person assistance for eating.

The care plan for resident #58 was last reviewed on 11-29-17 with the following goals; resident will not develop a pressure ulcer, resident will be free of pain, resident will not have any signs or symptoms of a urinary tract infection, resident will be neat, clean and odor free, resident will show ability to hear by answering appropriately, resident will not experience a severe and or anaphylaxis reaction, resident will have normal pace maker functions, will continue to use bed rails safely, staff will provide an adjustment in care to reflect residents usual and customary routines, resident will demonstrate adequate vision in her right eye, resident will have no injuries and feel safe in the environment.

An interview with the MDS nurse occurred on 4-5-18 at 2:44pm. She stated she was the one who updated and reviewed the care plans and that she did this every quarter or if there was a change in the resident. The MDS nurse also stated she did not know why the care plan for resident #58 was not updated or reviewed.

The interview with the Administrator occurred on 4-6-18 at 2:45pm at which time she stated she expected care plans to be reviewed in a timely

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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to have a physician order for the use and replacement of an indwelling urinary catheter for 1 of 3 residents sampled for urinary catheters. (Resident # 82) Findings included: Resident #82 was admitted to the facility on 11/21/2018 from the hospital with diagnoses which included chronic diastolic congestive heart failure, acute systolic, and essential hypertension. Review of the quarterly Minimum Data Set (MDS) dated 2/27/18 revealed resident was cognitively intact, dependent on staff for toileting, coded for catheter use with pressure ulcers. Record review of the admission and monthly physician's orders for November 2017 and December 2017 revealed no physician order for the use of a urinary indwelling catheter. Review of the progress notes dated 12/23/17 at 8:58 AM revealed resident complained of pain and burning. The indwelling urinary catheter was changed.	F 658	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. The position of Maple Grove Nursing and Rehabilitation center regarding the process that lead to this deficiency- staff	4/29/18

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F 658	Continued From page 31 Review of the January 2018 monthly physician orders revealed a handwritten order for an indwelling urinary catheter size 14 French to straight drainage due to a Stage 4 (advanced) sacral wound and change monthly or as needed for leakage or dislodgement. Review of the February 2018 monthly orders revealed no physician order for a urinary indwelling catheter. Review of the progress notes dated 2/15/18 at 3:25 PM revealed the indwelling urinary catheter was out . The catheter was replaced without difficulty. An interview and observation of Resident #82 on 04/03/18 at 2:50 PM revealed a urinary catheter was present. Resident #82 indicated the reason for the catheter was assisting in the healing of the advanced pressure ulcer. Interview on 04/06/18 at 11:31 AM with the Interim Director of Nurses (IDON) who stated her expectations for staff were to have physician orders for the use and the change of a urinary indwelling catheter. In addition the (IDON) indicated the orders for the indwelling catheter should have been transcribed onto the monthly orders upon review of the reconciliation for February 2018 physician orders. Nurse #14 that admitted Resident #82 and reviewed monthly orders for reconciliation was on leave and unable to be interviewed.	F 658	failure to document physician order for indwelling urinary catheter on Physician Order Sheet. Resident # 82 chart was reviewed by the Director of nursing on 4/6/2018 and a clarification order for an indwelling urinary catheter was written for pharmacy to carry over on Physician Order Sheets. . On 4/6 /2018 the Director of nursing conducted an audited on all residents to ensure that all resident physician orders for the use and replacement of an indwelling catheter was in place. No negative findings were revealed. On 4/9/2018 the Director of nursing initiated an in-service for all licensed nurses to ensure that the physician orders for indwelling urinary catheters included the use and the replacement. Completion of in-service for all licensed nurses was 4/19/2018. Any new hired licensed nurses will be in serviced in orientation. The administrator, or director of nursing will audit 100% of physician orders for the use and replacement of indwelling urinary catheters weekly x 4 weeks then 50% weekly x 8 weeks to ensure assessments were submitted. This audit will be documented on the catheter audit tool. The monthly QI committee will review the results of the physician orders for indwelling urinary catheters monthly for 3	

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F 658	Continued From page 32	F 658	months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations for monitoring for continued compliance. The administrator and/or DON will present the findings and recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight. The Director of nursing is responsible for implementing the acceptable plan of correction. .	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(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, record review, review of the manufacturer's instruction and staff interviews the facility failed to provide incontinent care in a manner to prevent the potential risk of a urinary tract infection. The facility failed to follow the manufacturer's instruction to rinse well after the use of the body wash. This was evident in 1 of 4 residents in the sample reviewed for activities of daily living. (Resident #105) Findings included: Review of the manufacturer's label on the	F 677	F-677 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.	4/26/18

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F 677	Continued From page 33 shampoo and body wash bottle indicated to gently cleanse the skin and rinse well. Resident #105 was admitted to the facility on 6/29/17 with cumulative diagnoses which included dementia with behavioral disturbances. Review of the quarterly Minimum Data Set (MDS) dated 3/12/18 revealed Resident # 105 had severe cognitive impairment, incontinent of urine and stool and totally dependent of 1 staff for personal hygiene and bathing. Review of the care plan revised 3/13/18 revealed in part: " Focus that resident required assistance to maintain maximum function for bathing related to dementia. The intervention included total assist by one staff with bathing. " Another focus required assistance maintain maximum function of incontinent care. The interventions/task included routine incontinent care. Observation of Resident #105 on 04/03/18 at 10:29 AM revealed Nursing Assistant #1(NA) bathed the resident's face with plain water. Shampoo and body wash was used to cleanse the skin on Resident's #105 back, under arms, chest and both legs. The water was soapy. Baby oil with Coco was then applied to the skin. The soiled brief was removed and Resident #105 had experienced an incontinent episode of urine and stool. NA #1 then stood the resident up with the assistance of a family member. Facing the resident, NA #1 cleansed the resident's perineal area starting from the rectum in a back to front motion several times. NA #1 placed the soiled washcloth in the soapy water then proceeded to	F 677	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. The position of Maple Grove health and Rehabilitation pertaining to the process that lead to the deficiency of failure to provide incontinent care to prevent the potential risk of a urinary tract infection. Also, the failure of the facility to follow manufacturer□s recommendation instruction to rinse well after the use of body wash for 1 of 4 residents observed was the staff□s failure to follow proper procedure for incontinent care and manufactures recommendation for rinsing well after body wash usage. The Certified Nursing Assistant #1 was in- serviced by the Interim Director of Nursing on 4 / 5/ 2018 for proper technique perineal care on dependent residents inclusive of rinsing skin after use of body wash. A Nursing Assistant Skills Checklist for bed bath and incontinence care was conducted by the Interim Director of Nursing on 4/5/2018 with Nursing Assistant #1. The resident # 105 was assessed on 4/ 5/2018 with no negative findings recovered by the Interim Director of Nursing.	

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F 677	Continued From page 34 wash Resident's #105 rectum and buttocks in a front to back motion. The body wash was never rinsed off the resident's skin. Interview on 4/5/18 at 2:50 PM with NA #1 revealed resident required total care. An inquiry was made on the proper techniques for female incontinent care. NA #1 stated while demonstrating with her hands staff should cleanse or wipe the perineal area from a back to front motion and was not aware the body wash required rinsing. Interview on 4/5/18 at 3:02 PM with the interim Director of Nurses revealed her expectation for staff would be to cleanse the perineal area in a front to back motion and expected the shampoo and body wash be rinsed off the skin after cleansing.	F 677	A 100% in service was initiated on all Certified Nursing Assistants on proper technique of incontinence care on dependent residents on 4/5 /2018 by the Interim Director of Nursing with completion on 4/19/2018. All new employment hires will be educated on the policy in orientation. A checklist for all Certified Nursing Assistants for proper technique for incontinence care on dependent residents was initiated on 4/5/2018 by the Interim Director of Nursing with completion on 4/25/2018 for all currently employed certified nursing assistants. All new employment hires will be receive completion of skills checklist in orientation. An audit tool for monitoring Certified Nursing Assistants technique for incontinence care on dependent residents initiated by the Interim Director of Nursing on 4/ 11/2018. The audit tool is titled ADL CARE Audit Tool for Dependent Residents. Performance of the tool will be 5 times weekly for 8 weeks on 10% of the census population, then 3 times weekly for 2 months on 10% of the census, then twice weekly X 2 months of 10% of the census. A Quality Improvement team was initiated consisting of the Interim Director of Nursing, Minimum Data Set Coordinator, Activity Director, Dietary Manager,	

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F 677	Continued From page 35	F 677	Assistant Activity Director, Manager, and Rehabilitation Manager. The Quality Improvement team will meet weekly X 8 weeks, then bimonthly X2 months then, monthly X 2 months to assess the proper technique of perineal care on dependent residents. The audit tool will be available for review of the Quality Improvement Committee for evaluation of plan. The Administrator and / or Director of Nursing will report quarterly to the executive Quality Improvement Committee X 2 quarters. The Executive Improvement Committee consist of, Medical Director, Interim Director of Nursing, Social Worker, Dietary Manager, Assistant Dietary Manager ,Medical Records Supervisor, Activity Director, Pharmacy Consultant ,and the Administrator. The first Executive Quality Improvement meeting was on April 25, 2018 and the proper technique of incontinence are and rinsing after use of body wash on dependent residents deficient practice was discussed. All recommendations to continue, alter or modify the plan will be explored at that time. Recommendations were considered to continue the current plan with emphasis on the Certified Nursing Assistants delivering incontinence care and rinsing skin after usage of body wash to dependent residents. The Interim Director of Nursing is responsible for implementation the acceptable plan of correction.	

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F 761	Continued From page 36	F 761		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to dispose of expired medications and unlabeled, opened medications in 1 out of 4 medication carts (South hall cart #2) and in 2 out of 2 medication storage rooms (East and South halls) and the facility failed to refrigerate medications in 1 out of 2 medication storage rooms (East Hall) that are used to supply medications for the residents of the facility.	F 761	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	4/28/18

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F 761	Continued From page 37 Findings include: 1. a. An observation was conducted on 4/6/18 at 2:26pm of the South Hall Medication Room with Nurse #10 present. In the locked box for narcotics in the refrigerator, it was revealed one syringe with Lorazepam O.5mg/ml had expired on 4/4/18. Nurse #10 removed the syringe to be discarded. b. An observation was conducted on 4/6/18 at 3:32pm of the East Hall Medication Room with Nurse #11 present. It was revealed in the refrigerator there was an opened vial of Mantoux that was not labeled with a date opened. Nurse #11 removed the vial to be discarded. It was also revealed there were 2 100cc bags of Vancomycin lying on the counter. Both bags were labeled to keep refrigerated. Both bags of Vancomycin felt at room temperature. Nurse #11 reported she did not know when the medications had arrived. c. During an observation conducted of the South Hall medication cart #2 on 4/6/18 at 3:55pm with Nurse #12 present, it was revealed that there was a bottle of liquid Potassium Chloride, a bottle of Valproic Acid 250mg/5ml, and a bottle of Siltussin SA opened but not dated. Nurse #12 removed the bottles to be discarded. An interview was conducted on 4/6/18 at 4:10pm with the MDS nurse who was also passing medications on the East hall for first shift today. The MDS nurse reported all new medications are delivered at night and the third shift nurses are to put away the medications in the correct area. She stated the third shift nurse left her a 100cc bag of Vancomycin to hang at 9:00am in her medication cart so she did not go in medication room today. An interview was conducted on 4/6/18 at 4:17pm with the DON (Director of Nursing). The DON	F 761	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 The position of Maple Grove Health and Rehabilitation center regarding the process that lead to this deficiency-failure to properly dispose of expired, 1 out of 4 medication carts, open unlabeled medications in 2 out of 2 medication storage rooms and the facility failed to refrigerate medications in 1 out of 2 medication storage rooms. The staff failure to follow policies for labeling of expired, unlabeled, and required refrigerated medication. On 4/6/18, Nurse #10 removed a syringe to be discarded with Lorazepam O.5mg/ml which had expired on 4/4/18. Nurse #11 removed the vial to be discarded of opened Mantoux that was unlabeled. Interim Director of Nursing removed 2 100cc bags of Vancomycin, both bags required refrigeration. Nurse #12 removed a bottle of liquid Potassium Chloride, a bottle of Valproic Acid 250mg/5ml, and a bottle of Siltussin SA all opened but not dated. On 4/6/18 the Interim Director of Nursing	

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F 761	Continued From page 38 reported that all medications including infusion medications are delivered around midnight. She reported it is her expectation that the nurse who signs for the medications puts the medications in the appropriate places including refrigerated medications in the refrigerator. She reported it is her expectation that each nurse checks for and disposes of any expired medications daily. The DON stated it is her expectation that each nurse is to date any opened medications when that medication is first opened.	F 761	completed an audit of all medication storage rooms including refrigerators, and cabinets. All expired, open unlabeled medications or, medications requiring refrigeration. No additional items discovered. On 4/6/18 an in-service was started by the Interim Director of Nursing on labeling of opened medications, and removal /disposal of expired medications per facility policy for all licensed nurses. This in-service was completed on 4/19/18. This in-service will be included with orientation for all newly hired licensed nursing staff. On 4/6/18 an audit tool was initiated by the Interim Director of nursing to monitor, expired, unlabeled, refrigerated medications. The Interim Director of Nursing, staff facilitator, facility consultant, and/or minimum data set nurse will audit 100% of medication storage rooms weekly x 4 weeks then 50% weekly x 8 weeks to ensure no expired or open but undated medications are present. This audit will be documented on the medication storage audit tool. The monthly QI committee will review the results of the medication storage audit tool monthly for 3 months for identification of trends, actions taken, and to determine the need for and/or frequency of continued monitoring, and make recommendations of the monthly QI committee to the quarterly executive QA committee for further recommendations and oversight.	
F 809	Frequency of Meals/Snacks at Bedtime	F 809		4/26/18

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F 809 SS=D	Continued From page 39 CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, resident council representative interviews, staff interviews and record reviews, the facility failed to offer or deliver bedtime snacks to residents residing on 4 of 5 Resident Care Units. (North, South, East and West) The findings included: Interview on 04/05/18 at 10:30 AM during the Resident Council meeting revealed 10 of 12 residents who attended the resident council meeting indicated no bedtime snacks were provided except for residents who were on special diets.	F 809	F □ 809 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	

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F 809	Continued From page 40 Observation on 04/05/18 at 8:15 PM revealed the Cook delivered snacks to the North and South Hall that were labeled with resident names. An inquiry was made about the snacks and the Cook stated these were planned snacks which are delivered daily at 2 PM and 8 PM. An inquiry was made about snacks for residents not on a planned diet. The Cook stated that residents that are not on a planned snack or want a snack can come to the kitchen and request a PM snack or have a staff nurse come to the kitchen. Observation on 04/5/18 at 8:20 PM revealed planned snacks had been delivered to the West unit. Interview at this time with Nursing Assistant #2 (NA) revealed the snacks delivered were for diabetic residents only. Observation on 04/5/18 at 8:23 PM in the nourishment refrigerator revealed 1 cup of sherbet and 4 Magic cups (frozen nutrient supplement). Interview on 4/5/18 at 8:25 PM with NA #3 revealed snack are given to residents if they are diabetics or part of their diet. Interview on 4/5/18 at 8:30 PM with NA #4 who stated she passed out snacks that are labeled with a resident name. Interview on 04/06/18 at 4:20 PM with the Food Service Manager (FSM) revealed she had a list of bedtime (HS) snacks available for all residents that do not receive planned snacks. The FSM provided the planned snack list only. At 5 PM on 04/06/18, another inquiry was made and the FSM indicated that there was no other list of snacks.	F 809	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. The position of Maple Grove that lead to the alleged deficient practice of the facility that failed to deliver snacks to residents residing on 4 of 5 resident units was staff failure to deliver snacks although staff provided snacks upon request. Residents were informed that snacks will be available to them at night by way of a resident council meeting on April 12, 2018 by the Activiti Director. Dietary staff were in serviced on the Week at a Glance on the menu for bulk hour of sleep snacks, delivery and availability by the Dietary Manager with 100 % completion on 4/19/2018. Dietary staff were also in serviced by the dietary manager on a log audit tool to be competed daily by the dietary staff to ensure bulk hour of sleep snacks were delivered according to the Week at a Glance on the menu, 100% completion on 4/19/2018. An in service will be conducted on all new hires in orientation. An In-service was initiated on 4/11/2018 for all dietary and nursing staff to the location in each nourishment room for bulk hour of sleep snacks for all residents with 100% completion on 4/19/2018. All new hires will receive in service during orientation.	

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F 809	Continued From page 41 Interview on 04/06/18 at 4:29 PM with the administrator who stated her expectation was that all residents be offered HS snacks.	F 809	A monitoring tool title Snack Log was comprised for the Dietary and Assistant Dietary manager to audit the delivery of bulk hour of sleep snacks. The tool was utilized 4/11/2018 by the dietary and assistant dietary manager. The tool will be utilized by the Dietary Manager and Assistant Dietary Manager weekly X 8 weeks, then bimonthly X 2 months, then monthly X2. A Quality Improvement team was initiated consisting of the Administrator, Minimum Data Set Coordinator, Dietary Manager, Assistant Dietary Manager Rehabilitation Manager, Activity Director and Director of Nursing . The Quality Improvement team will meet weekly X 8 weeks, then bimonthly X2 months then, monthly X 2 months to assess the delivery of bulk hour of sleep snacks. The Dietary and Assistant Dietary Manager will present the auditing tool to the Quality Improvement Committee for evaluation of the plan. The Administrator will be notified immediately for any identified deficient practices. The Administrator and / or Director of Nursing will report quarterly to the Executive Quality Improvement Committee X 2 quarters. The Executive Improvement Committee consist of, Medical Director, Director of Nursing, Social Worker, Dietary Manager, Assistant Dietary Manager ,Medical Records Supervisor, Activity Director, Pharmacy Consultant ,and the Administrator.	

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F 809	Continued From page 42	F 809	The first Executive Quality Improvement meeting was on April 25, 2018 and the delivery of bulk hour of sleep snacks alleged deficient practice was discussed. All recommendations to continue, alter or modify the plan will be explored at that time. Recommendations were debated to continue the current plan with emphasis on the delivery and availability of snacks to all residents at hour of sleep. The Dietary Manager is responsible for implantation of this plan on correction.	
F 867 SS=D	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 4/7/2017 annual recertification survey. This was for 4 recited deficiencies in the areas of: Comprehensive Assessment after Significant Change (was F274 and now F637), Accuracy of Assessments (was F278 and now F641), Care Plan Timing and Revision (was F280 and now F657), and QAPI/QAA Improvement activities (was F520 and now F867). Findings include:	F 867	F 867 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	4/28/18

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F 867	Continued From page 43 This tag is cross referenced to: 1. F637 (was F274) Comprehensive Assessment after Significant Change - Based on record review and staff interviews, the facility failed to complete a significant change Minimum Data Set assessment within 14 days of the hospice enrollment date for 1 of 2 residents reviewed for hospice care (Resident #4). During the recertification survey dated 4/7/17, the facility was cited for F274 for failing to complete a significant change in status MDS assessment for 1 of 5 residents reviewed for unnecessary medications (Resident #105) and complete a significant change in status MDS assessment for 1 of 1 resident (Resident #124) who was started on hospice services. 2. F641 (was F278) Accuracy of Assessments - Based on record reviews and staff interviews, the facility failed to accurately code the MDS (Minimum Data Set) to reflect the correct discharge status for 1 of 2 residents (Resident #123) reviewed for community discharge and the facility failed to accurately code the MDS to reflect insulin administration for 1 out of 5 residents (Resident #104) reviewed for unnecessary medications. During the recertification survey dated 4/7/17, the facility was cited for F278 for failing to accurately code the oral status on the MDS in 1 of 3 residents (Resident #92) reviewed for dental services and accurate code the MDS to reflect PASARR (Preadmission Screening and Resident Review) level 2 for 1 of 1 resident (Resident #21) reviewed for PASARR. 3. F 657 (was F280) Care Plan Timing and Revision - Based on record review and staff interviews, the facility failed to update the residents' care plans for 7 of 37 residents for which care plans were reviewed for (Resident #5,	F 867	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. The position of Maple Grove Health and Rehabilitation center regarding the process that lead to this deficiency-failed to maintain implemented procedures and monitor interventions- was failure to follow established facility policy related to QAPI. On 4/25/2018 the facility QAA Committee held a meeting to review the purpose and function of the QAA committee and review on-going compliance issues. The Administrator, DON, MDS nurse, MDS Coordinator, maintenance director, Supply Clerk, Dietary Manager, Assistant Dietary Manager and Housekeeping Supervisor will attend QAPI Committee Meetings on an ongoing basis and will assign additional team members as appropriate. On 4/26/2018 the corporate facility consultant in-serviced the administrator related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to	

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F 867	Continued From page 44 Resident #69, Resident #16, Resident #50, Resident #326, Resident #324, Resident #58). During the recertification survey dated 4/7/17, the facility was cited for F780 for failing to invite the RP (Responsible Party) to participate in Care Plan meetings for 2 of 2 residents (Residents #147 and #8) reviewed for notification of participation in Care Plan meetings. 4. F867 (was F250) QAPI/QAA improvement activities - Based on staff interviews and record review, the facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 4/7/2017 annual recertification survey. During the recertification survey dated 4/7/17, the facility was cited for F520 for the QAA (Quality Assessment and Assurance Committee) failing to maintain implemented procedures and monitor interventions that the committee put into place following the 5/5/16 recertification survey. During the current annual recertification survey dated 4/6/18, the facility failed to maintain implemented procedures and monitor interventions that the committee put into place following the 4/7/17 annual recertification survey. An interview was conducted with the Administrator and the corporate nurse consultant on 4/6/18 at 8:26pm. The Administrator reported that the facility lost both MDS nurses at the same time and the facility is in the process of training the new MDS nurses. The Administrator reported she is the QAA committee leader and the committee consists of the director of nursing, the	F 867	F637-comprehensive assessments after a significant change , F867-QAPI/QAA, F641 accuracy of assessments , and F-657 care plan timing and revision. On 4/26/2018 the QIO Quality Advisor was consulted on site and will be available for further education, resource and ongoing support. On 4/27/2018 the administrator in-serviced the department heads related to the appropriate functioning of the QAPI Committee and the purpose of the committee to include identify issues and correct repeat deficiencies related to F641-accuracy of assessments, F867-QAPI/QAA, F-637 Comprehensive assessments after a significant change and, F - 657 care plan timing and revision. The Facility QAPI Committee will meet at a minimum of monthly and Executive QAPI committee meeting a minimum of quarterly to identify issues related to quality assessment and assurance activities as needed and will develop and implementing appropriate plans of action for identified facility concerns. Corrective action has been taken for the identified concerns related to F641-accuracy of assessments, F867-QAPI/QAA, F □ 637 comprehensive assessments after significant change and F □ 657 care plan timing and revision. The executive QAPI committee will	

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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 867	Continued From page 45 staff development coordinator, MDS nurse, admissions coordinator, dietary manager, social services director, activities director, and maintenance director. She reported the committee meets monthly but also assesses significant changes at the daily morning meetings. The corporate nurse consultant reported the facility had worked on ensuring that MDS assessments were coded accurately to reflect the resident's condition. The Administrator reported that the QAA committee will meet this month to discuss improvements and audits to ensure the assessments are being coded accurately and that the assessments are being completed when changes occur in the residents' conditions. She reported the MDS nurse will be given further education in the MDS process.	F 867	continue to meet at a minimum of Quarterly, and QAPI committee monthly with oversight by a corporate staff member. The Executive QAPI Committee, including the Medical Director, will review quarterly compiled QAPI report information, review trends, and review corrective actions taken and the dates of completion. The Executive QAPI Committee will validate the facility□s progress in correction of deficient practices or identify concerns. The administrator will be responsible for ensuring committee concerns are addressed through further training or other interventions. The administrator is responsible for implementation of the acceptable plan of correction.	
F 926 SS=D	Smoking Policies CFR(s): 483.90(i)(5) §483.90(i)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account nonsmoking residents. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews and record review the facility failed to permit safe smokers the opportunity to smoke whenever they choose. This was evident in 2 of 14 safe smokers. (Resident #34 and Resident #37)	F 926	F- 926 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	5/10/18

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 _____	04/06/2018

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F 926	Continued From page 46 Findings included: Review of the "Smoking Policy" revised 02/01/2018 read in part: Under Procedure: 3) b) When the Smoking Evaluation identifies a resident without any potential hazard risk and who is safe to smoke independently, the resident will be allowed to smoke unsupervised, at any time of his/her choice. Attached to the smoking policy was a sign that indicated smoking times were 10:00 AM -8:00 PM. Record review revealed the facility had 14 residents in the facility determined to be safe smokers. a. Resident #34 had a smoking evaluation to determine smoking safety on 3/2/18 and 4/4/18. The outcome of these evaluations indicated "a safe smoker and may smoke independently." Interview on 04/04/18 at 10:20 AM with Resident #34 revealed the entrance to the smoking area had a secured lock and the smoking hours are from 10 am -8 PM. Resident #34 stated he did not have a key to unlock the smoking area and sometimes he wanted to smoke after 8 PM but staff are busy putting residents to bed to unlock the door. b. Resident #37 had a smoking evaluation to determine smoking safety on 3/2/18 and 4/4/18. The outcome of these evaluations indicated "a safe smoker and may smoke independently." Interviews during the resident council meeting on 04/05/18 at 10:30 AM revealed Resident #37 stated he can only smoke during the designated smoking hours. Interview on 04/05/18 at 04:21 PM with the administrator and corporate representative was held. The administrator indicated smoking	F 926	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. The position of Maple Grove Health and Rehabilitation on the alleged deficient practice of the facility failing to permit safe smokers the opportunity to smoke whenever they choose was staff failure to follow policy regarding smoking policy for safe smokers. On April 5, 2018 an in service was initiated by the Administrator for staff to be aware that smoking times only pertain to supervised smoking residents. It also states that all unsupervised smoking residents are permitted to the designated smoking area at all times. 100% of staff inclusive of contracted services were completed on 4/19/2018. All new employment hires will be educated on the policy in orientation. For the avoidance of future confusion the signage stating Smoking Times was	

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F 926	Continued From page 47 restarted in the facility on 3/15/18 and she met with the resident council on 2/20/18 regarding the smoking policy. Further interview with the administrator revealed the safe smokers just informed her on 4/03/18 that they wanted access to the smoking area after 8 PM. The administrator stated her expectation of the facility was to respect the resident's right to smoke.	F 926	changed, and posted to Supervised Smoking Times 10 am □ 8 pm on April 9, 2018. A resident council meeting was held on April 12, 2018 with President of Resident Council and 13 members. The audience present were informed that unsupervised smoking is available to residents at any time. The resident council meeting was conducted by the Activities Director. A Quality Improvement team was initiated consisting of the Interim Director of Nursing, Minimum Data Set Coordinator, Dietary Manager, Assistant Dietary Manager, Rehabilitation Manager, Activity Director and the Assistant Activity Director. The Activity Director and /or Assistant Activity Director will present to the Quality Improvement Committee evaluation of the plan for supervised smoking resident to have availability to the designated smoking area at all times. The Administrator will be notified immediately for any identified deficient practices. The Quality Improvement team will meet weekly X 8 weeks, then bimonthly X2 month□s then, monthly X 2 months to assure that unsupervised residents have availability to the designated smoking area at all times. Documentation will be in the sign out book at the designated area for smokers. The Quality Improvement team met on April 18,2018. The Administrator and / or Interim Director of Nursing will report quarterly to the Executive Quality Improvement Committee X 2 quarters. The Executive Improvement Committee consist of,	

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F 926	Continued From page 48	F 926	Medical Director, Interim Director of Nursing, Social Worker, Dietary Manager, Medical Records Supervisor, Activity Director, Assistant Activity Director Pharmacy Consultant ,and the Administrator. The first Executive Quality Improvement meeting was on April 25, 2018 and the smoking alleged deficient practice was discussed. All recommendations to continue, alter or modify the plan will be explored at that time. Recommendations were debated to continue the current plan with emphasis on the policy of unsupervised residents allowed to smoke at any time as well as responsible parties.	