STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245462	A. Building B. Wing	12/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maranatha Care Center	5409 69th Avenue North Brooklyn Center, MN 55429

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43083 Based on interview and document review, the facility failed to ensure the Physician Orders for Life Sustaining Treatment (POLST) was reviewed and/or revised following a change in condition comprehensive assessment for 1 of 1 residents (R1) reviewed. Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of chronic kidney disease, dementia, and malignant neoplasm of sigmoid colon. Further, R1's cognition was noted to be moderately impaired. R1's POLST dated 9/13/24, which was signed by R1's health care agent and family member (FM)-A, indicated R1's wishes were to be do not attempt resuscitation (DNR), allow natural death, in the event R1 had no pulse and was not breathing, as well as comfort-focused treatment (allow natural death) to relieve pain and suffering through the use of any medications by any route, positioning, wound care, and other measures. Use oxygen, suction and manual treatment of airway obstruction as needed for comfort. Patient prefers no transfer to hospital for life-sustaining treatments. Transfer if comfort needs cannot be met in current location. R1's care conference summary printed 12/5/24, indicated a care conference was held on 11/21/24, with FM-A present. Further, the document revealed information shared included code status of DNR and comfort-focused treatment and to see R1's POLST for details. In addition, the questions: advanced directives reviewed with the resident/resident representative and does the POLST match the code status order were left blank and not completed by staff. The summary lacked evidence the POLST was reviewed with resident/resident representative. However, on 12/6/24, summary revealed revisions had been made by social services (SS)-A indicating advanced directives were reviewed with the resident/resident representative. (continued on next page)

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.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 12:03 p.m., FM-A indicated when R1 was admitted to the facility with hospice services and a POLST was completed for R1 by FM-A, which indicated R1 wished to be DNR and comfort focused treatment. FM-A stated R1's health improved and no longer qualified for hospice services. FM-A stated the facility initiated a care conference following R1 discharging from hospice services, however the facility staff did not review R1's POLST with FM-A at the meeting and R1 remained DNR and comfort focused treatment. FM-A stated had she been given the option to review the POLST at that time, she would have revised the POLST to not include comfort focused treatment due to R1 wanting to live and hospice was no longer involved in R1's care. FM-A stated she was R1's power of attorney and health care agent. On 12/6/24 at 12:17 p.m., registered nurse (RN)-A stated during each resident's care conference the POLST was expected to be reviewed. RN-A stated social services (SS) would review the POLST with the resident and the resident representative. Further, RN-A stated on the day of R1's care conference, RN-A was not present when the POLST would have been reviewed so she was unsure if SS-A reviewed the POLST. RN-A was not aware of any revisions to R1's POLST either. On 12/10/24 at 11:58 a.m., SS-A stated on 11/21/24, R1 had a significant change care conference related to ending hospice services. SS-A stated she checked R1's POLST order in the computer and offered the option to make changes, which no changes were requested. SS-A stated the discussion could be confirmed by RN-A. SS-A stated she did not lock the care conference summary following the meeting as expected, no revisions were made but confirmed she did not check the boxes related to code status prior. On 12/10/24 at 12:45 p.m., director of nursing (DON) stated staff were expected to review the resident's POLST during care conferences and change in condition or when a family requested. Review of facility policy titled Code Status: Physician's Order for Life Sustaining Treatment Policy dated 6/11, indicated advanced directors/other treatment options may be discussed in a care conference and at any time the form can be updated to reflect any changes requested and with any significant change in status.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40550 Based on interview and document review, the facility failed to monitor and evaluate response to interventions for 1 of 1 resident (R1) identified to have been taking antibiotics for a urinary tract infection (UTI). Findings include: R1's significant change Minimal Data Set (MDS) dated [DATE], indicated R1 had diagnoses of chronic kidney disease, dementia, and malignant neoplasm of sigmoid colon. Further, R1's cognition was noted to be moderately impaired. R1's medication administration record (MAR) and treatment administration record (TAR) for the month of November 2024, indicated Keflex 500 milligram (mg) twice daily for UTI until 11/15/24, ordered on 11/13/24 and Macrobid 100 mg twice daily for retention of urine for 5 days begin on 11/8/24 discontinued on 11/12/24. Further on 11/8/24, refer to infection progress note template for assessment and documentation requirements. Document at least with the start and the end of an antibiotic regimen and during the course of treatment with clinical change or vital signs/assessment that was not within normal limits one time a day for clinical monitoring for seven days. Review of R1's progress notes revealed the following: -On 11/8/24, resident had a new foley catheter inserted, urine sample was collected to rule out infection. Resident was started on Macrobid, and first dose had been given at the hospital. -On 11/8/24, R1 returned at 1:00 p.m. with a new catheter inserted and a five-day prescription for Nitrofurantoin 100 mg, twice a day with breakfast and dinner. -On 11/10/24, Infection Note included type of infection was urine retention, vital signs were obtained, treatment was Macrobid 100 mg twice a day for 3 days, response to treatment was ongoing, no notification to provider was needed, date resolved was ongoing. -On 11/14/24, Infection Note included type of infection urinary tract, vitals obtained, treatment included Keflex 500 mg by mouth twice daily until 11/15/24, response to treatment was ongoing, and date resolved was ongoing. R1's progress notes lacked consistent monitoring and evaluation for effectiveness of treatment through the antibiotic course. On 12/5/24 at 4:38 p.m., licensed practical nurse (LPN)-A stated if a resident was ordered antibiotics staff were expected to implement infection monitoring which would include obtaining vital signs every shift as well as documenting the medication and the reasoning for the medication. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/5/24 at 4:54 p.m., registered nurse (RN)-C stated she recalled R1 being prescribed an antibiotic for urinary infection. RN-C stated staff were expected to monitor a resident on antibiotics for at least seven days to ensure the treatment was effective and there were no adverse reactions, and the monitoring included obtaining vitals signs every shift. On 12/6/24 at 9:37 a.m., LPN-B stated staff were expected to monitor the resident for symptoms of the infection, obtain vital signs, and effectiveness of treatment for the duration of the antibiotic. The treatment for monitoring was typically added as a treatment order in the resident's record and would be expected to be completed every shift. On 12/6/24 at 12:17 p.m., RN-A stated at the start of the resident's antibiotic staff were expected to document a progress note related to the resident's status and condition as well as at the end of the antibiotic course. Further, RN-A stated staff would be expected to obtain vital signs with each administration of the antibiotic, or at least once a shift, due to resident having a change in condition requiring an antibiotic. RN-A stated monitoring a resident would be important during the antibiotic course to ensure the treatment was effective and no adverse reactions. RN-A stated R1 was started on an antibiotic for a urinary tract infection (UTI) and completed the antibiotic on 11/15/24. RN-A stated nurses were expected to be monitoring R1's urine for any signs or symptoms of a UTI and monitoring vital signs every shift because R1 was on treatment and staff should have been keeping a close eye on him for anything abnormal. Further, RN-A confirmed staff were not consistent with obtaining vital signs and there were very poor notes related to monitoring R1 during his antibiotic course. On 12/10/24 at 10:35 a.m., nurse practitioner (NP) stated the facility's goal was good stewardship of antibiotic use and would expect staff to obtain vital signs every shift for at minimum three days to ensure the resident was stable because the antibiotic should have kicked in and be effective. NP would also expect staff to update her with the effectiveness of the antibiotic. On 12/10/24 at 12:45 a.m., director of nursing (DON) stated there was a standard practice for monitoring infections that staff were expected to implement right away which included staff documenting a progress note in the resident's record with type of infection, symptoms, all vital signs, change in condition, isolation precautions, response to treatment, and notifications to the provider (if needed). Further, DON stated he would expect the clinical coordinator on the unit to initiate the monitoring and would expect the monitoring to be completed every shift as once daily would not reveal accurate information due to over a few hours the resident could have a change in condition. Further, DON confirmed R1 was on antibiotic treatment from 11/8 through 11/15/24 and there was only monitoring on 11/10/24 and 11/14/24. DON stated there was a problem with documentation and it was a learning opportunity. In addition, DON stated monitoring an antibiotic was important to ensure the treatment was effective and no further infection concerns were noted. Review of facility policy titled Infection Control-Antibiotic Stewardship Procedure dated 8/17, directed the nursing to complete progress note and documentation at the start and end of an antibiotic regimen, with any change in condition, and monitor/review response to antibiotics, and laboratory results when available, to determine if the antibiotics was still indicated or adjustments should be made. However, the policy lacked identification how often staff were required to monitor or evaluate the response to antibiotics or obtain vitals.