STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355050	A. Building B. Wing	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Manor Care Center	1116 9th Ave Langdon, ND 58249

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 37620 Based on observation, record review, review of facility policy, confidential interview, and staff interview, the facility failed to provide resident care for 2 of 11 sampled residents (Resident #8 and #14) requiring assistance with activities of daily living in a manner that promotes, maintains, or enhances their quality of life. Failure to cover a urinary catheter leg bag (Resident #8) and failure to clean and shave resident's face and change the soiled shirt (Resident #14) has the potential to affect the resident's psychosocial well being and personal dignity. Findings include: Review of the facility policy titled Dignity occurred on 07/10/24. This policy, revised February 2024, stated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. Staff are expected to promote dignity and assist residents: for example: helping the resident to keep urinary catheter bags covered. Review of the facility policy titled Activities of Daily Living (ADLs), Supporting occurred on 07/10/24. This policy, revised March 2024, stated, . Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. - Review of #8's medical record occurred on all days of survey. The current care plan stated, . I require assist of one for most ADL's . Observations throughout the day on 07/08/24 showed Resident #8's urinary catheter leg bag (containing urine) exposed below the resident's pant leg and uncovered. Observations on 07/09/24 at 12:09 p.m. and 5:20 p.m., and on 07/10/24 at 7:53 a.m. showed Resident #8 seated at the dining room table with the urinary catheter leg bag (containing urine) exposed below the resident's pant leg and uncovered. During an interview on 07/10/24 at 11:21 a.m., and administrative nurse (#1) stated staff are expected to cover resident's urine catheter leg bag at all times. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Review of Resident #14's medical record occurred on all days of survey. The current care plan stated, . I require assist. of 1 for all ADL's. I have an ADL self-care performance deficit r/t [related to] cognition/mobility. PERSONAL HYGIENE/ORAL CARE: I am an assist of one. DRESSING: I am an assist of one. An interview occurred 07/08/24 at 5:12 p.m. with Individual A. This individual stated Resident #14 is frequently unshaven and has a dirty face and clothing. Observations on 07/08/24 at 11:15 to 11:53 a.m.showed Resident #14 seated in a wheelchair in the front lobby or the dining room wtih an unshaven face, a soiled shirt, and food debris on his face. Observations on 07/09/24 from 8:34 a.m. to 12:12 p.m. showed Resident #14 seated in a wheelchair in the front lobby or in the dining room with an unshaven face, a soiled shirt, and food debris on his face. At 1:12 p. m., a progress note stated Resident #14 allowed a certified nurse aide (CNA) to wash his face but refused to have his shirt changed. Resident #14 remained unshaven and in the same soiled shirt the rest of the observation day. Observation on 07/10/24 at 9:00 a.m. showed Resident #14 seated in a wheelchair in the front lobby with his shirt and face soiled with food. The above observations showed facility staff had multiple encounters with Resident #14, but failed to change his soiled shirt, shave and wash his face. During an interview on 07/10/24 at 11:19 a.m., an administrative nurse (#1) confirmed Resident #14 frequently has a soiled shirt or dirty face and staff are expected staff to change his shirt and wash his face.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 47896 1. Based on record review, review of facility policy, review of professional reference, and staff interview, the facility failed to follow professional standards of practice for 1 of 1 sampled residents (Resident #15) reviewed with orders for specific parameters for blood glucose levels. Failure to notify the physician of high blood glucose levels as ordered placed the resident at risk for delayed treatment and adverse health events. Findings include: Kozier & Erb's Fundamentals of Nursing, Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 63, stated, Nurses are expected to analyze procedures and medications ordered by the physician or primary care provider. Review of the facility policy titled Physician, Physician Assistant, Nurse Practitioner or Clincal Nurse Specialist Lab Notification occurred on 07/10/24. This policy, revised 03/11/24, stated, . The physician . will determine parameters for 'immediate' and 'non-immediate' lab results. Notification parameters for 'immediate' lab results will be included in lab order. Immediate notifications. Call physician. with lab result and resident current condition. Review of Resident #15's medical record occurred on all days of survey. Diagnoses included Type 2 Diabetes Mellitus. A physician's order, dated 10/11/22, stated, Notify provider if blood glucose [sugar] is above 400 or below 70. Review of Resident #15's blood glucose levels from 05/10/24 through 07/10/24 showed the following: * 05/23/24: 445.0 mg/dL [milligrams per deciliter]. * 05/28/24: 436.0 mg/dL The medical record lacked documentation the facility notified Resident #15's provider of the elevated blood glucose levels. During an interview on 07/10/24 at 12:30 p.m., an administrative nurse (#1) confirmed the staff failed to notify the provider of Resident #15's elevated blood glucose levels. 45873 2. Based on observation and review of facility policy, the facility failed to follow professional standards of practice for 1 of 1 supplemental resident (Resident #34) observed for insulin preparation and administration. Failure to prime the insulin pen and administer the insulin over the required length of time may result in the resident receiving an inaccurate dose. Findings include: (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the facility policy titled Insulin Administration occurred on 07/10/24. This policy, dated 06/14/24, stated, Purpose: To provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the procedure for (insulin pen) administration . Prime the insulin pen. Priming means removing air bubbles from the needle. You must prime the pen before each injection. To prime the insulin pen, turn the dosage knob to the 2 units indicator. With the pen pointing upward, push the knob all the way. At least one drop of insulin should appear. Depress the plunger and remove the needle after approximately five (5) seconds. Observation on 07/08/24 at 5:20 p.m. showed a medication aide (MA) (#2) prepared Resident #34's Novolog insulin pen for administration. The MA (#2), without priming the insulin pen, dialed the insulin pen to the prescribed units, inserted the needle into the resident's abdomen, depressed the plunger and removed the needle without waiting the required length of time. During an interview on 07/10/24 at 11:35 a.m., an administrative staff member (#1) confirmed she expected staff to follow the policy for priming insulin pens and administering insulin.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40489 Based on observation, record review, review of professional reference, and staff interviews, the facility failed to provide supervision to prevent accidents for 1 of 2 sampled residents (Resident #33) observed during a gait belt transfer. Failure to provide supervision of certified nurse aides (CNAs) by a licensed nurse regarding resident transfer assistance may result in unnecessary pain, falls and/or injury for residents. Findings included: Review of the North Dakota Administration Code (NDAC) online at www.ndlegis.gov/information/acdata/pdf/33-43-01.pdf stated, . 33-43-01-12. Supervision and delegation of nursing interventions. An individual on the department's nurse aide registry [CNA] may perform nursing interventions which have been delegated by a licensed nurse. An individual on the departments nurse aide registry as delegated and supervised by a licensed nurse . Review of Resident #33's medical record occurred on all days of survey and included diagnoses of weakness and dementia. The current care plan stated, . TRANSFER: Resident is transfer of 1-2 depending on pt [patient] tolerance. If resident is shakier, will assist of 2 PRN [as needed]. A physical therapy note, dated 06/05/24, stated, Transfer of 1-2 depending on pt tolerance. If [Resident #13] is more shaky, use assist of 2 as needed. PT [physical therapy] observed transfer attempt with assist of 1 today and was safer with assist of 2. Observation on 07/08/24 at 4:01 p.m. showed Resident #33 seated in the wheelchair. A CNA (#8) placed the gait belt on Resident #33, placed a front wheeled walker (FWW) in front of the resident and assisted the resident to a standing position. As the resident attempted to stand, she was shaky, unsteady, and leaned backwards as she placed her left hand on the FWW and her right hand on the wall. The CNA (#8) continued to assist the resident to ambulate to the bathroom. During an interview on 07/10/24 at 12:35 p.m., when asked if Resident #33 is transferred with one or two assist, a CNA (#8) stated, I always just use one assist because that's what they told me to do. Observation on 07/10/24 at 11:28 a.m., showed a CNA (#7) attempted to assist Resident #33 from the bed to the wheelchair. The resident refused to get out of the bed. When asked how the CNA (#7) would have transferred the resident out of bed the CNA stated, She's a pivot transfer with one person. When asked if the CNA ever used two staff to transfer the resident, the CNA stated, She [Resident #33] had a fall a few months ago and then we started to use two staff sometimes. It depends on the kind of day she (Resident #33) is having. I can decide if I should use one or two assist to transfer her. During an interview on 07/10/24 at 1:26 p.m., an administrative nurse (#1) stated she expected the nurse to assess Resident #33 to make the decision if the resident needed to be transferred with two staff.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 40489 Based on observation, record review, review of a professional reference, and staff interview, the facility failed to provide appropriate toileting for 1 of 6 sampled residents (Resident #33) who required staff assistance with toileting. Failure to provide toileting may result in a loss of dignity and placed the resident at risk for skin breakdown, poor grooming/hygiene, decreased self-esteem, urinary tract infections, and risk for fall and/or injuries. Findings include: Kozier & Erb's Fundamentals of Nursing: Concepts, Process and Practice, 11th Edition eText, 2021, Pearson, Boston, Massachusetts, page 892, stated, Fecal and Urinary Incontinence: Moisture from incontinence promotes skin maceration [tissue softened by prolonged wetting or soaking] and makes the epidermis [skin] more easily eroded and susceptible to injury. Digestive enzymes in feces, urea in urine . also contribute to skin excoriation [area of loss of the superficial layers of the skin] . Any accumulation of secretions . is irritating to the skin, harbors microorganisms, and makes an individual prone to skin breakdown and infection. Page 1221 stated, Managing Urinary Incontinence . Habit training, also referred to as timed or prompted voiding and scheduled toileting, attempts to keep clients dry by having them void at regular intervals, such as every 2 to 4 hours. The goal is to keep the client dry . Review of Resident #33's medical record occurred on all days of survey and included a diagnosis of dementia. The care plan stated, . TOILET USE: The resident is an assist of 1 . Observation on 07/08/24 at 4:01 p.m. showed a certified nurse aide (CNA) (#8) assisted Resident #33 to the bathroom. The resident's saturated incontinent product leaked urine through the resident's jeans. Observation on 07/10/24 at 11:29 a.m. showed a CNA (#7) changed resident #33's incontinent product and showed it saturated with urine. Review of Resident #33's toileting record, dated June 9th through July 9th, 2024, identified 56 occasions where staff failed to assist the resident with toileting every three hours. The log showed gaps of approximately 3.5 to 12 hours between staff assistance with toileting. During an interview on 07/10/24 at 1:26 p.m., an administrative staff member (#1) stated she expected staff to assist residents with toileting every 2-3 hours.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45873 Based on observation, review of facility policy, and resident and staff interviews, the facility failed to serve foods at palatable temperatures on 2 of 3 days of survey (July 8-9, 2024). Failure to serve foods at a temperature acceptable to residents may result in decreased intake, weight loss, and inadequate nutrition. Findings include: Review of the facility policy titled Food Temperatures occurred on 07/10/24. This policy, dated 07/13/23, stated, . Foods will be served at the appropriate temperatures to ensure good flavor and to prevent food borne illnesses. All hot food items will be served to the resident at the temperature of at least 140 degrees. During an interview on 07/08/24, Resident A stated, The food is always cold. Observation of the noon meal occurred on 07/08/24 at 12:25 p.m. in dining room [ROOM NUMBER]-3 and showed a cook (#5) dished the final resident tray. A temperature of the three-bean vegetable showed a reading of 72.5 degrees Fahrenheit (F). Observation of the evening meal occurred on 07/09/24 at 5:35 p.m. in dining room [ROOM NUMBER]-3. The surveyors asked for a meal tray after all the residents had received their meals. Temperatures were obtained and showed the following: *Macaroni and Cheese at 132 degrees F *Mashed Potatoes at 139 degrees F *Green Peas at 95 degrees F During an interview on 07/10/24 at 11:45 a.m., an administrative staff member (#4) agreed she expected staff to serve food to residents at an acceptable temperature.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 45873 Based on observation, review of facility policy, and staff interview, the facility failed to store food in a sanitary manner in 1 of 1 main kitchen. Failure to apply an identifying label to food and add an open date has the potential to affect food quality/preparation and may result in the spread of foodborne illness to residents, staff, and visitors. Findings include: Review of the facility policy titled Storage and Cooking of Food occurred on 07/10/24. This policy, dated July 2023, stated, . Food Storage . Foods which have been opened or prepared will be placed in an enclosed container, dated and labeled. If food is ever found undated these will be thrown without exception. Observation of the main kitchen occurred on 07/08/24 at 11:20 a.m. with a dietary manager (#6) and showed the following: Walk-in Refrigerator: *Four individually dished containers identified as taco sauce by a dietary staff member with no identifying label or prepared date. *One brick of a white substance identified as cream cheese but not sure, by a dietary staff member with an unidentifiable date and no identifying label. *Two disposable bowls of a pudding like dessert and a crumble type dessert covered with unsealed plastic wrap with no identifying label or date. *One 1/2 full gallon size zip top plastic bag of sliced strawberries with no identifying label or date. *Three 1/2 full bags of shredded cheese with no open date. *One 1/4 full open jar of peach preserves with no open date. *A tray holding an onion, apples, and oranges with one orange soft and showing dark spots. *A tray with four containers of fruit juice sitting in spilled juice, with dark, sticky spots. Walk-in Freezer: *Three 1/2 full bags of frozen potato tots and french fries with no open dates. *A zip top plastic bag with what dietary staff identified as omelet patties, with no identifying label or open date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*An open bag of sausage patties and an open bag of sausage links inside their respective boxes which showed an open date of the box, but not the individual bags. Walk In Cooler: *One box of oranges, one of the oranges soft and black. Dry Storage: *Four open bags of pudding mix within a zip top plastic bag, with no open date. *One open bag of croutons wrapped in plastic wrap with no open date. During an interview on 07/10/24 at 11:45 a.m., an administrative staff member (#4) confirmed she expected staff to label and date food items when opened and throw away food items if not identifiabe.