STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525673	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE RIDGE CARE CENTER	510 FIRST ST SPOONER, WI 54801

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 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interview and record review, the facility did not promote and facilitate resident choice for 1 (R3) out of 15 residents. R3 was not informed of a change in his medication until he questioned a nurse on the change due to the size of the pill he was given. This is evidenced by: R3 had medical [DIAGNOSES REDACTED]. According to the most recent Minimum Data Set (MDS) assessment dated [DATE], R3 was evaluated as having a BI[CONDITION] (Brief Interview of Mental Status) score of 15/15. The score indicated R3 was alert and oriented and had no cognitive deficits. According to the face sheet, R3 was medically responsible for self and directed his daily care. R3's care plan, dated 02/25/20 included I have completed Advanced Directives indicating my personal preferences for my code status and future care if I am unable to verbalize this form myself. Approaches included, Honor R3's preference when reviewing possible care provision for acute or chronic illness by reviewing Advanced Directives, including Nursing Home Intensity of Care with MD, prior to providing care or accepting orders. On [DATE] at 7:46 AM, Surveyor interviewed R3 regarding his day-to-day life in the facility. The discussion with R3 started very friendly and then he became very angry, and upset over losing control of his decisions. R3 was most upset that the doctor increased his [MEDICATION NAME] (diabetic medication) and the nurses had been administering the medication to him without first asking his permission. R3 stated, The facility doesn't tell me when the doctor changes or adds a medication. This isn't the first time I discovered a change without them telling me. If I don't ask them a direct question, I would never know what I am getting. I told them months ago that I am over medicated. They laugh at me and think I am going looney. I have had diarrhea and stomach cramps nearly every day. R3 pointed out a calendar he had pinned to his room wall. The calendar had X marks on the majority of the days in February and the first two days in March. The X marks went back to January. R3 stated each X indicated either stomach cramping, diarrhea or both. In cases where there were two or three marks, R3 stated that was the number of times he had the diarrhea that day. R3 further stated, I told them that these cramps and diarrhea are nearly every day and this affects my decision on whether to get up out of this bed and sit in my wheelchair. If I am in my wheelchair, I can go to the dining room or certain activities, or even walk in the hall with the aides. If I am in bed, I just lay here watching television or sleep. So, it seriously affects my activity of the day. I don't want to lay here like a slug all day and night. R3 further stated, Awhile back the doctor decreased the [MEDICATION NAME] to 500 MG (Milligram) . Last night, I dumped my pills out on the table because I was suspicious of the [MEDICATION NAME] again, as the cramping and diarrhea started up again. I noticed a big horse pill, and asked the nurse if they increased the [MEDICATION NAME] again. She said the doctor increased it again on [DATE]. Why don't they tell me these things (yelling)? I still have my mind, damn it. I still am a human being with rights. I should be informed so that I have the choice whether or not I wish to comply. R3 then stated, I am sorry. But it is very embarrassing when I walk to the bathroom and dump in my pants. I have no control, it comes on so fast. Then the poor staff have to clean me up. I have said this over and over, either severe stomach cramping or diarrhea, sometimes both. Nobody listens to me. I am getting so frustrated. Do I have the right to tell them when they come in with the pills, that I am not going to take the [MEDICATION NAME]? According to the 2019 Nursing Drug Handbook by Lippincot, common side effects of [MEDICATION NAME] included diarrhea, nausea, vomiting, abdominal bloating, and excessive gas. At 11:38 AM, the Surveyor interviewed the Director of Social Services, SW-J. SW-J stated R3 does direct his own care verbally, is his own person and makes his own health care decisions. She stated that if any changes were made in treatment, medications, or whatever area, the expectation would be to go to him and discuss it with him and allow him the choice to agree or disagree. At 1:46 PM, the Surveyor approached LPN-F and LPN- G (Licensed Practical Nurses) regarding the process of receiving orders and R3's concern over his medication changes. LPN-F stated any changes made are written on the referral sheet by the doctor. LPN-F stated occasionally a verbal order will be taken and the nurse completes the referral sheet, gives to the charge nurse, who then puts the orders into the computer. The nurse on the resident's unit is then informed and a hard copy gets placed into Matrix. LPN-F further stated the resident and the resident's responsible party are then contacted and informed. The resident is then monitored on the 24 hour board, if it's a new order. When asked who took the order for the [MEDICATION NAME] change for R3, LPN-F stated, I took the order. I passed it on in report, but I did not talk to (R3) about it. I missed that. LPN-G then explained, Yes the expectation is to talk to the resident about it. But, we did not talk to him about the medication change, we did miss that.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on family and staff interview and record review, the facility did not notify the representative for 1 (R52) out of 15 residents with an injury of unknown origin. R52 developed a severe skin tear on her right upper arm. Family-K was not informed of the injury by the facility, but rather was approached in the grocery store by a Hospice CNA (Certified Nursing Assistant). Additionally, R52 had 2 other injuries and Family-K had not been notified. This is evidenced by: R52 had medical [DIAGNOSES REDACTED]. R52 was admitted to hospice on 11/6/19. R52's medical record indicated Family-K was R52's Power of Attorney for Health Care. On 3/2/20 at 12:03 PM, Surveyor interviewed Family-K. Family-K stated she was essentially satisfied with R52's care but was concerned about how much they tell me. Family-K stated R52 developed a severe skin tear to her right upper arm awhile back. Family-K stated CNA-L (Hospice CNA) had approached her in the grocery store and told me R52 had a skin tear. Family-K stated . the skin tear bled, and the blood dried, causing the pajama top to adhere to the sore. When the pajamas were removed, the skin ripped more. I still haven't been told by the facility about the initial injury, how it happened or the fact that it worsened. I guess it ripped more on this past Friday. Family-K further stated that R52 also had a sore on her back. They told me from the [MED]gen tank. They said they put something on it, but I still haven't heard from the nurse or the Hospice nurse about the real cause of this. The information I have was from a CNA. Family-K also stated, I am still waiting to hear what is going on with her toe. She has a sore on the toe of her right foot. I haven't been told how that happened or it's progress. I feel they should do a better job of keeping me updated than what they do. I seem to learn of these things when I come to visit, and usually from a CNA and not the nurses. In reviewing R52's Medical Record, the Surveyor noted the following: Spine: an initial entry for R52's spine was dated 12/29/19 at 6:07 PM, in which R52 had a reddened area on her spine. Right foot Second Toe: An initial entry for her right foot second toe was dated 2/10/20, but does not describe the area. The next entry was on 02/22/20 in which it had declined to being macerated broken down. Another entry on [DATE] in which it was documented as being 100% necrotic. Right upper arm:

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

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 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) An initial entry regarding the skin tear on R52's right arm was dated [DATE], in which the documentation noted a skin tear occurred. It does not state how this happened. There are no further entries regarding the arm, or when the skin tear ripped further as a result of bloody drainage drying to her pajamas. The medical record did not indicate Family-K was updated on these three injures. On 3/3/20, the Surveyor interviewed CNA-L who stated she had been taking care of R52 for several months, both at the facility and prior to admission. CNA-L stated she completed R52's bathing activities on Tuesday, 2/25/20 and, . I noticed a new bandage on her arm. I saw Family-K in the grocery store and I told her about the right arm then. I knew if I didn't say anything, she would be upset. That was new, I think it happened the night before, I guess. It was huge. I guess it was bleeding and the blood dried and caused the pajamas to stick, and when they removed the pajamas, made the wound larger. Family-K was a little upset because she wasn't told about it before I saw her in the store. On 3/3/20 at At 1:46 PM, Surveyor approached LPN-F (Licensed Practical Nurses) regarding the process of receiving orders and changes in condition. LPN-F stated that with any changes, the resident and their responsible party are updated either by telephone or if they are in the building, in person.
F 0637 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident when there is a significant change in condition** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not complete a significant change in status MDS (Minimum Data Set) assessment for 1 (R26) out of 15 sampled residents. This is evidenced by: R26 was admitted to the facility on [DATE] following a fall and [MEDICAL CONDITION]. R26's additional [DIAGNOSES REDACTED]. The facility completed an annual MDS assessment for R26 on 05/2[DATE]9 with the following data noted: ~able to make self understood and understand others. ~BI[CONDITION] (brief interview for mental status) score of 6 out of 15 indicative of moderate cognitive deficit. ~no depression indicators. ~exhibited wandering behavior daily ~required extensive assist of staff for transfers, ambulation, and hygiene. ~required limited assist of staff for dressing and toilet use. ~weight was 132#. The facility completed a quarterly MDS assessment for R26 on 01/03/20 with the following data noted: ~BI[CONDITION] score was 14 out of 15 indicative of minimal cognitive deficit. ~depression indicators of overeating and decreased energy. ~required limited assist for transfers and ambulation. ~required extensive staff assist for dressing and toilet use. ~weight was 164#. R26 had changes in cognition, depression indicators, behaviors, transfers, ambulation, hygiene, dressing, toilet use, and weight. On 03/04/20 at 9:39 a.m., Surveyor interviewed LPN-C (Licensed Practical Nurse) who confirmed she had completed both MDS assessments for R26. LPN-C stated she does not complete Sections C (cognition), D (mood), E (behaviors), or K (nutrition) but does complete Sections G. LPN-C stated R26 had at least 2 changes in her status and would have met the criteria for a significant change in status MDS assessment.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not ensure 5 (R30, R11, R3, R44, and R19) out of 15 sampled residents had accurate assessments. R30 had errors in Sections N and Z of the MDS (Minimum Data Set) assessment completed on 01/09/20 and errors in Section N of the MDS assessment completed on 12/29/19. R11 was inaccurately coded on the MDS assessment, Section P Restraints, the use of side rails daily. R3 was coded on the last three MDS assessments as using a side rail as a physical restraint. R3 utilized the side rails for bed mobility and these devices did not meet the definition of a physical restraint. R44 had bed rails used for repositioning in bed. The facility had inaccurately coded the rails as a restraint and the devices did not meet the definition of a physical restraint. R19 used side rails as a positioning device. The facility had inaccurately coded the side rails as a restraint when these devices did not meet the definition of a physical restraint. This is evidenced by: On [DATE] at 8:45 a.m., Surveyor interviewed DON-B (Director of Nurses) regarding oversight of LPN-C (Licensed Practical Nurse). DON-B stated she co-signed all MDS assessments completed by LPN-C. DON-B stated LPN-C was not authorized to sign Section Z. DON-B stated Section Z was signed by herself once the MDS assessment was complete. On [DATE] at 4:00 p.m., Surveyor interviewed LPN-C regarding her role with MDS assessments. LPN-C stated all MDS assessments were completed by herself. LPN-C stated all MDS assessments are co-signed by DON-B. According to the RAI (Resident Assessment Instrument) Manual Section P, physical restraints are any manual method or physical or mechanical device, material, or equipment, attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Example 1: R30 was admitted to the facility on [DATE] for long term care due to dementia, anxiety, depression, and heart conditions. The facility completed a significant change in status MDS assessment for R30 on 01/09/20 with the following errors identified: ~Section N Medications. R30 received 7 days of antipsychotics under N0410. The next question, N0450 noted R30 did not receive antipsychotic medications and had no gradual dose reduction. ~Section Z was signed by LPN-C and was not signed by a RN (Registered Nurse) as required according to the RAI manual. The facility completed a quarterly MDS assessment for R30 on 12/29/19 with the following errors identified: ~Section N Medications. R30 was coded as not on an antipsychotic in question N0410; however in the next question, N0450, R30 was coded as on an antipsychotic with no recent gradual dose reduction attempted. Review of the physician orders [REDACTED]. R30 had received [MEDICATION NAME] (an antipsychotic) daily during the assessment period for the above MDS assessments. On [DATE] at 4:00 p.m., Surveyor interviewed LPN-C regarding her role with MDS assessments. LPN-C confirmed the errors in R30's MDS assessments as described above. LPN-C stated I really messed up on R30's MDS assessments. Example 2: R11 was admitted to the facility on [DATE] following amputation of the toes on his right foot. The facility completed an admission MDS assessment for R11 on [DATE] with the following data noted: ~able to make self understood and understand others. ~required extensive staff assist with bed mobility, hygiene, and dressing. ~daily use of bed rails as a physical restraint. On [DATE] at 7:23 a.m., Surveyor interviewed R11 regarding the use of the side rails. R11 stated the only time the side rails were up was when staff were providing hygiene, dressing, or mobility assistance and when R11 request side rail to be up. R11 stated he has asked staff to leave one side rail up so that he can adjust the bed positions. R11 stated the side rail does not restrict his movement or access to his body, but rather helps him reposition in bed. R11 stated staff will keep the left side rail up when R11 requests. Surveyor observed both side rails down at the time of R11's interview and again later that same morning. Surveyor noted both side rails to have the bed adjustment controls and to extend from the head of the bed to just less than half way. Example #3: R3 had medical [DIAGNOSES REDACTED]. On [DATE] at 7:46 AM, the Surveyor entered R3's room to interview him on general care in the facility. The Surveyor noticed R3 was in bed with bilateral one-half size side rails on his bed. When asked about the rails, R3 stated that he used them to reposition himself. He wants them to maintain his independence while in bed. He denied that the rails were a restraint. He further stated that he has bone-on-bone in both hips and becomes uncomfortable. With the use of the rails, I can change my position, and I do, often. That way I don't have to wait for the staff to come in and help me. The facility completed MDS assessments for R3 on 8/27/19 (annual) , 11/25/19 (quarterly), and [DATE] (quarterly). In all three of these MDS assessments, the facility coded R3 as using a physical restraint daily in Section P. On 3/4/20 at 12:01 PM, the Surveyor approached LPN-C (Licensed Practical Nurse) regarding her completion of R3's MDS assessments. LPN-C stated that she recently learned that she should not be marking R3 as a physical restraint in Section P. The facility completed a Restraints/Adaptive Equipment assessment dated [DATE]. This was an annual assessment. According to this assessment, R3 uses side rails to enhance ability to be self sufficient and no restraint is in use. Example #4: On 3/02/20 at 3:10 p.m. Surveyor observed bed rails on the left and right side of R44's bed. The rails were approximately one quarter length of R44's bed. Surveyor asked R44 about her bed rails. R44 indicated the rails were used for movement side to side in bed and do not restrict movement from bed. On 3/03/20 Surveyor requested and reviewed the MDS assessments completed for R44. The facility coded daily use of side rails as a physical restraint on the following MDS assessments for R44: ~3/12/19, Quarterly. ~5/03/19, Quarterly. ~6/11/19; Quarterly. ~9/09/19; Quarterly. ~12/10/19; Annual. ~02/03/20; Significant Change. On 03/04/20 at 2:02 PM Surveyor spoke with the MDS Coordinator/LPN-C regarding coding of bed rails as a restraint on R44's MDS assessments. LPN-C explained she had been informed from the former Director of Nursing quite sometime ago that all bed rails are considered a restraint. Surveyor asked LPN-C if the bed rails meet the definition of a restraint as outlined in section P. LPN-C responded the rails are used by R44 to move and transfer independently in bed. The rails do not restrict her movement. The rails do not meet the definition of a restraint for R44. LPN-C further expressed going forward will evaluate each person for consideration of whether their bed rails meet the definition of restraint when completing the MDS. On 3/03/19 Surveyor requested and reviewed R44's Restraint/Adaptive Equipment assessments completed on 09/09/19 and on 12/10/19. Both assessments noted R44 used the side rails as a restraint. The

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) assessments noted the use of bilateral lollipop hand rails for positioning. On 3/03/20 at 3:20 P.M. Surveyor spoke with DON-B regarding R44's assessments as noted above. DON-B indicated R44's lollipop type side rails are an enabling bar to aide R44 with repositioning in bed. The rails do not meet the definition of a restraint. The assessments are inaccurate. Staff who completed the assessments completed them inaccurately. The lollipop-pop type side rails are not a restraint for R44. DON-B stated the rails do not limit her movement and they are not affixed to body. Example 5: R19 was admitted to the facility on [DATE]. R19 had a [DIAGNOSES REDACTED]. On 3/2/20 Surveyor observed R19 in bed with two round side rails, called lollipop side rails up on each side of bed. R19 had contracture (limited movement) of right hand and also limited movement to both legs and was unable to get out of bed independently. The side rails were not restricting R19 from moving. On 3/4/20 Surveyor reviewed R19 side rail assessment done on 6/17/18. The assessment noted R19 had demonstrated appropriate use of bed rails for repositioning purposes. R19 was not at risk for entrapment, and there was nothing else that could be utilized for repositioning at this time. On 3/4/20 Surveyor reviewed R19 side rail assessment dated [DATE] that stated no restraints were in use. The facility completed 2 MDS assessment for R19 dated 9/2[DATE]9 and 12/23/19. Under Section P, the facility coded R19 had daily use of side rails as a physical restraint. This was coded inaccurately as R19 was not limited in movement by the use of side rails. On 3/4/20 at 2:04 PM Surveyor interviewed MDS nurse LPN-C regarding how decisions are made when coding side rails as restraints. When Surveyor asked why LPN-C coded side rails as restraints LPN-C relayed that when I began my position as MDS nurse about a year and a half ago, my old DON printed out information on the mega rule. The rule suggested that all things attached to a bed could be looked at as a restraint. I was told that all side rails were considered a restraint. Surveyor then asked why some side rails were not coded as restraints LPN-C responded, I have no answer for that. I understand that there is a discrepancy between the side rail assessments and the MDS, and after being educated by the state I will be fixing these and reeducating the staff. I know I need to rely less on others to complete sections of the MDS and make a point of talking to the CNA's and nurses regarding any changes a resident might have.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not develop comprehensive care plans for 3 (R30, R26, and R27) out of 15 sampled residents. R30's care plans do not include measurable goals, risk factors, evidence, potential complications, resident strengths, and are not individualized. R26's care plans do not include measurable goals, risk factors, evidence, potential complications, resident strengths, and are not individualized. In addition, R26 has had a wandergard since August 2017 and there is no assessment or care plan for her wandergard. R27 was prescribed [MEDICATION NAME], an antidepressant medication. R27 does not have a care plan with measurable goals for targeted behaviors or non-pharmalogical approaches to aide staff in her care of her depressive symptoms. This is evidenced by: On [DATE] at 8:45 a.m., Surveyor interviewed DON (Director of Nurse)-B regarding care plans done by LPN (License Practical Nurses). DON-B stated she oversees the LPNs work including the care plans. DON-B stated care plans are initiated by LPN-C and LPN-F and when time permits, DON-B reviewed the care plans. DON-B stated care plans are updated at least quarterly or with the MDS (Minimum Data Set) assessment schedule. DON-B stated input from the CNA (Certified Nursing Assistant) staff was sought for need to change resident care plans. DON-B stated care plans should include measurable goals, risks and potential risks, resident strengths, and individualized approaches based on those strengths. Example 1: R30 was admitted to the facility for long term care on 04/05/19. R30's [DIAGNOSES REDACTED]. On [DATE] and 01/05/20 the facility completed a skin at risk assessment for R30. The facility identified R30 was at risk for skin breakdown due to [MEDICAL CONDITION], needing extensive staff assist for mobility, incontinence, [MEDICAL CONDITION], shear potential, inadequate nutrition, and impaired sensations. On [DATE] and 01/05/20 the facility completed a fall risk assessment for R30. The facility identified R30 was at risk for falls due to [MEDICAL CONDITION], incontinence, cognitive deficits, impaired balance, medication side effects, and functional loss. The facility's care plan titled Pressure Ulcer last revised by LPN-C on 01/13/20 did not include any of the identified risk factors, complications, supporting evidence, or resident strengths. The approaches were standard care interventions. The facility's care plan titled Falls last revised by LPN-C on 01/13/20 did not include any of the identified risk factors, complications, supporting evidence, or resident strengths. The approaches were standard care interventions. The facility's care plan titled Nutritional Status last revised by LPN-C on 01/13/20 did not include any of the identified risk factors, complications, supporting evidence, or resident strengths. The facility's care plan for ADL (activities of daily living) that was last revised on 01/22/20 by LPN-C did not include R30's strengths and did not have measurable specific goals. The goal was for R30 to remain clean, dry, and well groomed daily. Example #2: R26 was admitted to the facility for long term care on [DATE]. R26 had the following, but not all inclusive, Diagnoses: [REDACTED]. On 03/02/20 during the initial tour, Surveyor observed R26 with a wandergard around her ankle. Surveyor observed R26 propelling self throughout the facility in the wheelchair. On [DATE], Surveyor conducted a comprehensive record review and was unable to locate any elopement assessment or care plan that would address the use of the wandergard. Surveyor requested this information from LPN-C who stated there was no elopement assessment or care plan for wandergards. LPN-C stated SW (Social Worker)-J will be completing elopement assessments and develop care plans for those residents who are at risk for elopement. LPN-C stated R26 does wander into other resident rooms but has not eloped from the building. The facility developed a care plan titled ADL Functional for R26 with the last revision on 01/13/20 by LPN-C. The goal was for R26 to remain clean, dry, and appropriately dressed. This goal was not measurable. The care plan did not include R26's strengths. The facility developed a care plan titled Pressure Ulcer for R26 with the last revision on 01/13/20 by LPN-C. The problem did not include R26's risk factors of immobility, heart conditions, incontinence, and [MEDICAL CONDITION]. Example #3: Surveyor reviewed R27's 5/27/19 Significant Change in Status MDS and 1/02/20 Quarterly MDS and noted: Mood: No indicators of depressive symptoms medications: [REDACTED]. The surveyor reviewed R27's physician orders [REDACTED].~7/26/19: [MEDICATION NAME] 50 milligrams (mg) daily. Surveyor reviewed R27's care plan and noted their was no care plan in place with measurable goals for targeted behaviors of her individual depressive symptoms. In addition, the care plan did not include any non-pharmalogical approaches to aide staff in her care of her depressive symptoms. On 03/04/20 at 7:56 a.m. Surveyor spoke with LPN-C. LPN-C stated she completes the MDS assessments and develops the care plans for R27 and others. LPN-C verified R27's had received [MEDICATION NAME] 50 mg daily since 7/26/19. According to the physicians orders, R27 started [MEDICATION NAME] on 5/1[DATE]9 at 25 mg daily and had an increase of [MEDICATION NAME] to 50 mg daily on 7/26/19. LPN-C stated a care plan should be developed when medications are started. LPN-C stated care plans are reviewed with all MDS assessments. LPN-C stated R27's care plan should have been reviewed on the following dates: 1/20/20, 10/0[DATE]9, 8/20/19, 7/26/19 and 5/27/19. LPN-C confirmed R27 does not have a care plan for her targeted behaviors with specific goals or individual approaches or for the [MEDICATION NAME] use. There was no goal to monitor effectiveness of her medication related to R27's depressive symptoms. R27 had a care plan in place for monitoring the medication side effects. The care plan contained approaches from a generic template and are not specific to R27 depression treatment. LPN-C further expressed she does not have enough time to commit to the development of individual care plans due to her work responsibilities.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not update care plans for 2 (R26 and R56) out of 15 sampled residents. R26's antidepressant medication was discontinued on 05/27/19, yet her care plan said R26 remained on this medication. R56's anticoagulant medication was discontinued in April, 2019, yet her care plan said R56 remained on this medication. This is evidenced by: On 03/04/20 at 10:00 a.m., Surveyor interviewed RN (Registered Nurse)-I regarding care plans. RN-I stated all staff can update care plans. RN-I stated she often updated care plans when there were changes in mobility, diet, or overall function. RN-I stated when a care plan was updated, it should be printed off for the CNA point

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F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of care book kept at the nurse station and in the resident's room. Example #1: R26 was admitted to the facility for long term care on [DATE]. R26's has the following, but not all inclusive, Diagnoses: [REDACTED]. Review of the physician orders [REDACTED]. Review of the care plan titled Antidepressant/Antianxiety Medication for R26 was last revised on 01/13/20 by LPN (Licensed Practical Nurse)-C. On 03/04/20 at 9:39 a.m., Surveyor interviewed LPN-C regarding R26's care plan. LPN-C stated R26's care plan had been reviewed in August, November, and January but the care plan was not updated to reflect the discontuation of [MEDICATION NAME] for R26. LPN-C stated all staff are responsible to update the care plan. Example #2: R56 was admitted to the facility on [DATE] following a fall and right [MEDICAL CONDITION]. R56's additional [DIAGNOSES REDACTED]. R56 was previously a resident at this facility and was discharged to the community on 04/25/19. During R56's first stay, the physician ordered anticoagulant therapy to treat [MEDICAL CONDITION]. Review of R56's admission medications dated 02/13/20 did not include any anticoagulant therapy to treat [MEDICAL CONDITION]. Review of R56's comprehensive care plan included a problem titled Bleeding Potential dated 02/12/20 by LPN-C. The care plan noted R56 was taking an anticoagulant medication when in fact R56 had not been on anticoagulant therapy since April, 2019. On 03/04/20 at 9:39 a.m., Surveyor interviewed LPN-C who confirmed R56 was not on any anticoagulant therapy since her most recent admission.
F 0742 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews the facility did not provide care and services to 1 (R11) out of 15 sampled residents with a [DIAGNOSES REDACTED]. R11 was a resident from [DATE] until 0[DATE] and again beginning on [DATE] through survey. R11 had a [DIAGNOSES REDACTED]. triggers or symptoms. This is evidenced by: R11 was admitted to the facility on [DATE] for rehabilitation with plans to return home. R11 had the following, but not all inclusive, Diagnoses: [REDACTED]. R11 was discharged home after meeting his rehabilitation goals on 0[DATE]. R11 was admitted again on [DATE] following amputation of the toes on his right foot due to trauma and gangrene. Review of the initial history and physical dated 10/18/19, R11's physician noted [MEDICAL CONDITION] following military combat in the Vietnam War. Review of the discharge summary dated [DATE] noted R11 was started on [MEDICATION NAME] (an antidepressant) to treat [MEDICAL CONDITION]. Review of both discharge summaries dated [DATE] and [DATE] noted R11's [MEDICAL CONDITION] and depression diagnoses. Review of the physicians orders admit orders dated [DATE] noted R11 was taking [MEDICATION NAME] (an antidepressant) and [MEDICATION NAME] daily to treat depression and [MEDICAL CONDITION] respectively. The facility completed an admission MDS (Minimum Data Set) assessment for R11 on [DATE] with the following data noted: ~able to make self understood and understand others. ~Section D Mood. The resident interview was not conducted and questions were marked not assessed. The staff assessment portion noted R11 was down/depressed/hopeless, had trouble with sleep, and felt bad about self. All mood indicators were noted to occur on several days of the assessment period. ~Section I Active diagnoses. [MEDICAL CONDITION] was coded. Surveyor reviewed R11's comprehensive medical record and was unable to locate any assessment or care plan information on R11's [MEDICAL CONDITION]. Surveyor asked the DON (Director of Nurses)-B for any assessments or care plan documents that addressed R11's [MEDICAL CONDITION]. There was no information provided to Surveyor. The facility did have a care plan titled Antidepressant/Antianxiety Medication. that was initiated on 02/20/20 for R11. There was no mention of R11's [MEDICAL CONDITIONS], symptoms, or triggers. On [DATE] at 7:00 a.m., Surveyor interviewed R11. R11 did report problems sleeping and depressed feelings. R11's focused during the interview was on returning home once the surgical incision was healed. R11 was observed on [DATE] at 4:00 p.m. being wheeled by his spouse following a post surgery doctor appointment. R11 was smiling and reported a good physician report on the healing of the surgical incision. On 03/04/20 at 2:20 p.m., Surveyor interviewed SW-J regarding R11's [MEDICAL CONDITION]. SW-J stated she began employment at this facility on [DATE]. SW-J confirmed R11 did have a [DIAGNOSES REDACTED]. SW-J stated she had not assessed R11 or completed a care plan for R11's mood or [MEDICAL CONDITION]. SW-J stated the PASARR (preadmission screening and resident review) level 2 was due next week and SW-J planned to gather that information by the PASARR due date. On 03/04/20 at 2:40 p.m., Surveyor interviewed LPN (Licensed Practical Nurse)-F regarding R11's care needs. LPN-F stated she cared for R11 and was familiar with his care needs. LPN-F stated R11 was a Vietnam veteran and had [MEDICAL CONDITION] due to his military exposure. LPN-F stated she would assess R11's mood and sleep patterns on the days she cared for him. LPN-F was unaware of his [MEDICAL CONDITION] triggers or symptoms. LPN-F stated she thought R11 would report any [MEDICAL CONDITION] episodes to her, but R11 had not reported any [MEDICAL CONDITION] episodes as of today. On 03/04/20 at 4:15 p.m., SW (Social Worker)-J stated she had not interviewed R11, completed any assessments, social history, or developed a care plan for R11's [MEDICAL CONDITION].
F 0744 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility did not provide dementia care and services to 1 (R30) out of 15 sampled residents. R30 had dementia and took multiple medications for her anxiety and behaviors associated with dementia. The facility did not assess R30's dementia triggers, elicit historical approaches from family, identify nonmedicinal approaches, or develop a care plan to aide R30 with her dementia related behaviors and symptoms. This is evidenced by: R30 was admitted to the facility on [DATE] for long term care. R30 had the following, but not all inclusive, Diagnoses: [REDACTED]. Review of R30's comprehensive medical record over the past 6 months, including physician notes, noted multiple medication changes to help R30 manage her hallucinations, anxieties, and dementia related behaviors of calling out help me please. The following medications have been tried: ~R30 was started on [MEDICATION NAME] (antipsychotic) in October, 2019 and currently on 50 mgs (milligrams) daily. ~R30 was trialed on [MEDICATION NAME] ([MEDICATION NAME]), [MEDICATION NAME] (antianxiety), [MEDICATION NAME] (antipsychotic), [MEDICATION NAME] (antianxiety), and [MEDICATION NAME] (antidepressant) for anxiety but all were unsuccessful. ~R30 was prescribed [MEDICATION NAME] (antidepressant) and currently on 7.5 mgs daily. ~R30 was prescribed [MEDICATION NAME] (antidepressant) and currently on 50 mgs daily. ~R30 was prescribed [MEDICATION NAME] (antipsychotic) 0.25mgs started on 02/07/20 and increased to 0.5mgs daily on 02/14/20. Review of the facility behavior monitoring flowsheets shows R30 has anxious behaviors 50-100% of the days per month during September through January, 2020. There were no changes to the care plan with the exception of introducing another medication. There is no evidence of family discussions on past behaviors, past interventions, or suggested approaches from the family. There is no nonmedicinal approaches documented in the progress notes except for the standard care approaches including one to one staff reassurance, meeting basic care needs, and providing a calm environment. The facility did not develop a care plan to help staff identify triggers and attempt nonmedicinal approaches to manage R30's behaviors, hallucinations, or anxieties. Surveyor reviewed R30's nurses notes from September through present date and noted almost daily documentation about anxiety, panting, coughing, shortness of breath, hyperventilating, paranoia, hallucinations (visual and tactile) symptoms followed by documentation of ineffective interventions. On 03/04/20 at 8:30 a.m., Surveyor interviewed CNA-E regarding R30's care needs. CNA-E stated she was familiar with R30's care needs. CNA-E stated poor thing she has so much anxiety and she is so sweet. CNA-E stated R30 enjoyed sitting in her room or in a quiet setting. CNA-E stated R30 will call out help me or nurse and asks staff to sit with her and not leave her alone. CNA-E stated there was no pattern to her anxious outbursts but the anxiety was present much of the time. CNA-E stated she provided R30 with one to one attention and reassurance when time permitted. On 03/04/20 at 8:45 a.m., Surveyor interviewed DON (Director of Nurses)-B regarding dementia training. DON-B stated staff are provided annual dementia care training. DON-B stated there are no triggers to R30's behaviors. DON-B stated R30 enjoys the Hallmark channel on the television and to keep her environment quiet. These approaches are not found on R30's care plan. Surveyor asked DON-B why care plan approaches were not in R30's care plan and DON-B stated they should be. Surveyor requested any documentation of R30's dementia care including the care plan, interdisciplinary discussion notes, or documented family input into R30's care. DON-B stated there had been discussion with the family regarding R30's anxious behavior. R30's family confirmed anxiety has been a life long problem for R30. DON-B did not provide Surveyor with any evidence as requested. On 03/04/20 at 10:00 a.m., Surveyor interviewed RN (Registered Nurse)-I who stated she cared for R30 almost daily. RN-I stated R30's biggest problem

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525673	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLE RIDGE CARE CENTER	510 FIRST ST SPOONER, WI 54801

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F 0744 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 4) was anxiety. RN-I stated R30 has had multiple medications changes, but since the [MEDICATION NAME] was started, R30 was 100% better. RN-I stated a few months ago, R30 was out of control yelling constantly, hyperventilating, hallucinating, and paranoid. RN-I stated the medications attempted were unsuccessful until the [MEDICATION NAME] was tried. RN-I stated R30's triggers included a busy hallway, people walking past her room, and the television as it would increase her hallucinations and paranoia. RN-I stated she would put R30 in her room with the lights on and the curtain closed if the sun was too bright, provide her with juice and crackers. RN-I stated those interventions would calm her for hours. Surveyor asked if those interventions were in the care plan and RN-I stated they were not. RN-I stated she could put them in the care plan to help other caregivers calm R30. Surveyor observed R30 daily during the 3 day survey. On 03/02/20 at 10:30 a.m., R30 was seated in a wheelchair in her room. The room was quiet and dark and R30 was resting quietly. On 03/02/20 during lunch, R30 was seated in the wheelchair in the dining room at a table with 3 other female residents. R30 was not engaged in conversation, but rather focused on her drink in front of her. R30 was calm and quiet. On [DATE] during lunch, R30 was eating her meal independently. R30 was engaged in conversation with the caregivers at the table. R30 was smiling as it was her birthday and R30 was being recognized by staff. On 03/04/20 during breakfast, R30 was seated in the wheelchair at the dining room table with 3 other female residents. R30 was not engaged in conversation, but rather seated quietly and calmly in the wheelchair.
F 0758 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview the facility did not ensure that 2 (R53, R7) out of 6 residents reviewed for medications received these medications with adequate monitoring, approaches, and only after ineffective non-medicinal approaches were tried. R 53 was prescribed [MEDICATION NAME] ([MEDICATION NAME]) an antidepressant medication for hot flashes. R 53 does not have a care plan with targeted goals and individual approaches for her symptoms. R 53 has no system in place for monitoring the effectiveness of the medication. R7 has been taking [MEDICATION NAME] (anti-depressant) to treat a [DIAGNOSES REDACTED]. This is evidenced by: Example #1: The surveyor reviewed R 53's Annual Minimum Data Set ((MDS) dated [DATE] and Quarterly MDS dated [DATE] and noted R 53: ~is understood and understands ~is cognitively intact ~Received Antidepressant medication The surveyor reviewed R 53's Physician orders [REDACTED].~8/12/18: [MEDICATION NAME] 40 milligrams (mg) daily at 8:00 a.m. for hot flashes. The surveyor reviewed R 53's medical record and found no monitoring of R 53's hot flash symptoms. The surveyor reviewed R 53's care plan and found no targeted symptoms, measurable goal or individual non-pharmalogical approaches for her hot flashes. On 3/04/20 at 9:14 a.m. the surveyor spoke with Licensed Practical Nurse (LPN)- C. LPN-C confirmed she completed R53's MDS assessments. LPN-C confirmed she also developed and updated R53's care plans. LPN-C verified R 53's had received 40 mg of [MEDICATION NAME] daily since 8/12/18 for hot flashes. LPN-C indicated a care plan should be developed when medications are started and during the MDS cycle. LPN-C further indicated R 53 has had MDS completed since the start of her medication. R 53 does not have a care plan for her symptoms of hot flashes with specific goals or individual non-pharmalogical approaches. The facility has not attempted alternative treatment for [REDACTED]. LPN-C further indicated the facility does not have a system in place to monitor the effectiveness of her medication or evaluation of need for the medication. Example 2 R7 was admitted to the facility for long term care and on hospice services on 11/25/19. R7 had a [DIAGNOSES REDACTED]. On [DATE] Surveyor observed R7 lying in his bed most of the day. R7 took breakfast and lunch in his room. On [DATE] Surveyor interviewed R7 regarding mood. R7 state his mood was terrible due to all the things that have happened to him. On [DATE] Surveyor interviewed CNA-E (Certified Nurses Assistant) regarding behavior monitoring and approaches for R7. CNA-E stated that R7 can be sexual at times so we monitor that. CNA-E stated staff tell him that is not appropriate behavior. I told the nurse and it has gotten better. Surveyor asked what R7 [DIAGNOSES REDACTED]. Surveyor asked if CNA-E was aware that R7 had a [DIAGNOSES REDACTED]. On [DATE] Surveyor interviewed CNA-H regarding R7 and depression. When asked what R7 [DIAGNOSES REDACTED].? When asked what specific things are monitored CNA-H stated, mood, pain and hunger. Surveyor asked, Was CNA-H aware that R7 had a [DIAGNOSES REDACTED]. Regarding monitoring mood CNA-H stated, Well like today he is in a funny mood, but he can be mean, then we wonder if he is in pain. Nothing specific. On [DATE] Surveyor interviewed LPN-C (Licensed Practical Nurse) regarding behavior tracking for the use of [MEDICATION NAME]. LPN-C stated, There is none, I started it last night. On [DATE] Surveyor interviewed DON-B (Director of Nursing) regarding behavior monitoring. DON-B stated, There is no behavior monitoring for his [MEDICATION NAME]. Review of MDS assessment dated [DATE] noted R7 felt down 2-6 days per week, and that R7 felt bad about self almost every day. Review of CNA care plan said to monitor R7 mood/behavior. There were no specific approaches or symptoms documented to monitor. Review of nursing care plan revealed that it addresses R7 depression related to side effects of the antidepressant medication. There are no specific side effects documented. There are general approaches noted but nothing specific to R7's needs. There are no specific measurable objectives or goals. There are no targeted behaviors being monitored.
F 0759 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility did not ensure a medication administration rate of 5% or less. There were 2 errors out of 25 opportunities observed yielding a medication administration rate of 8%. 1. There was no rinsing of R17's mouth following the administration of a Corticosteroidal inhaler. 2. R53 received her meal 45 minutes after the administration of a fast-acting [MED]. This is evidenced by: Example 1: On [DATE] at 3:31 PM, the Surveyor observed LPN-D (Licensed Practical Nurse) administer medications to R17. Included in the observation was the administration of [MEDICATION NAME] propionate 50 MCG ([MEDICATION NAME]) inhaler. She assisted R17 with inhaling two puffs of the medication. There was no rinse and spit offered or encouraged by LPN-D following the inhaling of the medication. The pharmacy label on the inhaler stated Special Instructions: Rinse mouth with water after use. Do not swallow. Drugs. com for [MEDICATION NAME] propionate 50 MCG inhaler stated .To reduce the chance of developing a yeast infection in your mouth, rinse with water (but do not swallow) after using this medicine. At 4:35 PM, the Surveyor interviewed LPN-D regarding the observation made, and asked her, what can happen if [MEDICATION NAME] was given without a rinse and spit:. LPN-D stated, They can develop a sore mouth. Yeah, we didn't rinse and spit. Example 2: On 3/2/20 at 4:26 PM, LPN-D administered 6 units of [MEDICATION NAME] [MED], a fast-acting [MED], to R53. At 4:52 PM, the Surveyor noted that R53 still had not received her meal and approached R53 and asked if this is a common occurrence. R53 stated, Sometimes yes, but tonight is more because of the special spaghetti dinner, I think. At 4:57 PM, the Surveyor approached LPN-D and asked when R53 generally receives her evening meal. LPN-D stated, I told the kitchen that she needs her meal. I guess they still didn't bring it. At 5:09 PM, CNA-M (Certified Nursing Assistant) came down the hall with a small cart and two resident meal trays. The Surveyor asked CNA-M if they need to observe special practices with a resident given [MED]. CNA-M stated, We should give them something to eat. I was waiting for her tray, they (dietary) dish it up and tell me when it's ready. R53 began to eat her meal at 5:11 PM, 45 minutes after she was administered the [MED]. At 5:14 PM, Surveyor interviewed LPN-D once again and asked her what can result if meals are not served within 10-15 minutes of injecting [MEDICATION NAME]. LPN-D stated, their blood sugars can bottom out, can be critical if injected a large amount of [MED]. She then shrugged her shoulders and stated, I told the kitchen twice to give her the meal tray. Drugs. com states [MEDICATION NAME] is a fast-acting [MED] that starts to work about 15 minutes after injection . [MEDICATION NAME] is a fast-acting [MED] that begins to work very quickly. After using it, you should eat a meal within 5 to 10 minutes.