DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0W7R
Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**

2.STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLETON COMMUNITY HOME**
(L4) **301 TROENDLE STREET**
(L5) **MAPLETON, MN** (L6) **56065**

4. TYPE OF ACTION: 7 (L8)

1. Initial
2. Recertification
3. Termination
4. CHOW
5. Validation
6. Complaint
7. On-Site Visit
9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/18/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 08/21/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/21/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245362

August 21, 2014

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, Minnesota 56065

Dear Ms. Gosson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 14, 2014 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 60 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697
cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 21, 2014

Ms. Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, Minnesota 56065

RE: Project Number S5362022

Dear Ms. Gosson:

On July 17, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 3, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of July 17, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from October 3, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on July 1, 2014. The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 18, 2014, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) and the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 1, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 1, 2014, as of August 14, 2014.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of July 17, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective October 3, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective October 3, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective October 1, 2014, is to be rescinded.

In our letter of July 17, 2014, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from October 1, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on August 14, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245362	A. Building B. Wing	8/18/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 07/30/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 07/30/2014	ID Prefix F0318 Reg. # 483.25(e)(2) LSC	Correction Completed 07/30/2014
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/KFD	08/21/2014	03048	08/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/3/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245362	01 - MAIN BUILDING 01	8/18/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	07/15/2014	ID Prefix Reg. # NFPA 101 LSC K0069	07/11/2014	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	08/21/2014	19251	08/18/2014

Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 7/1/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245362	02 - 2011 ADDITION	8/18/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 07/15/2014	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/KFD	08/21/2014	19251	08/18/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/1/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES | CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 0W7R
Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**

2. STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLETON COMMUNITY HOME**
(L4) **301 TROENDLE STREET**
(L5) **MAPLETON, MN** (L6) **56065**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/03/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
09/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **60** (L18)

13.Total Certified Beds **60** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel
__ 3. 24 Hour RN
__ 4. 7-Day RN (Rural SNF)
__ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	60			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Wendy Buckolz HFR Nursing Evaluator II 08/01/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 08/20/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 5439

July 17, 2014

Ms Roxanne Gosson, Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, Minnesota 56065

RE: Project Number S5362022

Dear Ms. Gosson:

On July 7, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an abbreviated survey, completed on July 1, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On July 3, 2014, the Minnesota Department of Health and on July 1, 2014, the Minnesota Department of Public Safety completed a standard survey to determine if your facility was in compliance with federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective October 3, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 3, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 3, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mapleton Community Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 3, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Kathryn Serie, Unit Supervisor
Minnesota Department of Health
1400 E. Lyon Street

Marshall, MN 56258
Office: (507) 537-7158
Fax: (507) 537-7194

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your ePoC must:

Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

Include electronic acknowledgement signature of provider and date.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedy be imposed:

Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. I

order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 1, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:

http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING ______ B. WING ______	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

(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 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	See POC following.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279 approved 8/1/13 KMJ	All Completion dates of 7/30/2014 RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/31/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING ______ B. WING ______	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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F 279	Continued From page 1	F 279		

by:
Based on interview and document review the facility failed to develop a plan of care that included monitoring of anti-coagulant (blood thinning) medications, a diuretic (fluid pill) medication and an antidepressant medication for 1 of 5 residents (R32) reviewed for unnecessary medications. Additionally, the facility failed to develop a plan of care related to a heel ulcer for 1 of 3 residents (R10) reviewed who for pressure ulcers.

Findings include:

R32's physician orders dated and signed 6/12/14 included: Coumadin 2.5 milligrams (mg) daily (blood thinner), aspirin 162 mg daily, Lasix 40 mg twice a day (removes fluid) and Zoloft 100 mg daily (anti-depressant).

R32's care plan revised 6/25/14, identified diagnoses to include atrial fibrillation, congestive heart failure (CHF), and depressive disorder. The care plan lacked a problem statement, goals and approaches related to the use, side effects/risks and monitoring of the anticoagulants, diuretic, and antidepressant medication.

When interviewed on 7/3/14, at 8:10 a.m., registered nurse (RN)-B confirmed the care plan did not address R32's use of anticoagulant, diuretic, and antidepressant medication and should have. RN-B further stated finding it hard to believe that the diuretic was not addressed on the care plan as R32 was weighed daily due to edema.
R10 was admitted with an ulcer to the right heel and a comprehensive care plan had not been developed.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 2	F 279		
	R10 was admitted to the facility 5/16/14, with diagnosis including diabetes type 2 and ulcer of heel and mid foot. R10 was transferred to the hospital on 5/28/14 and returned to the facility on 6/3/14.			
	The admission Minimum Data Set (MDS) dated 6/10/14, identified the presence of a diabetic foot ulcer. The hospital discharge note from 6/3/14, identified R10 as having a history of a right heel diabetic ulcer that had been present for quite some time. R10 had received intravenous (IV) antibiotic therapies for the ulcer. R10 was referred to the infectious disease department to determine whether or not ongoing antibiotic therapy was needed.			
	Review of the medical record contained only an admission care plan dated 6/3/14, that said "ulcer right heel." No comprehensive care plan was provided by the facility.			
	During an interview with registered nurse (RN)- B on 7/2/14, at 9:00 a.m. she verified that no comprehensive care plan for skin condition/heel ulcer had yet been developed for R10.			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN	F 282		
	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.		RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	
	This REQUIREMENT is not met as evidenced by:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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F 282	Continued From page 3 Based on observation, interview and document review the facility failed to follow the plan of care related to the intervention of a hand splint for 1 of 2 residents (R52) reviewed with limited range of motion. Findings include: R52's diagnoses identified on the annual OBRA (Omnibus Budget Reconciliation Act) assessment included arthritis. During observation on 6/30/14, at 12:15 p.m., R52 was seated in a geri chair in the dining room holding his left hand in a curled position with no left wrist splint in place. During observation on 6/30/14, at 1:19 p.m., R52 was transferred by NA-A and NA-B from geri chair to bed using a mechanical lift. R52 did not have his left wrist splint in place. NA-B stated R52 was supposed to have a left wrist splint on when up but that he hadn't been wearing it. R52 was observed to keep his left hand curled on his midline the entire time he was being transferred. During observations on 7/1/14, from 4:44 p.m. until 6:08 p.m., R52 was seated in his geri chair and was not wearing a left wrist splint. R52 had been provided assistance by staff from the activity room to the dining room for supper and then to his bedroom after supper during this observation. No alternative to the left wrist splint was observed to be used during the observation. During observation on 7/1/14, at 7:00 p.m., R52 was seated in his geri chair in the activity room with his left hand in his lap and fingers curled inward; there was not a left wrist splint in place.	F 282	RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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F 282	Continued From page 4 R52 was observed to move his left hand and arm in small increments, but did not open his hand or uncurl his fingers. Review of R 52's care plan dated 4/25/14, indicated R52 had chronic pain related to arthritis with interventions that included: "Put splint on left wrist daily when out of bed". When interviewed on 7/2/14, at 10:45 a.m. registered nurse (RN)-A verified R52 was to wear a splint on his left wrist when out of bed. RN-A further stated the splint had been missing for 2-3 weeks. RN-A verified the physician order dated 4/11/13, which indicated R52 was to have left wrist splint on when out of bed and further verified this was also indicated on R52's care plan.	F 282		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services to prevent further decrease in range of motion (ROM) related to the intervention of a hand splint for 1 of 2 residents (R52) reviewed with limited range of motion.	F 318	RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING ______ B. WING ______	07/03/2014

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MAPLETON COMMUNITY HOME	**301 TROENDLE STREET MAPLETON, MN 56065**

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F 318	Continued From page 5 Findings include: R52's diagnoses identified on the annual OBRA (Omnibus Budget Reconciliation Act) assessment included arthritis. During observation on 6/30/14, at 12:15 p.m. R52 was seated in a geri chair in the dining room holding his left hand in a curled position with no left wrist splint was in place. During observation on 6/30/14, at 1:19 p.m. R52 was transferred by NA-A and NA-B from geri chair to bed using a mechanical lift. R52 did not have his left wrist splint in place. NA-B stated R52 was supposed to have a left wrist splint in place when up but that he hadn't been wearing it. R52 was observed to keep his left hand curled on his midline the entire time of transfer. During observations on 7/1/14, from 4:44 p.m. until 6:08 p.m. R52 was seated in the geri chair and without the left wrist splint. R52 had been provided assistance by staff from the activity room to the dining room for supper and then to his bedroom after supper during this observation. No alternative to the left wrist splint was observed to be used during the observation. During observation on 7/1/14, at 7:00 p.m. R52 was seated in his geri chair in the activity room with his left hand in his lap and fingers curled inward; there was not a left wrist splint in place. R52 was observed to move his left hand and arm in small increments, but did not open his hand or uncurl his fingers. Review of R 52's care plan reviewed 4/25/14, indicated R52 had chronic pain related to arthritis	F 318	RECEIVED AUG 01 2014 Minnestoa Department of Health Marshall	

PRINTED: 07/14/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING ______ B. WING ______	07/03/2014

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MAPLETON COMMUNITY HOME	**301 TROENDLE STREET MAPLETON, MN 56065**

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F 318	Continued From page 6 with interventions that included: "Put splint on left wrist daily when out of bed." When interviewed on 7/2/14, at 10:45 a.m. registered nurse (RN)-A verified R52 was to wear a splint on his left wrist when out of bed. RN-A further stated the splint was missing and had been missing for 2-3 weeks. RN-A verified the physician order dated 4/11/13, which indicated R52 was to have left wrist splint on when out of bed. RN-A stated she had notified the director of nursing (DON) 2-3 weeks previously to update her that R52's splint was missing. During a subsequent interview at 12:05 p.m., RN-A stated she had checked with the the therapy department who confirmed a new splint had not been ordered for R52. When interviewed on 7/2/14, at 12:45 p.m. certified occupational therapy assistant (COTA)-A revealed that she was the therapy representative who attended report and other meetings at the facility. COTA-A then added that she recalled that it was stated in report that R52's splint was missing, COTA-A stated she had asked whether R52 needed an occupational therapy (OT), but was told to wait and see if the splint was found. COTA-A stated she was uncertain of the date when this incident actually occurred but thought it was 2-3 weeks previously. COTA-A stated she had no recollection of this issue being mentioned again. When interviewed on 7/2/14, at 1:40 p.m. RN-A stated R52's left wrist splint had been found in R52's locker located in his room. When interviewed on 7/3/14, at 8:31 a.m. RN-C stated that if a resident had a splint ordered that it	F 318	RECEIVED AUG 01 2014 Minnestoa Department of Health Marshall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING ______ B. WING ______	07/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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F 318	Continued From page 7 should be worn according to that order. RN-C confirmed that in this instance there had been an error in nursing judgment. RN-C stated that staff should have continued to look for R52's missing left wrist splint until it was found or use an alternative such as a rolled washcloth until a replacement was obtained. RN-C verified that RN-A had reported the splint was missing but there was no follow up after that point. RN-C stated she was not aware of a policy regarding notification or replacement of a splinting device. RN-C further verified that there should have been documentation as to the process being followed regarding obtaining a replacement wrist splint. RN-C stated that, to the best of her knowledge, the splint had been missing at a minimum 2-3 weeks.	F 318		

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Minnestoa Department of Health
Marshall

Mapleton Community Home Plan of Correction

TAG F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS

1) A template is added to Care Plans and will be initiated for (R32) on antidepressants, diuretics and anticoagulants. The template will address the labs required by the MD. related to the use of these drugs, along with behavior screening for depression as ordered by MD. This will ensure proper monitoring for those with diagnosis of any depressive disorder, atrial fibrillation, congestive heart failure or other diagnosis requiring those classifications of medications. A template for wound care is in place on the Care Plan of (R10) so that wounds will be managed from admission and continued or changed until it would no longer apply.

2) Each resident, on admission and taking an antidepressant, diuretic and/or anticoagulant will have that use specified on their Care Plans and be monitored by the labs ordered by the MD. as they apply to the resident. Behavior Screening Form will be used for monitoring of depression. Residents with wound(s) will have the wound(s) addressed on the Care Plan. Wound(s) requiring treatment will be discussed at the Daily Staff Report Meetings to monitor the effectiveness of the treatment and if a change is needed. Unless there is a change in condition, the wound will be addressed when the resident is seen on Dr. rounds.

3) All-Staff Meeting, attended by nursing staff were instructed in the initiation of these additions to the Care Plans:
   A) Antidepressant use - address in Care Plan, monitor as required by MD.
   B) Anticoagulation use – address in Care Plan, monitor as required by MD.
   C) Diuretic use – address in Care Plan, monitor as required by MD.
   D) Wound Care – address in Care Plan, monitor weekly, through Daily Staff Report Meetings for effectiveness of treatment and make changes as needed until healed. Seen by MD on scheduled rounds.

4) The facility will monitor the effectiveness of these additions to the Care Plans by the discussions at Daily Staff Report Meetings in addition to the MDS Coordinators regularly scheduled assessments that will directly be involved in the sustaining of these solutions.

5) Sherry Slinger R.N., Director of Nursing *Sherry Slinger RN DON*
   Date of Completion 7/30/2014

F TAG 282 483.20(k)(3)(ii)SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

1) Use of splint on (R52) is documented in the Treatment Book. The use of the splint and its purpose is included in the Care Plan. Use of this device will be signed off by nursing staff as being applied to resident. If not worn, there is documentation for the non-use. Daily Report Meetings discuss any missing devices being used for therapeutic purposes and the plan for replacement discussed.

2) Any resident requiring the use of a device for comfort and/or therapy will have the use for this device entered in the Treatment Book and this will be signed each shift by the Charge Nurse as being used. If not able to be used, documentation will explain the non-use. Supervisors will be notified when any device used for comfort and/or therapy, is missing. This will initiate a search in appropriate areas as applicable. If device is not found, a therapeutic replacement will be used until original device is found or replacement obtained.

3) Daily Staff Report Meetings will address the use of device(s) and the effectiveness of that use. The scheduled MDS assessments will evaluate the effectiveness and continuation of use of the device(s). The required, routine MD visits will be used as assessment opportunities to determine the effectiveness of the device.

4) All-Staff Meeting to train staff in the reporting to supervisors, when appliances used for comfort and/or therapy is missing. Until appliance is replaced, a therapeutic replacement will be used.

5) Sherry Slinger R.N., Director of Nursing *Sherry Slinger RN DON*
   Date of Completion 7/30/2014

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Marshall

Mapleton Community Home Plan of Correction

F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION

1) Range of Motion will be done for (R52) daily by trained staff each morning with the application of the hand splint. This is documented each day by the charge nurse when charting daily duties in the Treatment Book.

2) Any resident requiring the use of a device for comfort and/or therapy will have the use for this device entered in the Treatment Book and this will be signed each shift by the Charge Nurse as being used. Staff is aware of the need to do Range of Motion for those residents that use devices that may restrict movement. The Range of Motion exercise will be done prior to the application of the device and documented daily.

3) Daily Staff Report Meetings will address the use of device(s) and the effectiveness of that use, as well as the ROM exercises that are done prior to use. The scheduled MDS assessments will evaluate the effectiveness and continuation of use of the device(s). The required, routine MD visits will be used as assessment opportunities to determine the effectiveness of the device.

4) All-Staff Meeting held to bring awareness of the process of ROM exercises prior to application of the device on the resident. MDS Assessment will monitor the use of the splints and the ROM exercise that accompanies its use.

5) Sherry Slinger R.N., Director of Nursing Sherry Slinger RN DON
Date of Completion 7/30/2014

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AUG 01 2014
Minnesota Department of Health
Marshall

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5362022

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

(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
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 01, 2014. At the time of this survey, Building 01 of Mapleton Community Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	PoC ok FS 8-7-14 RECEIVED AUG - 1 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	

Dc. 8-10-14

Exit. 7-3-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/31/14

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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MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

(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
K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a	K 000	RECEIVED AUG 01 2014 Minnestoa Department of Health Marshall	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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K 000	Continued From page 2 capacity of 60 beds and had a census of 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all 53 residents. Findings include: On facility tour between 10:30 AM and 1:30 PM on 7/01/2014, it was revealed during dcumentation review that the facility failed to conduct a Day-shift fire drill in the 1st quarter and a Night-shift fire drill in the 3rd quarter of 2013-2014 not in accordance with NFPA 101 LSC	K 050	FIRE DRILLS WILL BE MONITORED BY THE E.S. DIRECTOR AND BY THE E.S. ASSISTANT TO ENSURE THAT THEY ARE COMPLETED AS REQUIRED. RECEIVED AUG 01 2014 Minnesota Department of Health Marshall	7/15/14

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING 01 - MAIN BUILDING 01 B. WING	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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K 050	Continued From page 3 Section 19.7.1.2. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 050		
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility's commercial kitchen hood mesh filter system is not in accordance with NFPA 101 (2000) Section 9.2.3. This deficient practice could adversely affect 15 of 53 residents or staff.. FINDINGS INCLUDE: During the facility tour between 10:30 AM and 1:30 PM on 7/01/2014, it was observed that the kitchen hood had the mesh type filiters and not the stainless steel baffled filters in accordance with NFPA LSC(00) edition section 9.2.3. This deficient practice was confirmed with the Maintenance Supervisor.	K 069	THE MESH TYPE FILTERS HAVE BEEN REPLACED WITH SS. BAFFLED FILTERS	7/11/14

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AUG 01 2014
Minnesota Department of Health
Marshall

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING 02 - 2011 ADDITION B. WING	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 01, 2014. At the time of this survey, Building 02 of Mapleton Community Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	POC ok TS 8-7-14 FIRE DRILLS WILL BE MONITORED BY THE E.S. DIRECTOR AND BY THE E.S ASSISTANT TO ENSURE THAT THEY ARE COMPLETED AS REQUIRED.	7/15/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Dan Schager	E.S. Director	7/15/14

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING 02 - 2011 ADDITION B. WING ______	07/01/2014

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K 000	Continued From page 1 By eMail to: Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Mapleton Community Home consists of the 2011 nursing home addition, which included a link to an assisted living facility. The link incorporates a barber/beauty shop, storage rooms and staff office space. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 53 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 050		

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K 050	Continued From page 2 varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 18.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to provide quarterly drills for each shift in the last 12-month period in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Improper reaction by staff would affect all 53 residents. Findings include: On facility tour between 10:30 AM and 1:30 PM on 7/01/2014, it was revealed during dcumentation review that the facility failed to conduct a Day-shift fire drill in the 1st quarter and a Night-shift fire drill in the 3rd quarter of 2013-2014 not in accordance with NFPA 101 LSC Section 19.7.1.2. This deficient practice was verified by the Maintenance Supervisor at the time of the inspection.	K 050		