DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 17, 2026

Administrator
MAPLE LAWN SENIOR CARE
400 SEVENTH STREET NE
FULDA, MN 56131

RE: CCN:245570
Cycle Start Date: February 26, 2026

Dear Administrator:

On Cycle February 26, 2026, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, 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 your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
  What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 26, 2026 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 26, 2026 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.
A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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: https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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March 17, 2026

Administrator
MAPLE LAWN SENIOR CARE
400 SEVENTH STREET NE
FULDA, MN 56131

Re: State Nursing Home Licensing Orders
Event ID: 1E0C36-H1

Dear Administrator:

The above facility survey was completed on February 26, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html.

The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Nicole Dahl, RN, Regional Operations Supervisor
Marshall District Office
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: Nicole.Dahl@state.mn.us
Office: 507-476-4230

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245570	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LAWN SENIOR CARE	400 SEVENTH STREET NE , FULDA, Minnesota, 56131

(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
E0000	Initial Comments On 2/23/26 through 2/26/26, a survey for compliance with CFR §483.73, Appendix Z, Emergency Preparedness Requirements was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E0000		03/26/2026
F0000	INITIAL COMMENTS On 2/23/26 through 2/26/26, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with §42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed: H55706473C (2701253) and H55706320C (2742921, 2743066, and 2747345). NO deficiencies were cited. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F0000		03/26/2026
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the	F0553	The Care Plan Meeting policy will be reviewed and updated to reflect the process for completion of the initial and future care conferences.	04/07/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245570	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/26/2026

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F0553 SS = D	Continued from page 1 development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the resident had a care conference to be able to participate in the planning process and development of interventions of their care for 1 of 1 sampled resident (R7) who had been at the facility for 3 months with no care conference scheduled. Findings include: R7's 12/01/25, accepted admission Minimum Data Set (MDS) assessment identified that R7 had admitted to the facility in the middle of November 2025. R7 cognition	F0553	Continued from page 1 R7 care conference was held on 3/6/26 with the resident and family in attendance. An audit of all current resident charts will be completed to ensure that all residents have had a care conference held within 21 days of admission and 92 days thereafter. Any resident that has not had a care conference within this time frame will immediately be scheduled a care conference Education will be conducted with all members of the interdisciplinary team who participate in care conferences re: the Care Plan Meeting policy The DON or their Designee will complete audits of all resident charts to ensure care conferences are held within the required timeframe for 3 wks, and if compliant, reduce to 1 random audit per wk for 3 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 3, 2026	

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F0553 SS = D	Continued from page 2 was intact. She used a walker or a wheelchair for mobility and required partial assistance with some activities of daily living (ADL's). She had diagnoses of arthritis, thyroid disorder, diabetes, renal disease, and hypertension. R7's plan was to remain living in the facility. Additionally, a 2/20/26, accepted quarterly MDS assessment was completed identifying again R7's cognition was intact. Interview on 2/23/26 at 2:33 p.m., with R7 identified, she had not been invited to or attended a care conference since coming to the facility. Review of R7's progress 11/12/25 through 2/22/26, had no mention of a care conference occurring since admission to the facility. Interview on 2/24/26 at 1:42 p.m., with the activity director identified that care conferences followed the MDS schedule. There was to be a progress note made and the multidisciplinary care conference form filled out by each department following a care conference. Review of R7's assessments lacked any assessment titled "Interdisciplinary care conference" and there were no assessments identified as a care conference form. Interview on 2/25/26 at 10:47 a.m., with registered nurse (RN)-A identified that typically a care conference was scheduled by the social service designee (SSD) within 2 weeks of the MDS assessment completion. The facility would document a care conference meeting on the care conference form under the assessment section in point click care (PCC) and make a progress note. RN-A confirmed she could not find documentation that a care conference had occurred for R7 since admission. Interview on 2/25/26 at 10:58 a.m., with SSD identified that when a resident admitted to the facility a care conference would be set up within the first 2-4 weeks of admission. Care conference would then take place every quarter after that. She confirmed that R7's initial care conference had been missed stating it was "just an overlook" but she did have one scheduled now in March, confirming that was 4 months after admission to the facility.	F0553		

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F0553 SS = D	Continued from page 3 Interview on 2/26/26 at 8:23 a.m., with the director of nursing (DON) identified she was unsure of when resident care conferences should take place and stated, “I would have to reference our policy”. Review of the undated, Care Plan Meeting policy identified each resident admitted to the facility would receive a person-centered, comprehensive care plan developed through the interdisciplinary team and the resident and/or representative. The care plan would be developed via assessments and consultation with the residents and/or representatives. The care planning meeting would be held, 7-10 days following the completion of the comprehensive MDS assessment and then quarterly thereafter. Care plan meeting shall also be held when there is a significant change in the resident’s status, or when requested by the resident/representative or facility. The residents shall participate in the care planning process and if unable the representative will be involved. The care plan meeting would be documented and include the date and time of the meeting, who attended, and a summary of the meeting.	F0553		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2)(i)-(iii) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate.	F0628	A fax communication with all the required information will be sent monthly to the Office of the Ombudsman regarding the transfers and/or discharges of residents out of the facility for the previous month. A record of faxed notifications with proof of fax being sent will be kept in the file of the Social Services Coordinator. An audit will be completed for the last 30 days of transfers and discharges, and the ombudsman will be notified of those residents The administrator or their designee will complete an audit monthly of the faxed notifications for the first 3 months, and if compliant, reduce to random audits conducted for the next 6 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	04/07/2026

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F0628 SS = D	Continued from page 4 (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by	F0628		

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F0628 SS = D	Continued from page 5 the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes	F0628		

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F0628 SS = D	Continued from page 6 available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F0628		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0628 SS = D	Continued from page 7 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to ensure the ombudsman was notified following discharge from the facility for 3 of 3 sampled residents (R1, R3, and R41). Findings include: R1’s 1/2/26, accepted discharge return anticipated Minimum Data Set (MDS) assessment identified he had an unplanned discharged to the hospital on 12/17/25. Review of nursing progress note dated 12/17/25 at 1:47 p.m., identified R1 was sent to the hospital emergency department via ambulance for evaluation due to having poor color, lips cyanotic, and R1 was shaking. Review of nursing progress note dated 12/22/25 at 12:13 p.m., identified the facility had received a nurse-to-nurse report from the hospital. R1 was admitted to the hospital on 12/17/25, with diagnoses of acute hypoxia with respiratory failure. R1 returned to the facility on 12/22/25. Confirmation of ombudsman notice of discharge was requested for R1; however, the facility did not provide one by the end of the survey period. R3’s 2/16/26, accepted modified Minimum Data Set (MDS) assessment identified she had diagnoses including chronic obstructive pulmonary disease (COPD), dementia with moderate mood disturbance, Alzheimer's, congestive heart failure (CHF), A-fib, hepatic failure, CKD stage	F0628		

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F0628 SS = D	Continued from page 8 3, anxiety disorder, type II diabetes, hypertension (HTN), and chronic respiratory failure with hypoxia. R3's 2/20/26 at 5:59 p.m. progress note identified beginning of a change in condition, and following notification of the MD and review of ordered laboratory results R3 was hospitalized on 2/21/26. R41's 2/6/26, accepted discharge with return not anticipated, MDS identified R41 was admitted on 1/16/26 and discharged on 1/30/26. R41's1/30/26 at 10:00a.m. Discharge Summary identified R41's family arrived at the facility on 1/30/26 and reported they were taking R1 home without waiting for results of the home safety evaluation. R41 was discharged to home Against Medical Advice (AMA). Interview on 2/25/26 at 1:09 p.m. with the social services designee (SSD) reported she had not completed Ombudsman notifications since 2024. She stated, she thought she might have done some notifications in 2025 but had no record of doing so. She reported she was not aware of the requirement to provide notification of hospital admissions or facility discharges, and as a result she had not done so. Interview on 2/25/26 at 2:07 p.m. with the director of nursing (DON) identified she was aware of the regulation for notification of the ombudsman of hospitalizations and discharges, but not aware it was not being completed. Confirmation of ombudsman notice of discharge was requested for R1, R3 and R41; however, the facility did not provide documentation the ombudsman had been notified of the discharges by the end of the survey period.	F0628		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan	F0656	R28's care plan was immediately updated to include anticoagulant use and signs and symptoms of side effects. All Residents who are on an anticoagulant had their charts audited to ensure that their care plans reflected the use of an anticoagulant, and the side effects associated with that medication. Staff involved in care plan development will be educated on the importance of person-centered care plans	04/07/2026

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F0656 SS = D	Continued from page 9 must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive person-centered care plan for 1 of 5 sampled residents (R28) reviewed for unnecessary medication review. Findings include: R28's 12/29/25, accepted quarterly Minimum Data Set (MDS) assessment identified R28's cognition was intact.	F0656	Continued from page 9 The DON or their Designee will complete audits of care plans on all new residents to ensure care plans reflect the use of an anticoagulant and the side effects for 3 wks, and if compliant, reduce to 1 random audit per wk for 3 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	

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F0656 SS = D	Continued from page 10 R28 used a walker or wheelchair for mobility and required partial to moderate assistance from staff for activities of daily living (ADL's). R28 took a daily anticoagulant medication. R28's 2/25/26, printed diagnosis list identified persistent atrial fibrillation (abnormal heart rhythm), high blood pressure, history of broken wrist, long term use of anticoagulants (blood thinner) and a history of stroke. R28's 2/24/26, Order Summary Report identified R28 took Apixaban (anticoagulant medication to prevent blood clots or stroke for people with atrial fibrillation) 2.5 milligrams twice a day for atrial fibrillation. There was no order or mention of monitoring for side effects of the anticoagulant medication that can cause bleeding, nausea, and increased bruising. R28's September 2025, care plan identified R28 had potential for nutritional problems related to low body mass, high blood pressure, atrial fibrillation, irritable bowel syndrome, and gout. There was no mention that R28 took an anticoagulant medication or the need for staff to monitor any side effects of that medication. Interview and document review on 2/2/26 at 9:44 a.m., with registered nurse (RN)-A identified she completed a review and updated the care plan following completion of an MDS assessment. All nurses were able to and should be updating the resident care plans "as things change" as she was not the only one who updated care plans. She confirmed there was no mention on R8"s care plan of anticoagulant medication or for staff to monitor for side effects on R28's care plan. She agreed that information should be on the care plan. Interview on 2/26/26 at 8:23 a.m., with the director of nursing (DON) identified any resident taking anticoagulant should have interventions and monitoring identified on the care plan and include the side effects of the medication. Review of January 2025, Care plans, Comprehensive Person-Centered policy identified that each resident would have a person-centered care plan that included measurable goals to meet the resident's physical,	F0656		

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F0656 SS = D	Continued from page 11 psychosocial and functional needs. The care plan interventions would be developed through assessments, gathering information from the interdisciplinary team, the resident/representative, and the attending physician. The care plan would include goals, treatments, specialized services, to aid in preventing or reducing decline in the resident's status and enhance optimal functioning while reflecting current standards of practice. The care plan should be developed or revised within 7 days of the completion of the MDS assessment.	F0656		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to appropriately assess, document, and revise	F0657	R8 was interviewed and restorative exercises were re-assessed. Care plan updated to reflect appropriateness and accuracy. All current resident charts will be audited for documentation of a restorative therapy program, and the care plan will be reviewed and updated to reflect appropriateness and accuracy of the program. Education provided to staff on exercise plans and the frequency of completing exercises to comply with standards. Audits will be completed in alignment with the MDS schedule and with changes in condition for 3 weeks and if compliant, reduce to 1 random audit per wk for 2 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	04/07/2026

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F0657 SS = D	Continued from page 12 the care plan for 1 of 1 sampled resident (R8) who had restorative therapies identified on his care plan, but was not receiving or completing those therapies as indicated. Findings include: R8's 2/16/26, accepted quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 was noted to have impairments bilaterally on his upper and lower extremities. R8 used a wheelchair for mobility. R8 was independent with eating, required substantial assistance from staff for dressing, personal hygiene, and required total assistance from staff for toileting and bathing. R28 used a Sit to Stand mechanical device with substantial assistance from staff for transfers. R8 was not noted to ambulate. R8 had not participated in any formal type of therapy or restorative program. R8's 2/26/26, printed Medical Diagnosis list identified pulmonary disease, symptoms involving the musculoskeletal system, asthma, tremors, radiculopathy of lumbar region (compressed or irritated nerve roots in lower spine often referred to as sciatica), functional implants, emotional liability (exaggerated, and uncontrollable swings in emotion), polyneuropathies (widespread damage of peripheral nerves, causing numbness, tingling, burning pain, and muscle weakness), Arthritis, high blood pressure, and restless leg syndrome. R8's 7/10/25, care plan identified R8 was at risk for weakness and loss of self-care and mobility independence. R8 would participate in an informal restorative program with staff assistance to maintain lower and upper body strength and ambulation through the review date. R8's exercises included 3-4 times a week dowel (a ¾ inch rod or broomstick) exercises with 3 pounds while seated for 15 repetitions. R8 was also to perform seated legs exercises with a number 2 therapy band times 15-20 repetitions and had a walking plan for 5 times a week to ambulate with four-wheeled walker assisted by a restorative aid bringing the wheelchair along. Review of R8's Functional Abilities and Goals assessments identified:On 1/10/25, R8 used a walker and wheelchair. For mobility R8 required partial/moderate assistance with transfers and supervision or touching assistance for ambulation of up to 50 feet.On 7/10/25,	F0657		

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F0657 SS = D	Continued from page 13 R8 used a walker and wheelchair. R8 only walked occasionally with the restorative aides who walked with him bringing a wheelchair behind. For mobility, R8 required substantial/maximal assistance with transfers and was dependent on staff to ambulate 10 feet. R8 did not attempt to ambulate 50 feet due to medical conditions or safety concerns.On 10/18/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 or 50 feet due to medical condition or safety concerns.On 11/14/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 due to medical condition or safety concerns.On 2/11/26, R8 used a wheelchair. For mobility R8 required substantial/maximal assistance with transfers. Walking 10 feet was identified as Not applicable.There were no other assessments related to R8's restorative exercise abilities found in his medical record. Review of progress notes identified on:On 12/10/25 R8's restorative therapy plan was reviewed. R8's restorative program was changed to ambulate to breakfast in the morning as tolerated. There was no mention of why the restorative program was reviewed or details of the assessed program even though the 11/14/25 functional assessment identified R8 did not attempt to walk.On 12/17/25, Staff reported R8 was having more difficulty, and at times unable to stand as his legs buckled and then he would hang from the lift. R8 seemed weaker and less able to assist with his cares. There was no mention of any nurse assessing the reported difficulty with standing or safety concern of using the standing lift.On 1/8/26, R8 was uncooperative throughout the day, during a transfer he would repeatedly refuse to place his hands on the equipment handles as instructed. Only after 5 verbal prompts did R8 comply with assisting. R8 also refused to wear his shoes during the transfer process. Interview on 2/23/26 at 1:25 p.m., with R8 identified he did not participate in a restorative exercise program. He reported he squeezed a ball he had and that it worked just the same. R8 reported he used to go and exercise where he rode the bike; however, the facility had cut that to save money. Interview on 2/26/26 at 9:14 a.m., with nursing assistant (NA)-A identified that R8 never walked, he did have a walking restorative program, but he was very particular with his cares and how he wanted things, he refused to walk. R8 used a standing lift for all	F0657		

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F0657 SS = D	Continued from page 14 transfers with one staff assistance. If staff note a decline in a residents function the staff are to tell the nurse. The nurse would assess the resident and if needed the resident was seen by the physician if they did not get better. Interview on 2/26/26 at 9:21 a.m., with licensed practical nurse (LPN)-A identified R8 used to walk but he would not walk anymore. When he was participating in his restorative program, he did not want to walk and would tell staff he was just “waiting to die”. Staff would try to get him to walk, but he refused. R8 not wanting to walk, “might have something to do with his leg issues”. He has an implant in his back that needs to be charged in a special chair every week. When the battery in his implant is getting low sometimes his legs don’t want to work, and they really start to “bother him”. All nurses could update a resident’s care plan, however, registered nurse (RN)-A typically reviewed and made updates to care plans following the completion of a resident’s MDS assessment. Interview on 2/26/26 at 9:44 a.m., with RN-A identified she reviewed care plans following completion of the MDS; however, all nurses were able to and should be updating the resident care plans “as things change”. R8 did have a restorative program and there was a task for staff to document on his completion of the restorative program however, she had removed the task that would identify staff were to ensure R8 completed his walking, as he was refusing to walk. R8 had been working with restorative therapy until the staff that worked in that department had resigned; however, she was unsure if he was walking with the restorative staff either. IF a nurse identified a need for a change in the residents care they were responsible for updating the care plan. She confirmed R8’s care plan should have been updated to reflect his status. Review of R8’s medical record lacked identification of refusals of his restorative exercises and lacked an updated assessment for identified restorative exercises or risk to benefit showing R8 was made aware of potential decline by not completing his restorative treatments. Interview on 2/26/26 at 9:58 a.m., with the director of nursing (DON) identified she had re-assessed R8’s restorative program back in December 2025 and changed his program to walking once a day to breakfast with	F0657		

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F0657 SS = D	Continued from page 15 staff assistance. She reported R8 was walking at the time, but he kept refusing to walk. She confirmed she should have updated the care plan when she first changed his restorative program back in December 2025 and when she was made aware he was refusing to walk at all. The facility had a good formal restorative program back around November or December of 2025 with a couple of staff. When she and the administrator had spoken to the restorative staff about some charting concerns, both staff placed their resignation, and the program was no longer fully staffed at that time. The facility had the direct care staff complete as many of the restorative programs as possible and had a light duty staff recently returned to work that was working on restorative programs, but the facility was unable to staff a formal program. She confirmed the residents were getting their restorative therapy, but not as “much restorative therapy as they should” as the facility still needed to fill the restorative positions. She revealed there was room for “improvement” in the restorative program and with the new therapy department starting on 3/2/26, all residents would be re-assessed at that time. Review of January 2025, Care plans, Comprehensive Person-Centered policy identified that each resident would have a person-centered care plan that included measurable goals to meet the resident’s physical, psychosocial and functional needs. The care plan interventions would be developed through assessments, gathering information from the interdisciplinary team, the resident/representative, and the attending physician. The care plan would include goals, treatments, specialized services, to aid in preventing or reducing decline in the resident’s status and enhance optimal functioning while reflecting current standards of practice. The care plan should be developed or revised within 7 days of the completion of the MDS assessment.	F0657		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.	F0684	The pressure ulcer/skin breakdown clinical protocol policy is to be reviewed and updated as appropriate. R42's wound was assessed, the physician contacted, a treatment identified, and a progress note written. Education to be provided to staff, regarding admission assessments, provider notification, and physicians providing the clinical basis of ulcer/wound type and diagnosis, along with appropriate treatment orders, as well as the standard for labeling and initialing a	04/07/2026

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F0684 SS = D	Continued from page 16 This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to re-assess nursing interventions and communicate findings for skin wound for 1 of 1 sampled resident (42) once an open area had been identified by nursing. Findings include: R42's 2/24/26, Admission Record identified that R42 was admitted to the facility mid-February 2026, from an assisted living facility. R42 had diagnoses of heart failure, diabetes, dementia, high blood pressure, and a history of stroke. Interview on 2/23/26 at 1:08 p.m., with R42 identified she had a sore on the back of her right leg that the nurse kept covered because otherwise she scratched it. ' R42's 2/19/26, baseline care plan identified R42 required partial assistance of one staff for cares, transfers, and ambulation. There was no mention of wounds or risk of wounds on R42's care plan. R42's 2/20/26, Weekly Skin Audit/Bath Form identified 3 small bruises on her left arm, and some bruising was noted on her lower abdomen caused by insulin injections for her diabetes. The skin audit identified there were no open lesions, cuts, lacerations, open skin folds, or skin tears. There were also no identified blisters, open ulcers, no dry or flaky skin, and no edema. R42's progress notes from 2/19/26 through morning of 2/24/26 identified on: 2/19/26, an initial skin assessment was completed. No open areas were noted. 2/22/26, R42 received a small bandage to her right shin for a small broken scab, measuring less than 1 centimeter all around. The progress notes made no mention of a wound on the back of R42's right leg lacking evidence that the wound had been communicated for continued monitoring for healing. Interview on 2/24/26 at 9:59 a.m., with nursing assistant (NA)-B identified R42 did have dressing on the back of her leg but she was not sure what was under	F0684	Continued from page 16 dressing, and the expectations for completing the skin audits/bath forms. DON will audit new admissions within 24 hours to ensure that a complete head-to-toe skin assessment is completed on the day of admission for the next 30 days and if compliant, reduce to 1 random audit per week for the next 60 days. Results of audits and recommended changes in processes will be brough to QAPI for review. Date of compliance is April 7, 2026.	

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F0684 SS = D	Continued from page 17 the dressing. R42's February 2025, treatment record and orders had no mention of a dressing to the back of R42's right leg. Interview, document review and observation on 2/24/26 at 12:58 p.m., with licensed practical nurse (LPN)-A and R42 identified LPN-A was unable to find in R42's medical record, any documentation R42 had a wound on the back of her right leg. There were no nursing or physician orders for wound treatment or monitoring. LPN-A also reviewed R42's last skin audit that was completed on 2/20/26 that only identified small bruises on arms and abdomen. She was unable to find any progress note about a wound since R42's admission the prior week however, she did find a note that a band aide had been applied to the front of R42 right shin. LPN-A then went to observe the back of R42's right leg and identified a self-adhesive padded dressing on R42 right calf that was dated 2/20/26 with no initials of who applied. The dressing was removed by LPN-A with a small amount of drainage on the bandage and a small open wound. LPN-A described as a "possible scab" that was scratched open. R42 at this time denied she scratched the back of her leg but maybe she had rubbed it on her recliner. LPN-A stated she "had no clue" R42 had an open sore on the back of her leg. LPN-A confirmed the nurse that identified the sore and applied the dressing should have made a progress note, set up a treatment, and updated the provider. Interview on 2/24/26 at 3:36 p.m., with director of nursing (DON) identified R42 had admitted from an assisted living facility and the day she arrived she refused to get undressed for the male staff. She was uncomfortable with the male staff completing the skin audit and that should have been delegated to another nurse. R42's wound was a recurrent one and it had just opened prior to her coming here and was one of the indications for her coming here as well. When the nurse identified the wound on the back of R42's leg the nurse should have contacted R42's primary provider for orders and set up the treatment. The DON revealed she would also expect a progress note of the wound assessment. Review of the undated, Pressure Ulcer/Skin Breakdown-Clinical Protocol policy identified newly admitted residents will have a skin examination done by the nurse to identify any existing pressure ulcers or other skin concerns.	F0684		

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F0684 F0688 SS = D SS = D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide services to maintain and/or prevent decrease in range- of-motion (ROM) for 1 of 1 sampled resident (R35) reviewed for limited range of motion. Findings include: R35's 8/19/2025, comprehensive Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He had diagnoses of cerebral palsy (condition primarily affecting leg movement and muscle stiffness) and dementia. R35's 2/10/26, Functional Abilities and Goals assessment identified R35 was dependent on staff for Activities of Daily Living (ADL)'s. He had no impairment to his upper extremities but was impaired on both sides of his lower extremities and used a manual wheelchair for mobility. R35's current, undated care plan identified he was at risk for decline in his physical condition related to cerebral palsy (condition primarily affecting leg	F0684 F0688	Staff education was completed immediately on the arm bike exercise and plan of care for R35. R 35 resident ROM was reassessed, and the restorative services and plan of care were reviewed and appropriate DON or Designee will randomly audit R35 ROM services 2x per wk. For 3 weeks, to ensure compliance, and the results of audits will be brought to QA Restorative Nursing policy reviewed and updated as appropriate. Education provided to clinical staff on exercise plans and the importance of completing exercises per plan of care to comply with standards. All other residents on restorative services were reviewed to ensure follow-through on the plan of care The DON or Designee will complete 3 random POC task audits weekly on residents receiving restorative services for the first month, and if compliant, transition to 1 audit per week for 2 months to ensure ROM exercises are completed. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	04/07/2026

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F0688 SS = D	Continued from page 19 movement and muscle stiffness) and was dependent on a wheelchair for mobility. The goal was for R35 to participate in a restorative exercise program to maintain his upper body strength. On 6/30/25, staff were to begin assisting R35 with the use of an arm bike (used to maintain upper body strength while limiting lower body movement) with moderate resistance for 15 minutes daily. Interview on 2/23/26 at 2:11 p.m., R35 identified staff do not do any ROM exercises with him. Interview on 2/26/26 at 8:04 a.m., with nursing assistant (NA)-A identified staff sometimes do “some” restorative exercises but generally NA-B was responsible to do that. NA-A was unable to recall the last time she had completed restorative with R35. Interview on 2/26/26, at 8:20 a.m., with director of nursing (DON) identified the facility had recently started having NA-B complete “some” restorative exercises with residents. R35 was to have the arm bike offered to him daily, however, she was aware they had a “gap”, and it was unlikely R35’s restorative exercise were getting done every day. Staff are “just not getting it done”. Re-education of staff and audits are needed as “We know our restorative program needs work”. Interview on 2/26/26, at 13:32 a.m., with NA-B identified she was on light duty following an injury. She previously had been the bath aid but was temporarily assisting residents with light restorative exercise. Mainly helping residents on and off the NuStep exercise bike. The DON gave NA-B a list of residents she was to assist with using the NuStep bike but R35 was not on the list, and she has not completed any restorative exercises with R35. Interview on 2/26/26, at 8:24 a.m., with the administrator identified she would expect staff to complete restorative exercises with residents as care planned. They recently discussed this and plan to hire restorative aid for the facility. Review of the facility provided, undated, Restorative Nursing Policy, identified restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services	F0688		

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F0688 SS = D	Continued from page 20 and promotes the resident's ability to adapt and learn to live as independently and safely as possible. Restorative goals and objectives are individualized, resident-centered, and are outlined in the resident's care plan. Restorative goals may include but are not limited to adjusting or adapting to changing abilities, developing, maintaining, or strengthening his/her physiological and psychological resources. Maintaining dignity, independence, and self-esteem; and participating in the development and implementation of his/her care plan.	F0688		
F0727 SS = F	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 1919(b)(4)(C);1919(b)(4)(C)(i);1819(b)(4)(C);1819(b)(4)(C)(i);483.35(c)(1)-(3) Social Security Act §1919 [42 U.S.C. 1396r] §1919(b)(4)(C) Required nursing care; facility waivers.- §1919(b)(4)(C)(i) General requirements.-With respect to nursing facility services provided on or after October 1, 1990, a nursing facility- (II) except as provided in clause (ii), must use the services of a registered professional nurse for at least 8 consecutive hours a day, 7 days a week. Social Security Act §1819 [42 U.S.C. 1395i-3] §1819(b)(4)(C) REQUIRED NURSING CARE.- §1819(b)(4)(C)(i) IN GENERAL.-Except as provided in clause (ii), a skilled nursing facility … must use the services of a registered professional nurse at least 8 consecutive hours a day, 7 days a week. §483.35(c)(3) Except when waived under paragraph (f) or (g) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(c)(4) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is NOT MET as evidenced by:	F0727	DON will audit the schedule on Mondays to ensure that an RN will be on site for 8 consecutive hours per day that week. If the schedule fails to have an RN scheduled, a message will be sent out to all RNs asking for volunteers to cover 8 hours. If no RN is available and the services of an RN are required during that time of no RN for 8 hours per day due to emergency etc, the DON or Designee will report on-site to fulfill any services that would be required". Request for an RN Waiver in MN SNF submitted with POC. The facility will attempt to fill this position by continuously posting for additional RN staff and have had the Medical Director review the need for the waiver, to which they have agreed and this will cause no harm to residents" Results of audits and hiring practices related to RN applicants will be brought to QA for review and recommendations in changes in processes Date of Compliance: April 7, 2026	04/07/2026

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F0727 SS = F	Continued from page 21 Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days a week for 1 of 92 days reviewed. This had the potential to affect all 33 residents. Findings include: Review of the facilities November 2025, December 2025, and January 2026 schedules identified on 11/29/25 the facility had no registered nurse on duty. Interview on 2/26/26 at 8:23 a.m., with the director of nursing identified she was responsible for the licensed nurse schedule. She reported she was on duty Monday through Friday 8 consecutive hours and if she needed to leave early, she would ensure there was another RN to cover the 8-hour requirement. On the weekends she ensured there was a RN scheduled 8 consecutive hours and if the facility did not have an RN to work over the weekend, she or another facility RN would come in and cover the RN 8 consecutive hours requirement. She confirmed that there had been no RN coverage on 11/29/25. Review of undated, RN Coverage policy identified the facility would ensure the services of a registered nurse were provided onsite for 8 consecutive hours per day, 7 days a week. Review of the Sufficient and Competent Nurse Staffing Review pathway, located in the Surveyor Resources Folder at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes , identified "Note: The rule of 4 or more days is used for the purposes of the PBJ Staffing Data Report. The expectation of CMS is that the survey team would consider issuing a citation when a minimum of one day is identified to not meet the nurse staffing requirement for both a Registered Nurse and Licensed nursing staff."	F0727		
F0801 SS = F	Qualified Dietary Staff CFR(s): 483.60(a)(1)(2) §483.60(a) Staffing	F0801	The Dietary Manager enrolled in an approved ANFP CDM certification program through the University of North Dakota and is set to finish the course in March of 2027.	04/07/2026

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F0801 SS = F	Continued from page 22 The facility must employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. This includes: §483.60(a)(1) A qualified dietitian or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who- (i) Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose. (ii) Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional. (iii) Is licensed or certified as a dietitian or nutrition professional by the State in which the services are performed. In a State that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization, or meets the requirements of paragraphs (a)(1)(i) and (ii) of this section. (iv) For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016 or as required by state law. §483.60(a)(2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services. (i) The director of food and nutrition services must at a minimum meet one of the following qualifications-	F0801	Continued from page 22 A contract is in place for the Dietary Manager to operate under the supervision of a qualified consultant dietitian. The Dietician is contracted to provide 1:1 support for a minimum of 2 hours per quarter, and as needed A review by a qualified consultant dietitian of all dietary operations will be completed, including but not limited to menus, sanitation practices, and clinical support, has been initiated to ensure compliance with current standards. The Dietary Manager will complete all required coursework, supervised practice hours, and sit for the CDM credentialing exam. The Administrator will be responsible for monitoring progress towards completion of certification, and progress reports will be brought to QA for updates	

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F0801 SS = F	Continued from page 23 (A) A certified dietary manager; or (B) A certified food service manager; or (C) Has similar national certification for food service management and safety from a national certifying body; or D) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or (E) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving; and (ii) In States that have established standards for food service managers or dietary managers, meets State requirements for food service managers or dietary managers, and (iii) Receives frequently scheduled consultations from a qualified dietitian or other clinically qualified nutrition professional. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department. This had the potential to affect all 33 residents. Findings include: Interview on 2/23/26 at 12:00 p.m., with the facility designated dietary manager (DM) revealed she was not certified. She had been enrolled but dropped the class this past December because of “personal life issues” that made it difficult for her to continue. She had not submitted any of her course work that was required to complete the class and currently was not enrolled in any program. Interview on 2/24/26 at 11:22 a.m., with the registered dietician identified she was the DM’s preceptor and was	F0801		

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F0801 SS = F	Continued from page 24 available to her to help her with any questions and review her coursework, however, her understanding was the DM was out on medical leave and was unable to complete the course work, therefore she had dropped the class. Interview on 2/26/26 at 8:31 a.m., with the administrator identified she would have expected the DM to be certified for the position, but at minimum, be enrolled in the class and have a serve safe certification to safely oversee the department and staff. Review of the facility provided 10/20/21, Dietary Director Job Description signed by the dietary director on 3/28/23, identified qualification for the position included taking or willing to take the Dietary Managers Course and THAT STAFF must pass the sanitation test or be willing to take a course approved by the state.	F0801		

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20000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/23/26 through 2/26/26, a standard licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Nursing Home Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders, and identify the date when they will be completed.	20000		03/26/2026

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

Minnesota State Department of Health

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20000	Continued from page 1 The following complaints were reviewed: H55706473C (2701253) and H55706320C (2742921, 2743066, and 2747345). NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled “ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor’s findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	20000		
20565	Comprehensive Plan of Care; Use CFR(s): MN Rule 4658.0405 Subp. 3 Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This LICENSURE REQUIREMENT is NOT MET as evidenced by:	20565	The Care Plan Meeting policy will be reviewed and updated to reflect the process for completion of the initial and future care conferences. R7 care conference was held on 3/6/26 with the resident and family in attendance.	04/07/2026

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20565	Continued from page 2 Based on interview and document review, the facility failed to ensure the resident had a care conference to be able to participate in the planning process and development of interventions of their care for 1 of 1 sampled resident (R7) who had been at the facility for 3 months with no care conference scheduled. Findings include: R7's 12/01/25, accepted admission Minimum Data Set (MDS) assessment identified that R7 had admitted to the facility in the middle of November 2025. R7 cognition was intact. She used a walker or a wheelchair for mobility and required partial assistance with some activities of daily living (ADL's). She had diagnoses of arthritis, thyroid disorder, diabetes, renal disease, and hypertension. R7's plan was to remain living in the facility. Additionally, a 2/20/26, accepted quarterly MDS assessment was completed identifying again R7's cognition was intact. Interview on 2/23/26 at 2:33 p.m., with R7 identified, she had not been invited to or attended a care conference since coming to the facility. Review of R7's progress 11/12/25 through 2/22/26, had no mention of a care conference occurring since admission to the facility. Interview on 2/24/26 at 1:42 p.m., with the activity director identified that care conferences followed the MDS schedule. There was to be a progress note made and the multidisciplinary care conference form filled out by each department following a care conference. Review of R7's assessments lacked any assessment titled "Interdisciplinary care conference" and there were no assessments identified as a care conference form. Interview on 2/25/26 at 10:47 a.m., with registered nurse (RN)-A identified that typically a care conference was scheduled by the social service designee (SSD) within 2 weeks of the MDS assessment completion. The facility would document a care conference meeting on the care conference form under the assessment section in point click care (PCC) and make a progress note. RN-A confirmed she could not find documentation that a care conference had occurred for R7 since	20565	Continued from page 2 An audit of all current resident charts will be completed to ensure that all residents have had a care conference held within 21 days of admission and 92 days thereafter. Any resident that has not had a care conference within this time frame will immediately be scheduled a care conference Education will be conducted with all members of the interdisciplinary team who participate in care conferences re: the Care Plan Meeting policy The DON or their Designee will complete audits of all resident charts to ensure care conferences are held within the required timeframe for 3 wks, and if compliant, reduce to 1 random audit per wk for 3 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 3, 2026	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LAWN SENIOR CARE	**400 SEVENTH STREET NE , FULDA, Minnesota, 56131**

(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
20565	Continued from page 3 admission. Interview on 2/25/26 at 10:58 a.m., with SSD identified that when a resident admitted to the facility a care conference would be set up within the first 2-4 weeks of admission. Care conference would then take place every quarter after that. She confirmed that R7's initial care conference had been missed stating it was "just an overlook" but she did have one scheduled now in March, confirming that was 4 months after admission to the facility. Interview on 2/26/26 at 8:23 a.m., with the director of nursing (DON) identified she was unsure of when resident care conferences should take place and stated, "I would have to reference our policy". Review of the undated, Care Plan Meeting policy identified each resident admitted to the facility would receive a person-centered, comprehensive care plan developed through the interdisciplinary team and the resident and/or representative. The care plan would be developed via assessments and consultation with the residents and/or representatives. The care planning meeting would be held, 7-10 days following the completion of the comprehensive MDS assessment and then quarterly thereafter. Care plan meeting shall also be held when there is a significant change in the resident's status, or when requested by the resident/representative or facility. The residents shall participate in the care planning process and if unable the representative will be involved. The care plan meeting would be documented and include the date and time of the meeting, who attended, and a summary of the meeting. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care planning includes the resident, care plans are used and followed in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs.	20565		

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20565	Continued from page 4 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20565		
20570	Comprehensive Plan of Care; Revision CFR(s): MN Rule 4658.0405 Subp. 4 Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to appropriately assess, document, and revise the care plan for 1 of 1 sampled resident (R8) who had restorative therapies identified on his care plan, but was not receiving or completing those therapies as indicated. Findings include: R8's 2/16/26, accepted quarterly Minimum Data Set (MDS) assessment identified R8's cognition was intact. R8 was noted to have impairments bilaterally on his upper and lower extremities. R8 used a wheelchair for mobility. R8 was independent with eating, required substantial assistance from staff for dressing, personal hygiene, and required total assistance from staff for toileting and bathing. R28 used a Sit to Stand mechanical device with substantial assistance from staff for transfers. R8 was not noted to ambulate. R8 had not participated in any formal type of therapy or restorative program. R8's 2/26/26, printed Medical Diagnosis list identified pulmonary disease, symptoms involving the musculoskeletal system, asthma, tremors, radiculopathy of lumbar region (compressed or irritated nerve roots in lower spine often referred to as sciatica), functional implants, emotional liability (exaggerated, and uncontrollable swings in emotion), polyneuropathies (widespread damage of peripheral nerves, causing numbness, tingling, burning pain, and muscle weakness), Arthritis, high blood pressure, and restless leg	20570	R8 was interviewed and restorative exercises were re-assessed. Care plan updated to reflect appropriateness and accuracy. All current resident charts will be audited for documentation of a restorative therapy program, and the care plan will be reviewed and updated to reflect appropriateness and accuracy of the program. Education provided to staff on exercise plans and the frequency of completing exercises to comply with standards. Audits will be completed in alignment with the MDS schedule and with changes in condition for 3 weeks and if compliant, reduce to 1 random audit per wk for 2 months. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	04/07/2026

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20570	Continued from page 5 syndrome. R8's 7/10/25, care plan identified R8 was at risk for weakness and loss of self-care and mobility independence. R8 would participate in an informal restorative program with staff assistance to maintain lower and upper body strength and ambulation through the review date. R8's exercises included 3-4 times a week dowel (a ¾ inch rod or broomstick) exercises with 3 pounds while seated for 15 repetitions. R8 was also to perform seated legs exercises with a number 2 therapy band times 15-20 repetitions and had a walking plan for 5 times a week to ambulate with four-wheeled walker assisted by a restorative aid bringing the wheelchair along. Review of R8's Functional Abilities and Goals assessments identified:On 1/10/25, R8 used a walker and wheelchair. For mobility R8 required partial/moderate assistance with transfers and supervision or touching assistance for ambulation of up to 50 feet.On 7/10/25, R8 used a walker and wheelchair. R8 only walked occasionally with the restorative aides who walked with him bringing a wheelchair behind. For mobility, R8 required substantial/maximal assistance with transfers and was dependent on staff to ambulate 10 feet. R8 did not attempt to ambulate 50 feet due to medical conditions or safety concerns.On 10/18/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 or 50 feet due to medical condition or safety concerns.On 11/14/25, R8 used a wheelchair. For mobility R8 was dependent on staff for transfers. R8 did not attempt to walk 10 due to medical condition or safety concerns.On 2/11/26, R8 used a wheelchair. For mobility R8 required substantial/maximal assistance with transfers. Walking 10 feet was identified as Not applicable.There were no other assessments related to R8's restorative exercise abilities found in his medical record. Review of progress notes identified on:On 12/10/25 R8's restorative therapy plan was reviewed. R8's restorative program was changed to ambulate to breakfast in the morning as tolerated. There was no mention of why the restorative program was reviewed or details of the assessed program even though the 11/14/25 functional assessment identified R8 did not attempt to walk.On 12/17/25, Staff reported R8 was having more difficulty, and at times unable to stand as his legs buckled and then he would hang from the lift. R8 seemed weaker and less able to assist with his cares.	20570		

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20570	Continued from page 6 There was no mention of any nurse assessing the reported difficulty with standing or safety concern of using the standing lift.On 1/8/26, R8 was uncooperative throughout the day, during a transfer he would repeatedly refuse to place his hands on the equipment handles as instructed. Only after 5 verbal prompts did R8 comply with assisting. R8 also refused to wear his shoes during the transfer process. Interview on 2/23/26 at 1:25 p.m., with R8 identified he did not participate in a restorative exercise program. He reported he squeezed a ball he had and that it worked just the same. R8 reported he used to go and exercise where he rode the bike; however, the facility had cut that to save money. Interview on 2/26/26 at 9:14 a.m., with nursing assistant (NA)-A identified that R8 never walked, he did have a walking restorative program, but he was very particular with his cares and how he wanted things, he refused to walk. R8 used a standing lift for all transfers with one staff assistance. If staff note a decline in a residents function the staff are to tell the nurse. The nurse would assess the resident and if needed the resident was seen by the physician if they did not get better. Interview on 2/26/26 at 9:21 a.m., with licensed practical nurse (LPN)-A identified R8 used to walk but he would not walk anymore. When he was participating in his restorative program, he did not want to walk and would tell staff he was just “waiting to die”. Staff would try to get him to walk, but he refused. R8 not wanting to walk, “might have something to do with his leg issues”. He has an implant in his back that needs to be charged in a special chair every week. When the battery in his implant is getting low sometimes his legs don’t want to work, and they really start to “bother him”. All nurses could update a resident’s care plan, however, registered nurse (RN)-A typically reviewed and made updates to care plans following the completion of a resident’s MDS assessment. Interview on 2/26/26 at 9:44 a.m., with RN-A identified she reviewed care plans following completion of the MDS; however, all nurses were able to and should be updating the resident care plans “as things change”. R8 did have a restorative program and there was a task for staff to document on his completion of the restorative program however, she had removed the task that would	20570		

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20570	Continued from page 7 identify staff were to ensure R8 completed his walking, as he was refusing to walk. R8 had been working with restorative therapy until the staff that worked in that department had resigned; however, she was unsure if he was walking with the restorative staff either. IF a nurse identified a need for a change in the residents care they were responsible for updating the care plan. She confirmed R8's care plan should have been updated to reflect his status. Review of R8's medical record lacked identification of refusals of his restorative exercises and lacked an updated assessment for identified restorative exercises or risk to benefit showing R8 was made aware of potential decline by not completing his restorative treatments. Interview on 2/26/26 at 9:58 a.m., with the director of nursing (DON) identified she had re-assessed R8's restorative program back in December 2025 and changed his program to walking once a day to breakfast with staff assistance. She reported R8 was walking at the time, but he kept refusing to walk. She confirmed she should have updated the care plan when she first changed his restorative program back in December 2025 and when she was made aware he was refusing to walk at all. The facility had a good formal restorative program back around November or December of 2025 with a couple of staff. When she and the administrator had spoken to the restorative staff about some charting concerns, both staff placed their resignation, and the program was no longer fully staffed at that time. The facility had the direct care staff complete as many of the restorative programs as possible and had a light duty staff recently returned to work that was working on restorative programs, but the facility was unable to staff a formal program. She confirmed the residents were getting their restorative therapy, but not as "much restorative therapy as they should" as the facility still needed to fill the restorative positions. She revealed there was room for "improvement" in the restorative program and with the new therapy department starting on 3/2/26, all residents would be re-assessed at that time. Review of January 2025, Care plans, Comprehensive Person-Centered policy identified that each resident would have a person-centered care plan that included measurable goals to meet the resident's physical, psychosocial and functional needs. The care plan interventions would be developed through assessments,	20570		

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20570	Continued from page 8 gathering information from the interdisciplinary team, the resident/representative, and the attending physician. The care plan would include goals, treatments, specialized services, to aid in preventing or reducing decline in the resident's status and enhance optimal functioning while reflecting current standards of practice. The care plan should be developed or revised within 7 days of the completion of the MDS assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are used, revised as needed and followed in order to meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are used and followed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20570		
20810	Nursing Personnel; On-site coverage CFR(s): MN Rule 4658.0510 Subp. 3 Subp. 3. On-site coverage. A nurse must be employed so that on-site nursing coverage is provided eight hours per day, seven days per week. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a registered nurse (RN) was on duty a minimum of 8 consecutive hours per day, 7 days a week for 1 of 92 days reviewed. This had the potential to affect all 33 residents. Findings include: Review of the facilities November 2025, December 2025, and January 2026 schedules identified on 11/29/25 the facility had no registered nurse on duty. Interview on 2/26/26 at 8:23 a.m., with the director of nursing identified she was responsible for the licensed	20810	DON will audit the schedule on Mondays to ensure that an RN will be on site for 8 consecutive hours per day that week. If the schedule fails to have an RN scheduled, a message will be sent out to all RNs asking for volunteers to cover 8 hours. If no other RN is available, the DON or Designee is to be on-site to fulfill 8-hour RN coverage. Request for an RN Waiver in MN SNF submitted with POC (uploaded to attachments). Results of audits and hiring practices related to RN applicants will be brought to QA for review and recommendations in changes in processes Date of Compliance: April 7, 2026	04/07/2026

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20810	Continued from page 9 nurse schedule. She reported she was on duty Monday through Friday 8 consecutive hours and if she needed to leave early, she would ensure there was another RN to cover the 8-hour requirement. On the weekends she ensured there was a RN scheduled 8 consecutive hours and if the facility did not have an RN to work over the weekend, she or another facility RN would come in and cover the RN 8 consecutive hours requirement. She confirmed that there had been no RN coverage on 11/29/25. Review of undated, RN Coverage policy identified the facility would ensure the services of a registered nurse were provided onsite for 8 consecutive hours per day, 7 days a week. Review of the Sufficient and Competent Nurse Staffing Review pathway, located in the Surveyor Resources Folder at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes , identified "Note: The rule of 4 or more days is used for the purposes of the PBJ Staffing Data Report. The expectation of CMS is that the survey team would consider issuing a citation when a minimum of one day is identified to not meet the nurse staffing requirement for both a Registered Nurse and Licensed nursing staff." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) should develop and/or review or revise policies and procedures to ensure nursing coverage is provided 8 hours per day, 7 days per week. The DON or designee could educate staff regarding these polices and perform measurable audits of staff schedules for compliance. The DON or designee should take the results of those audits to the QAPI committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20810		
20835	Adequate and Proper Nursing Care; Criteria CFR(s): MN Rule 4658.0520 Subp. 2 A Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: Evidence of adequate care and kind and considerate	20835	The Pressure Ulcer/skin breakdown clinical protocol policy is to be reviewed and updated as appropriate. R42’s wound was assessed, the physician contacted, a treatment identified, and a progress note written. Education to be provided to staff, regarding admission	04/07/2026

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20835	Continued from page 10 treatment at all times. Privacy must be respected and safeguarded. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to re-assess nursing interventions and communicate findings for skin wound for 1 of 1 sampled resident (42) once an open area had been identified by nursing. Findings include: R42's 2/24/26, Admission Record identified that R42 was admitted to the facility mid-February 2026, from an assisted living facility. R42 had diagnoses of heart failure, diabetes, dementia, high blood pressure, and a history of stroke. Interview on 2/23/26 at 1:08 p.m., with R42 identified she had a sore on the back of her right leg that the nurse kept covered because otherwise she scratched it. ' R42's 2/19/26, baseline care plan identified R42 required partial assistance of one staff for cares, transfers, and ambulation. There was no mention of wounds or risk of wounds on R42's care plan. R42's 2/20/26, Weekly Skin Audit/Bath Form identified 3 small bruises on her left arm, and some bruising was noted on her lower abdomen caused by insulin injections for her diabetes. The skin audit identified there were no open lesions, cuts, lacerations, open skin folds, or skin tears. There were also no identified blisters, open ulcers, no dry or flaky skin, and no edema. R42's progress notes from 2/19/26 through morning of 2/24/26 identified on: 2/19/26, an initial skin assessment was completed. No open areas were noted. 2/22/26, R42 received a small bandage to her right shin for a small broken scab, measuring less than 1 centimeter all around.The progress notes made no mention of a wound on the back of R42's right leg lacking evidence that the wound had been communicated for continued monitoring for healing. Interview on 2/24/26 at 9:59 a.m., with nursing	20835	Continued from page 10 assessments, provider notification, and physicians providing the clinical basis of ulcer/wound type and diagnosis, along with appropriate treatment orders, as well as the standard for labeling and initialing a dressing, and the expectations for completing the skin audit/bath form DON will audit new admissions within 24 hours to ensure that a complete head-to-toe skin assessment is completed on the day of admission for the next 30 days and if compliant, reduce to 1 random audit per week for the next 60 days. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	

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20835	Continued from page 11 assistant (NA)-B identified R42 did have dressing on the back of her leg but she was not sure what was under the dressing. R42's February 2025, treatment record and orders had no mention of a dressing to the back of R42's right leg. Interview, document review and observation on 2/24/26 at 12:58 p.m., with licensed practical nurse (LPN)-A and R42 identified LPN-A was unable to find in R42's medical record, any documentation R42 had a wound on the back of her right leg. There were no nursing or physician orders for wound treatment or monitoring. LPN-A also reviewed R42's last skin audit that was completed on 2/20/26 that only identified small bruises on arms and abdomen. She was unable to find any progress note about a wound since R42's admission the prior week however, she did find a note that a band aide had been applied to the front of R42 right shin. LPN-A then went to observe the back of R42's right leg and identified a self-adhesive padded dressing on R42 right calf that was dated 2/20/26 with no initials of who applied. The dressing was removed by LPN-A with a small amount of drainage on the bandage and a small open wound. LPN-A described as a "possible scab" that was scratched open. R42 at this time denied she scratched the back of her leg but maybe she had rubbed it on her recliner. LPN-A stated she "had no clue" R42 had an open sore on the back of her leg. LPN-A confirmed the nurse that identified the sore and applied the dressing should have made a progress note, set up a treatment, and updated the provider. Interview on 2/24/26 at 3:36 p.m., with director of nursing (DON) identified R42 had admitted from an assisted living facility and the day she arrived she refused to get undressed for the male staff. She was uncomfortable with the male staff completing the skin audit and that should have been delegated to another nurse. R42's wound was a recurrent one and it had just opened prior to her coming here and was one of the indications for her coming here as well. When the nurse identified the wound on the back of R42's leg the nurse should have contacted R42's primary provider for orders and set up the treatment. The DON revealed she would also expect a progress note of the wound assessment. Review of the undated, Pressure Ulcer/Skin Breakdown-Clinical Protocol policy identified newly admitted residents will have a skin examination done by	20835		

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20835	Continued from page 12 the nurse to identify any existing pressure ulcers or other skin concerns. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related non-pressure wound assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20835		
20890	Rehab - Range of Motion CFR(s): MN Rule 4658.0525 Subp. 2 A Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to provide services to maintain and/or prevent decrease in range- of-motion (ROM) for 1 of 1 sampled resident (R35) reviewed for limited range of motion. Findings include: R35's 8/19/2025, comprehensive Minimum Data Set (MDS) assessment identified his cognition was moderately impaired. He had diagnoses of cerebral palsy (condition primarily affecting leg movement and muscle	20890	R 35 resident restorative program and plan of care reviewed and appropriate Staff education was completed immediately on the arm bike exercise and plan of care for R35. Restorative Nursing policy reviewed and updated as appropriate. Education provided to staff on exercise plans and the frequency of completing exercises to comply with standards. All other residents on a restorative program were reviewed to ensure to follow through on the program 3 random POC task audits will be completed weekly on residents receiving restorative services for the first month, and then if compliant, transition to 1 audit per week for 2 months to ensure ROM exercises are completed. Results of audits and recommended changes in processes will be brought to QA for review. Date of compliance is April 7, 2026	04/07/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **02/26/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE LAWN SENIOR CARE	**400 SEVENTH STREET NE , FULDA, Minnesota, 56131**

(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
20890	Continued from page 13 stiffness) and dementia. R35's 2/10/26, Functional Abilities and Goals assessment identified R35 was dependent on staff for Activities of Daily Living (ADL)'s. He had no impairment to his upper extremities but was impaired on both sides of his lower extremities and used a manual wheelchair for mobility. R35's current, undated care plan identified he was at risk for decline in his physical condition related to cerebral palsy (condition primarily affecting leg movement and muscle stiffness) and was dependent on a wheelchair for mobility. The goal was for R35 to participate in a restorative exercise program to maintain his upper body strength. On 6/30/25, staff were to begin assisting R35 with the use of an arm bike (used to maintain upper body strength while limiting lower body movement) with moderate resistance for 15 minutes daily. Interview on 2/23/26 at 2:11 p.m., R35 identified staff do not do any ROM exercises with him. Interview on 2/26/26 at 8:04 a.m., with nursing assistant (NA)-A identified staff sometimes do "some" restorative exercises but generally NA-B was responsible to do that. NA-A was unable to recall the last time she had completed restorative with R35. Interview on 2/26/26, at 8:20 a.m., with director of nursing (DON) identified the facility had recently started having NA-B complete "some" restorative exercises with residents. R35 was to have the arm bike offered to him daily, however, she was aware they had a "gap", and it was unlikely R35's restorative exercise were getting done every day. Staff are "just not getting it done". Re-education of staff and audits are needed as "We know our restorative program needs work". Interview on 2/26/26, at 13:32 a.m., with NA-B identified she was on light duty following an injury. She previously had been the bath aid but was temporarily assisting residents with light restorative exercise. Mainly helping residents on and off the NuStep exercise bike. The DON gave NA-B a list of residents she was to assist with using the NuStep bike	20890		

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20890	Continued from page 14 but R35 was not on the list, and she has not completed any restorative exercises with R35. Interview on 2/26/26, at 8:24 a.m., with the administrator identified she would expect staff to complete restorative exercises with residents as care planned. They recently discussed this and plan to hire restorative aid for the facility. Review of the facility provided, undated, Restorative Nursing Policy, identified restorative nursing care consists of nursing interventions that may or may not be accompanied by formalized rehabilitative services and promotes the resident's ability to adapt and learn to live as independently and safely as possible. Restorative goals and objectives are individualized, resident-centered, and are outlined in the resident's care plan. Restorative goals may include but are not limited to adjusting or adapting to changing abilities, developing, maintaining, or strengthening his/her physiological and psychological resources. Maintaining dignity, independence, and self-esteem; and participating in the development and implementation of his/her care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should create and/or review or revise policies and procedures to ensure care plans are implemented as written, including restorative exercise. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure individual care plans are followed and restorative exercises are completed. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20890		
20980	Director of dietary service; Director CFR(s): MN Rule 4658.0605 Subp. 2 Subp. 2. Director of dietary service. If a qualified dietitian is not employed full time, the administrator must designate a director of dietary service who is enrolled in or has completed, at a minimum, a dietary manager course, and who receives frequently scheduled consultation from a qualified dietitian. The number of	20980	The Director of Dietary Services has been certified as a Food Production Manager since 2023. The Director of Dietary Services enrolled in an approved ANFP CDM certification program through the University of North Dakota and is set to finish the course in March of 2027.	04/07/2026

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20980	Continued from page 15 hours of consultation must be based upon the needs of the nursing home. Directors of dietary service hired before May 28, 1995, are not required to complete a dietary manager course. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to designate a qualified person to serve as the director of food service to oversee the dietary department. This had the potential to affect all 33 residents. Findings include: Interview on 2/23/26 at 12:00 p.m., with the facility designated dietary manager (DM) revealed she was not certified. She had been enrolled but dropped the class this past December because of “personal life issues” that made it difficult for her to continue. She had not submitted any of her course work that was required to complete the class and currently was not enrolled in any program. Interview on 2/24/26 at 11:22 a.m., with the registered dietician identified she was the DM’s preceptor and was available to her to help her with any questions and review her coursework, however, her understanding was the DM was out on medical leave and was unable to complete the course work, therefore she had dropped the class. Interview on 2/26/26 at 8:31 a.m., with the administrator identified she would have expected the DM to be certified for the position, but at minimum, be enrolled in the class and have a serve safe certification to safely oversee the department and staff. Review of the facility provided 10/20/21, Dietary Director Job Description signed by the dietary director on 3/28/23, identified qualification for the position included taking or willing to take the Dietary Managers Course and that staff must pass the sanitation test or be willing to take a course approved by the state. SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure the facility has a qualified dietary manager. The facility	20980	Continued from page 15 The Director will operate under the supervision of a qualified consultant dietitian. A review by a qualified consultant dietitian of all dietary operations, menus, and sanitation practices has been initiated to ensure compliance with current standards. The Director will complete all required coursework, supervised practice hours, and sit for the CDM credentialing exam. Progress towards completion of certification will be brought to QA for updates Date of Compliance: 3/10/2026	

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20980	Continued from page 16 should create, review, and/or update or policies and procedures, and educate on specific requirements for the dietary manager required qualifications. The administrator, registered dietician, or designee should perform audits to ensure the dietary staff are qualified for their assigned role or enrolled in an approved program. The facility should report results of those audits to QAPI for further recommendations and determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245570	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 02/24/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Maple Lawn Senior Care was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: If PARTICIPATING IN THE E-POC PROCESS, a paper copy of the plan of correction is not required. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K0000		

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245570	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026

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K0000	Continued from page 1 By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Maple Lawn Senior Care This one-story with partial basement facility was built in 1964, with building additions constructed in 1991 and 2001. All are fully sprinklered. The 1991 addition was determined to be of Type II (000) construction. The 1964 and 2001 buildings were determined to be of Type II (111) construction. BLDG 02 was constructed in 2004, as an addition to the existing nursing home. It is one-story, has a partial basement and is fully sprinklered, and was determined to be of Type II (111) construction. It consists of a new activities room, new entrance and an elevator/elevator lobby. There are no patient sleeping or treatment areas in Building 02. The facility has a capacity of 46 beds and had a census of 33 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K0000		
K0324 SS = E	Cooking Facilities	K0324	The Maintenance Director installed a timer on the oven located in the Activities Room.	03/27/2026

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K0324 SS = E	Continued from page 2 CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain proper inspection and safety measures associated to cooking devices in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5, 19.3.2.5.3(9), 19.3.2.5.4, 19.3.2.5.5, 9.2.3. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/24/2026 at 11:13 AM, it was revealed by observation that the residential stove located in the Activity Room does not have a switch located in a restricted location, that is on a timer, not exceeding a 120-minute capacity, that automatically deactivates the cook top or range, independent of staff action. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K0324	Continued from page 2 Date of Compliance: 3/27/2026	
K0918 SS = F Bldg. 01	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101	K0918	Maintenance Director scheduled Cat to come to the facility to complete Essential Electric System Maintenance and Testing.	04/10/2026

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K0918 SS = F Bldg. 01	Continued from page 3 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to maintain generators per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.4.1.1.3, and NFPA 110 (2010 edition), Standard for Emergency and Standby Power Systems, section 8.4.9, 8.4.9.5.1, 8.4.9.5.2. This deficient finding could have a widespread impact on the residents within the facility Findings include: On 02/24/2026 at 10:31 AM, it was revealed by a review of available documentation at the time of the survey the facility could not provide documentation for a 36-month load bank test for the emergency generator. An interview with the Maintenance Director verified	K0918	Continued from page 3 Date of Compliance: 4/10/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245570	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 0... B. WING	(X3) DATE SURVEY COMPLETED 02/24/2026

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K0918 SS = F Bldg. 01	Continued from page 4 this deficient finding at the time of discovery.	K0918		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 14, 2026

Administrator
MAPLE LAWN SENIOR CARE
400 SEVENTH STREET NE
FULDA, MN 56131

RE: CCN: 245570
Cycle Start Date: February 26, 2026

Dear Administrator:

On April 15, 2026 and 16, 2026, the Minnesota Department of Health and Public Safety, completed revisits to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 14, 2026

Administrator
MAPLE LAWN SENIOR CARE
400 SEVENTH STREET NE
FULDA, MN 56131

Re: Reinspection Results
Event ID: 1E0C36-H2

Dear Administrator:

On April 15, 2026 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 26, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112