



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 24, 2026

Administrator
MAPLETON COMMUNITY HOME
301 TROENDLE STREET SW
MAPLETON, MN 56065

RE: CCN:245362
Cycle Start Date: June 30, 2026

Dear Administrator:

On June 30, 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:

Elizabeth Silkey, Regional Operations Supervisor
Mankato District Office
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 September 30, 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 December 30, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245362		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026		
NAME OF PROVIDER OR SUPPLIER MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET SW , MAPLETON, Minnesota, 56065				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
E0000	Initial Comments On 6/29/26-6/30/26, 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			08/03/2026	
F0000	INITIAL COMMENTS On 6/29/26-6/30/26, a standard recertification survey (S5362039) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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				08/03/2026
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.			F0641				

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
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F0641 SS = D	Continued from page 1 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's fall history for 2 of 3 residents (R2 and R10) reviewed for falls. Findings include: R2's significant change Minimum Data Set (MDS) assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play	F0641	Continued from page 1 completed on 3/6/26. However, there was a Quarterly completed on 2/17/26 that was not in compliance. The resident had one fall – injury except major on 1/7/26 (scratches to left shoulder blade). The Quarterly on 2/17/26 was coded as one fall – no injury. The prior assessment (OBRA or Scheduled PPS) was completed on 11/18/25, thus the fall on 11/17/25 would not be included on the Quarterly dated 2/17/26. The MDS Coordinator completed a Modification of Quarterly dated 2/17/26 on 7/31/26 to indicate one fall – injury except major. Resident R2: The MDS Coordinator reviewed this tag and identified there was not a Significant Change assessment completed on 4/30/26. However, there was a Significant Change completed on 4/15/26 that was not in compliance. The Significant Change indicated the resident had one fall – no injury, and one fall – injury except major. After review of progress notes, accident reports, and neurological assessments, the resident had falls on 3/29/26, 3/30/26, and 4/14/26 that would be included in the look back period. Of these falls, two were falls – no injury (3/29/26 and 3/30/26) and one fall – injury except major (abrasion to forehead on 4/14/26). The MDS Coordinator completed a Modification of Significant Change dated 4/15/26 on 7/31/26 to indicate two or more falls – no injury. There was no change to the one fall – injury except major, as that was in compliance. Resident R10: The MDS Coordinator reviewed progress notes and accident reports confirming the resident had falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26. The Quarterly completed on 4/29/26 was reviewed and determined was not in compliance. The resident had three falls during the look back period (2/14/26, 3/11/26, and 3/24/26). Of these falls, two were falls – no injury (2/14/26 and 3/11/26) and one fall – injury except major (pain requiring ED visit on 3/24/26). The fall on 4/30/26 would not be included in this MDS, as it was after the ARD of 4/29/26.	08/11/2026

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F0641 SS = D	Continued from page 2 cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. R2's quarterly MDS assessment dated 3/6/26, indicated falls since the prior assessment that included one fall with no injury. Review of R2's falls during that assessment period indicated two falls had occurred. R2's significant change MDS dated 4/30/26, indicated falls since the prior assessment that included one fall with no injury and one fall with minor injury. Review of R2's falls during that assessment period indicated three falls had occurred. During interview on 6/30/26 at 10:20 a.m., assistant director of nursing (ADON) stated she was the MDS nurse for the facility and completed R2's MDS assessments. ADON stated she did not think the facility used point click care (PCC- facility electronic health record) to its full potential, still had a lot of paper charting, and it was likely falls could be missed when reviewing for assessments. ADON reviewed R2's falls and confirmed some falls were missed on her assessments. R10's quarterly MDS assessment dated 4/29/26 indicated R10 had no cognitive impairment, utilized a walker, was independent with walking, and had diagnoses that included non-Alzheimer's dementia, repeated falls, and chronic pain. Section J indicated R10 had experienced falls since admission or the prior assessment and was coded as having one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, identified R10 as being at risk for falls related to poor balance and a history of falls. Interventions included anticipating and meeting R10's needs, keeping the call light within reach and encouraging its use for assistance as needed, and following the facility's fall protocol. Review of R10's Accident Reports indicated R10 sustained falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26. On 6/30/26 at 8:47 a.m., the ADON, who also served as the facility's MDS nurse, stated they completed R10's MDS fall coding on 5/13/26. The ADON confirmed R10 experienced falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26, including two falls			F0641	Continued from page 2 The MDS Coordinator completed a Modification of Quarterly dated 4/29/26 on 7/31/26 to indicate two or more falls – no injury. There was no change to the one fall – injury except major, as that was in compliance. MDS Coordinator will complete an audit on current residents with falls within the last year and review correlating MDS to assure accuracy. MDS Coordinator will thoroughly review progress notes and neurological assessments and cross reference with accident reports to assure all falls are accurately captured and coded accordingly. A random audit of five charts will be conducted quarterly on residents to cross reference accident reports, progress notes and neurological assessments to determine compliance. Audits will be completed quarterly for one year and then as needed thereafter. The deficiencies listed above were corrected on 7/31/26. The process for tracking falls has been updated so that either the DON or designee will update the care plan after a fall with the date of the fall and the intervention added related to that fall. The MDS Coordinator was educated on this new process on 8/6/26. The MDS Coordinator will be expected to review the care plan to identify dates of falls within the look back period then review progress notes, neurological assessments and accident reports to assure accurate documentation on the MDS to include both the amount of falls and the type of fall (no injury, injury – except major, injury – major).		08/11/2026

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F0641 SS = D	Continued from page 3 with injury (except major) and two falls with no injury during the applicable MDS look-back period. The ADON confirmed the MDS assessment was coded incorrectly and should have indicated two or more falls and two or more falls with injury (except major). On 6/30/26 at 11:18 a.m., the director of nursing (DON) stated they expected the MDS to accurately reflect residents' falls. Facility MDS Accuracy Policy, dated 3/2019, indicated the Resident Assessment Instrument (RAI) Manual would be followed to ensure accuracy in all coding areas.			F0641			08/11/2026
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:			F0657	Residents R10, R2 and R3 have had their care plans updated and modified to reflect new care plan layout for falls. New care plan layout as followed: Problem Goal Intervention Fall Date- specific intervention Fall Date- specific intervention DON will copy over all falls and interventions listed hand written binder log to the electronic care plan in the layout as listed above for fall interventions, including the fall date and specific intervention. All current residents that have sustained falls in the facility will have their care plans updated on 7/31/26 according to the layout listed above. Falls policy and procedure updated to reflect the updated policy with the new fall intervention layout. The DON and ADON will verify for any new falls that this layout is implemented into the fall section of the electronic care plan for all nursing staff to see. The ADON will observe at quarterly care conferences that the fall section of the care plan is completed and updated for any resident that has sustained a fall. Written education given to all nursing staff via OnShift with the following message: Nursing Staff: All resident fall interventions are listed in their care plan under the FALLS section. Please see me if you are having difficulty finding this. IDT Notes will have a new format in each wing's binder noting falls closer to the top. The handwritten binder is no longer utilized as the		08/11/2026

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F0657 SS = D	Continued from page 4 Based on interview, observation, and document review, the facility failed to revise and update the comprehensive care to include new fall interventions implemented for 3 of 3 residents (R2, R3, and R10) reviewed for falls. Findings include: R10's quarterly Minimum Data Set (MDS) Assessment dated 4/29/26, indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol. R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated: Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions: 12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor. 2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting. 3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care. 3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed.			F0657	Continued from page 4 only form for tracking falls and interventions. Each resident has a section in their electronic care plan listed for falls. In the fall section of the care plan, the date and intervention of each fall is listed. This allows all nursing staff (RN, LPN, TMA, CNA) access to the fall interventions. All residents that have sustained falls now have listed in their electronic care plan under the fall section the fall date and specific intervention for that fall.		08/11/2026

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F0657 SS = D	Continued from page 5 4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired. 6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education. Review of the comprehensive care plan failed to identify the interventions developed following the falls on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26. On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier because she lost her balance while walking without her walker. R10 stated staff reminded her to use her walker following the fall. On 6/29/26 at 2:41 p.m., licensed practical nurse (LPN)-B stated fall interventions were developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. LPN-A was observed to review R10's electronic medical record (EMR) and confirmed interventions form R10's most recent fall on 6/8/26, were not added to the care plan. On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a fall risk and relied on the care plan to identify current fall interventions. On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, known as the nurse manager, stated following a resident fall the nurse completes a fall report on paper and puts an immediate intervention in place and emails the nursing staff of the new interventions or writes a progress note. RN-B stated the the interdisciplinary team (IDT) meets and reviews the fall, and discusses interventions and the implemented interventions would be expected to appear in the resident's care plan. RN-B stated the IDT team consists of themselves, director of nursing (DON), assistant director of nursing (ADON), social worker, dietary, activities, business office, therapy and nursing floor staff. RN-B confirmed no new care plan interventions were documented following the 6/8/26, fall. RN-B stated DON or ADON updated			F0657			08/11/2026

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F0657 SS = D	Continued from page 6 resident care plans. On 6/29/26 at 3:09 p.m., the DON stated the IDT reviews each fall and attempts to implement a new intervention unless all appropriate interventions are already in place. The DON reviewed R10's fall investigation forms for the falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the comprehensive care plan. The DON stated the paper fall investigation forms containing the interventions were maintained in the DON's office and acknowledged staff would not be able to readily identify the interventions from the care plan. The DON confirmed the DON and ADON were responsible for updating resident care plans. On 6/29/26 at 5:03 p.m., an LPN-C stated fall interventions are communicated during report or by email but should also be included in the care plan because staff rely on the care plan to identify resident-specific interventions. 6/29/26 at 5:57 p.m., R10 was observed ambulating independently in the hallway using a two-wheeled walker. On 6/29/26 at 6:06 p.m., R10 was seated on a bench outside the facility smoking a cigarette. On 6/30/26 at 7:58 a.m., a NA-B stated new fall interventions were communicated during shift report and would also be expected to be documented in the care plan. On 6/30/26 at 8:08 a.m., a RN-C stated following a fall, interventions should be updated in the resident's care plan and confirmed the DON and ADON were responsible for revising and upateing the care plan. R2's significant change MDS assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in			F0657			08/11/2026

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F0657 SS = D	Continued from page 7 the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/17/25: Wide bed 1/7/26: Clip call light to chest for easier access 3/29/26: Fall mat at bedside 3/30/26: Hospice referral 4/14/26: Medication change 5/18/26: Remove or flip out foot pedal if wheeling self 5/23/26: Medication change 6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medication R3's significant change MDS assessment dated 6/17/26, indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture. R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at bedside and bed at knee height. R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26. Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/7/25: decreased medication 5/18/26: Remind to wear shoes in room and let staff get large items and carry for her			F0657			08/11/2026

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F0657 SS = D	Continued from page 8 5/28/26: Offer to move to room closer to nurses, discontinued medication During interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan. During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report. During interview on 6/30/26 at 10:20 a.m., DON stated she reviewed all fall investigations for R2 and R3 and confirmed those interventions were not added to the comprehensive care plan. DON stated interventions were shared in verbal report with staff. DON further stated the investigation forms were kept in her office and not always available to staff, and it would be important for all staff working with R2 and R3 to be aware of their fall interventions to prevent falls. The facility Care Planning and Care Conference policy dated 8/28/17, indicated; The care plan will be reviewed quarterly with the IDT, resident and/or resident representative and staff. Corrections will be made to the plan of care as needed. Care plans are an on-going process and will have updates made on PRN basis with any changes. Auding will be done weekly on two random care plan by the Director of Nursing to endsure that care plans are up to date. The facility Falls Policy and Procedure dated 9/23, indicated A plan of care will be developed to include measures to aid in prevention of falls. Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the			F0657			08/11/2026

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F0657 SS = D	Continued from page 9 fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI. Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference			F0657			08/11/2026
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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess new bruises and abrasions for 1 of 2 residents (R3) reviewed for non-pressure skin conditions. Findings include: R3's significant change Minimum Data Set (MDS) assessment dated 6/17/26, indicated severely impaired cognition, no behaviors, diagnoses of arthritis, hip fracture, dementia, and use of anticoagulant (blood thinning medication). R3's care plan dated 11/23/24, indicated self-care performance deficit related to recent hip fracture and repair. Skin inspection: requires weekly skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. During observation on 6/29/26 at 10:39 a.m., R3 was walking in the hallway independently with wheeled walker. R3 stated she fell about a month ago and broke her hip. R3's nursing admission/readmission evaluation completed by registered nurse (RN)-B dated 5/26/26, indicated skin issues present, right antecubital bruising from hospitalization, left antecubital bruising from hospitalization, coccyx			F0684	R3 bruise has healed. Facility procedure for skin impairments has been updated to include comprehensive data to be collected. This now includes the location, measurement, color and shape of the noted skin impairment. The procedure has been updated with steps to notify DON if a cause for the skin impairment can not be identified to determine if a Nursing Home Incident Report should be filed through MDH. Instructions added to incident report for skin impairment for nursing order to be placed into TAR (nursing order) by nurse finding skin impairment: Order to read- measure bruise weekly to (specific location) until healed. The DON and/or ADON will choose two skin impairment forms to audit each week during August and September to verify the following: Is the form completed? If not, query the nurse completing the form as to why the form was not completed. Is there an order in the TAR for weekly monitoring of skin impairment? Is the weekly skin assessment reflective of the incident report? Ongoing audits by DON and/or ADON will be completed as followed: October and November = 1x/week, December= 2x/month, then, as needed.This was corrected on 7/30/26. Written education sent to all nurses on 8/6/26 that included the policy update and new form. Email read receipt attached for this email that was sent. Email is as follows: Nurses, The Skin Incident Reports have been updated and		08/11/2026

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F0684 SS = D	Continued from page 10 blanchable redness, left hip known surgical incision covered with dressing, bruising present. There was no further information about the bruise sizes, shapes, dimensions, or coloring. The assessment indicated a care plan goal focus area: anticoagulation with goal of free from discomfort related to anticoagulant use and intervention of labs as ordered. There was no intervention to monitor/document/report signs or symptoms of anticoagulant complications, such as bruising. R3's nursing weekly skin check completed by licensed practical nurse (LPN)-B dated 5/29/26, indicated bruising related to fall, abrasion left forearm, redness to right knee from recent fall. See readmission assessment for skin concerns related to hospitalization/falls. New abrasion to left forearm and redness to right knee from fall sustained yesterday. No further information was on the assessment form. There was no further descriptive information about the new abrasion or knee redness. R3's nursing weekly skin check completed by RN-A dated 6/21/26, indicated new skin condition, injury or skin change noted. New bruise of unknown origin measuring three centimeters by two centimeters located on left knee (rear). No further information was on the assessment form. There was no further descriptive information about the new bruise. R3'S incident report for skin tears and bruises completed by RN-A dated 6/21/26, indicated new bruise to back of left leg below knee. No redness/warmth/swelling, pain with walking, scheduled Tylenol helps. Measurement three centimeters by two centimeters. There was no further description of the bruise. During interview on 6/30/26 at 2:06 p.m., RN-A stated she did not recall anything specific about R3's bruise, but she documented it in Point Click Care (PCC- facility electronic health record) and filled out the incident report provided by the facility. RN-A stated she was unsure if she should have done a focused assessment when finding the new bruise, and that she was unsure how other nurses would be able to tell if the bruise was worsening or healing. During interview on 6/30/26 at 10:12 a.m., director of nursing (DON) stated she was unaware nurses were not completing comprehensive, descriptive assessments of new non-pressure skin conditions. DON stated she thought the incident form they used covered everything. DON stated without comprehensive assessment of the skin conditions,			F0684	Continued from page 10 replaced on both New Wing and Old Wing. The new information that is included in this is as follows and must be completed to have a comprehensive assessment: Location, Color, Shape, Measurement IF INJURY IS OF UNKNOWN SOURCE IT MUST BE REPORTED TO DON IMMEDIATELY TO DETERMINE IF REPORTABLE TO MDH Order placed into TAR (NURSING ORDER) by nurse finding skin impairment: Order to read – measure bruise weekly to (specific location) until healed. Check box located as a reminder to place order into TAR. Please review the attached policy and procedure. There is also an attached copy of the incident report. Please see DON or ADON for any questions.		08/11/2026

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F0684 SS = D	Continued from page 11 other nurses would not be able to compare when monitoring for worsening of the skin condition and this could lead to something being missed for the resident. DON stated she expected comprehensive skin assessments with more detailed descriptions of bruises. Facility Skin Integrity Management Program provided 6/30/26, indicated the following: For new bruises, measure and document a skin progress note in PCC. Enter an order to measure bruises weekly until resolved into the treatment administration record (TAR) in PCC. Notify the family and provider within 24 hours. Complete an incident report and place in filing location at each nurse's station. For pre-existing bruises, measure bruise weekly and document a skin progress note in PCC until resolved. Notify provider if bruise worsens.			F0684			08/11/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure interventions developed following resident falls were implemented through a system that was available to staff to prevent further falls for 3 of 3 residents (R2, R3, R10) reviewed for accidents. Findings include: R10's quarterly Minimum Data Set (MDS) Assessment dated 4/29/26, indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history			F0689	Residents R10, R2 and R3 have had their care plans updated and modified to reflect new care plan layout for falls. New care plan lay out as followed: Problem Goal Intervention Fall Date- specific intervention Fall Date- specific intervention DON will copy over all falls and interventions listed hand written binder log to the electronic care plan in the layout as listed above for fall interventions, including the fall date and specific intervention. All current residents that have sustained falls in the facility will have their care plans updated on 7/31/26 according to the layout listed above. Falls policy and procedure updated to reflect the updated policy with the new fall intervention layout. The DON and ADON will verify for any new falls that this layout is implemented for all nursing staff to see. The ADON will observe at quarterly care conferences that the fall section of the care plan is completed and updated for any resident that has sustained a fall. F689 Weekly IDT minutes have been updated to reflect new format, with falls elevated to one of the top focuses.		08/11/2026

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F0689 SS = D	Continued from page 12 of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol. R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated: Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions: 12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor. 2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting. 3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care. 3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed. 4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired. 6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education. Review of the interventions on 2/14/26, 3/24/26, 4/30/26, and 6/8/26, were not present on the care plan. On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier after walking without her walker because she lost her balance. R10 stated staff reminded her to use her walker following the fall. On 6/29/26 at 2:41 p.m., licensed practical nurse			F0689	Continued from page 12 Updated Weekly IDT Minutes Agenda layout Written education given to all nursing staff via OnShift with the following message: Nursing Staff: All resident fall interventions are listed in their care plan under the FALLS section. Please see me if you are having difficulty finding this. IDT Notes will have a new format in each wing's binder noting falls closer to the top. The paper tracking of fall interventions has been updated to all residents care plans so that it is no longer tracked on just paper. All nursing staff have access to the electronic care plan.		08/11/2026

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F0689 SS = D	Continued from page 13 (LPN)-B stated fall interventions are developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. After review of the electronic medical record, LPN-B confirmed interventions developed following the resident's 6/8/26 fall were not added to the care plan and stated she was not aware of all interventions in place to prevent R10's falls. On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a known fall risk and staff relied on the care plan to identify the resident's current fall prevention interventions and prevent further falls. On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, the nurse manager, stated immediate interventions are implemented following a fall and later reviewed by the interdisciplinary team. RN-B stated IDT-developed interventions are expected to be incorporated into the care plan so staff were aware of and able to implement measures to prevent further falls. RN-B stated if fall interventions were not added to the care plan, staff may not be aware of interventions intended to prevent R10's falls. RN-B further stated she was not aware of all specific interventions in place following R10's falls. On 6/29/26 at 3:09 p.m., the director of nursing (DON) reviewed the post-fall investigations for R10's falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the resident's comprehensive care plan. The DON stated the interventions remained on paper fall investigation forms maintained in the DON's office and acknowledged staff would not have a readily available method to identify the resident's current fall interventions to further prevent falls. On 6/29/26 at 5:03 p.m., LPN-C stated staff rely on the resident's care plan to identify current fall prevention interventions and, if the care plan is not updated, staff would not be aware of the interventions to prevent further falls. On 6/30/26 at 7:58 a.m., nursing assistant (NA)-B stated new fall interventions were communicated during shift report but are also expected to be documented in the care plan so all staff know what interventions to implement to prevent falls. On 6/30/26 at 8:08 a.m., registered nurse (RN)-C stated resident care plans should be updated following a fall to include new interventions to prevent further falls.			F0689			08/11/2026

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F0689 SS = D	Continued from page 14 R2's significant change MDS assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/17/25: Wide bed 1/7/26: Clip call light to chest for easier access 3/29/26: Fall mat at bedside 3/30/26: Hospice referral 4/14/26: Medication change 5/18/26: Remove or flip out foot pedal if wheeling self 5/23/26: Medication change 6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medication R3's significant change MDS assessment dated 6/17/26, indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture. R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at			F0689			08/11/2026

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F0689 SS = D	Continued from page 15 bedside and bed at knee height. R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26. Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/7/25: decreased medication 5/18/26: Remind to wear shoes in room and let staff get large items and carry for her 5/28/26: Offer to move to room closer to nurses, discontinued medication During interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan. During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report. On 6/30/26 at 8:15 a.m., DON stated post-fall investigations had been completed and fall interventions had been decided for the above falls for R2 and R3. DON stated the interventions were passed on by word of mouth to the nurses in report. DON stated the interventions were not a part of the comprehensive care plan and were kept on paper in a binder in her office. DON further confirmed the interventions would not be available for staff if she were not there and it would be important for staff to know fall interventions to prevent future falls. Facility Falls Policy and Procedure dated 9/23, indicated; A plan of care will be developed to include measures to aid in prevention of falls. Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the			F0689			08/11/2026

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F0689 SS = D	Continued from page 16 fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI.			F0689			08/11/2026
F0880 SS = D	Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a			F0880	R5 and R11 were placed on enhanced barrier precaution on 6/30/26. Both R5 and R11 remained on enhanced barrier precautions until removed when seen by wound care provider on site through shared clinical decision making and ruled skin injuries as healed. R11 returned to enhanced barrier precautions on 7/30/26 as new blisters formed on right leg. R58 was removed from precautions on 7/13/26 upon completion of antibiotic treatment. R58 completed planned discharge to long term memory care on 7/29/26. All residents screened for contact and droplet precautions; no new identified. All residents reviewed with DON and wound care nurse to identify any wounds that may require EBP. Facility wound care nurse and DON will review residents with wound care weekly to determine if appropriate residents are enrolled into EBP. Review of residents with new skin impairments will be reviewed upon identification to determine if EBP is required. DON and/or ADON will audit residents on EBP to observe staff for proper use and disposal of PPE (gown and gloves) 2x / week in August and September. Ongoing audits by DON and/or ADON will be completed as followed: October and November = 1x/week, December= 2x/month, then, as needed. Residents who admit to the facility and require contact or droplet precautions will follow the same auditing procedures. Staff who are audited and not found in compliance with proper use of PPE will be provided with on the spot re-education on use of PPE. Auditing may occur in direct observation or by means of camera footage review. This deficiency was corrected on 7/30/26. Written education provided to all nursing staff on 8/7/26 via OnShift message systems. The following		08/11/2026

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F0880 SS = D	Continued from page 17 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to implement appropriate infection prevention and control practices by ensuring Enhanced Barrier Precautions (EBP), including gown and glove use during wound care, were implemented for 2 of 2 residents (R5 and R11) reviewed for skin conditions and by ensuring transmission-based contact precautions, including gown and glove use during direct personal care, were implemented for 1 of 1 resident (R58) reviewed for infection prevention. Findings include: R5's face sheet printed 6/30/26, indicated diagnoses of blister of left and right lower leg. R5's quarterly Minimum Data Set (MDS) assessment dated 6/25/26, indicated intact cognition, no			F0880	Continued from page 17 education was provided in writing: Nursing Staff: Enhanced Barrier Precautions are required to be followed when caring for residents under them. You will find an ORANGE SIGN outside the room and a 3 drawer cart with supplies. You MUST wear a GOWN and GLOVES when completing the following: dressing, bathing, transferring, changing linens, providing hygiene, toileting device use or wound care		08/11/2026

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F0880 SS = D	Continued from page 18 rejection of care, use of wheelchair, dependent for dressing and hygiene, and application of ointments/medications and nonsurgical dressings. R5's care plan dated 9/28/23, indicated potential for pressure ulcer development, goal of skin remaining intact through review dates, and interventions of administering treatments as ordered and checking skin when assisting with toileting and dressing daily and also weekly in the bath. R5's physician's order dated 6/6/26, indicated left lower extremity (LLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Right lower extremity (RLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Apply skin prep to periwound skin and allow to dry. Apply a single layer cut-to-fit piece of foam over blisters. Cover with small pad, secure with wrap and tape from base of toes to just below the knee. R5's provider visit note dated 6/19/26 indicated RLE blister measuring 0.4 centimeters by 1.1 centimeters. Prep: cleansed with saline. Noted serosanguineous (thin fluid that is a mixture of water and blood) drainage. Surrounding skin noted to have tenderness. Patient tolerated procedure well. Moisturized and applied foam dressing. R5's progress note dated 6/29/26, indicated R5 had a hospice bath this shift. Wound continue to right lower extremity. Review of R5's treatment administration record (TAR) indicated licensed practical nurse (LPN)-A completed R5's RLE wound treatment on 6/29/26 and 6/30/26. During observation on 6/29/26 at 1:34 p.m., no enhanced barrier precaution (EBP) signs were noted on R5's room door. No personal protective equipment (PPE) for EBP was observed at his room entrance. During interview on 6/0/26 at 1:13 p.m., LPN-A state she completed R5's wound care for his RLE wound. LPN-A stated she did wear gloves but did not wear a gown. LPN-A stated she was not aware she needed to wear EBP PPE while taking care of R5's wound and he had not been placed on EBP as far as she knew.			F0880			08/11/2026

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F0880 SS = D	Continued from page 19 During interview on 6/30/26 at 11:20 a.m., director of nursing (DON) also known as the infection preventionist, stated EBP should be used for R5 during cares and wound treatments due to his RLE wound with drainage. R11's significant change in status MDS assessment dated 6/19/26, indicated no cognitive impairment, independent with personal cares and transfers, and diagnoses included non-Alzheimer's dementia and cellulitis (bacterial infection of the skin) of left lower limb. R11's care plan dated 5/19/26, indicated impairment to skin integrity r/t (related to) cellulitis and monitor/document location, size and treatment of skin injury. R11's wound care provider note dated 6/19/26, identified two open ulcers to the left lower extremity requiring daily wound care, including cleansing, application of topical treatments, Xeroform (sterile, non-adherent medical dressing) dressing, ABD (absorbent medical dressing) pad, and Kerlix (gauze bandage) wrap. On 6/29/26 at 2:39 p.m., R11 was seated in a recliner in their room with a dressing to the left lower leg. R11 stated nursing staff performed daily dressing changes and wore gloves during wound care but did not wear gowns. R11's room identified no EBP signage or PPE cart outside or outside the room. On 6/30/26 at 10:00 a.m., RN-C performed R11's wound care, including removal of the dressing, cleansing the wound, application of prescribed treatments, and placement of a new dressing. RN-C performed hand hygiene and wore gloves throughout the dressing change; however, a gown was not worn. RN-C stated R11 would be expected to be on enhanced barrier precautions because of the wound requiring dressing changes. RN-C stated the director of nursing (DON) determined which residents were placed on EBP and was responsible for EBP signage and PPE carts. On 6/30/26 at 11:18 a.m., the DON stated residents with wounds requiring dressing changes would be expected to be on enhanced barrier precautions with gown and glove use during wound care. The DON stated she believed R11 only had a scratch and was unaware the resident had active wound care orders. The DON confirmed R11 should have been on EBP			F0880			08/11/2026

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F0880 SS = D	Continued from page 20 and stated any nurse could initiate EBP by posting signage and placing a PPE cart outside the resident's room. R58's entry MDS assessment dated 6/22/26, indicated reentry from short term hospital on 6/22/26. R58's treatment administration record (TAR) dated 6/1/26-6/30/26, indicated start date 6/22/26, contact precautions used as directed per CMS guidelines every shift for VRE in urine (Vancomycin-Resistant Enterococci- bacteria primarily spread through direct contact with contaminated hands or surfaces). R58's After Visit Summary dated 6/22/26, indicated skin care/pressure management instructions wound care: buttocks; pressure injury. R58's care plan dated revised on 6/22/26, indicated at risk of transmitting an infection, contact isolation: wear gowns and gloves when entering room. On 6/29/26 at 12:23 p.m., observation identified a PPE cart containing gowns and gloves and contact precaution signage posted outside R58's room. On 6/29/26 at 12:26 p.m. trained medication aide (TMA)-A was observed providing toileting assistance to R58 while wearing gloves but no gown. TMA-A exited the resident's bathroom without having a gown. TMA-A confirmed R11 was on contact precautions for VRE in the urine, and confirmed a gown and gloves were required during care, and stated they forgot to put on the gown. On 6/29/26 at 4:51 p.m., the DON confirmed R58 was on contact precautions for VRE in urine and stated staff should know to use gown and gloves when providing toileting assistance, due to the signage posted and the PPE cart outside of R58's room. Facility Infection Prevention and Control Manual Policy dated 2024, indicated; Enhanced Barrier Precautions: "refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident			F0880			08/11/2026

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F0880 SS = D	Continued from page 21 care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: •Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or •Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.			F0880			08/11/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and			F0883	F883 How corrective action will be accomplished for those residents found to have been affected by deficient practice R1 and R9 were reviewed by DON using PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they were eligible for. Consent obtained from each family and approved vaccine administration. Vaccine ordered from pharmacy and will be administered on 8/3/26 (or sooner, pending arrival from pharmacy). 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 deficient practice will not occur. All current residents screened by DON with PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they were eligible for. New spreadsheet built to track eligibility and need for all residents with pneumonia vaccine status. Residents that were identified as eligible, regardless of Medicare A stay status, were offered pneumonia vaccines. Four residents were identified and offered. Of the four, one deferred and three refused. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not reoccur. When a new resident admits to the facility, the DON will reference the PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they are eligible for or if they are up to date. By the scheduled care conference (within three weeks of admission) the DON will notify the ADON of which pneumonia vaccines the resident is eligible for and seek consent and provide Vaccine Information Statement. Decision from resident and or residents		08/11/2026

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F0883 SS = D	Continued from page 22 potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to offer the recommended update for pneumococcal immunizations for 2 of 5 residents (R1, R9), reviewed for immunizations. Findings include: R1's face sheet printed on 6/30/26, included diagnoses of dementia, chronic kidney disease, congestive heart failure (when the heart does not pump as well as it should) and chronic obstructive pulmonary disease (lung condition that obstructs airflow and causes breathing difficulty). R1's admission Minimum Data Set (MDS) assessment dated 2/27/26, indicated intact cognition, clear speech, could understand and be understood. R1 was dependent upon staff for activities of daily living (ADLs). R1's physician orders did not include vaccinations. R1's vaccine history indicated pneumococcal 23-valent vaccine was received in 2011. PneumoRecs VaxAdvisor application, a product created by the CDC (Centers for Disease Control and Prevention) for healthcare providers to determine which pneumococcal vaccines were needed,			F0883	Continued from page 22 responsible party will be documented in the resident immunization tab (administered or declined). A routine audit, twice yearly by Thrifty White Pharmacy will be completed to determine eligibility for pneumonia vaccines during bi-annual clinics that Thrifty White Pharmacy hosts at Mapleton Community Home.		08/11/2026

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F0883 SS = D	Continued from page 23 recommended to give one dose of PCV15, PCV20, PCV21 at least one year after the last dose of PPSV23. During an interview on 6/30/26 at 2:30 p.m., R1 had been sleeping in bed; family member FM-A stated she could not recall if the facility had talked to them about R1 receiving additional vaccinations, but stated if one were recommended, R1 would take it. FM-A stated she knew R1 had received pneumococcal, influenza and covid vaccines, but gave up trying to keep track. R9's face sheet received on 6/30/26, included primary and secondary diagnoses of hepatic encephalopathy (brain dysfunction caused by liver disease) and nonalcoholic steatohepatitis (aggressive form of fatty liver disease). R9's admission MDS assessment dated 6/11/26, indicated moderately impaired cognition, clear speech, could understand and be understood. R9 required substantial assistance or was dependent upon staff for ADLs. R9's physician orders did not include vaccines. R9's vaccine history indicated pneumococcal 23-valent vaccine in 2017, and PCV13 in 2020. PneumoRecs VaxAdvisor recommended to give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. During an interview on 6/30/26 on 3:13 p.m., R9 stated if vaccines were recommended and offered, she would take them. R9 stated no vaccines had been offered or received since admission. During an interview on 6/30/26 at 12:44 p.m., the director of nursing (DON) who was also the infection preventionist, stated R1 had been admitted on 2/13/26, for short term rehabilitation, which was Medicare part A, so the facility would not automatically update any vaccines. Then on 4/17/26, R1 moved to long term care status, and missed the vaccine clinic held on 4/20/26. The next vaccine clinic would be held at the end of July. The DON stated the facility conducted quarterly vaccine clinics in conjunction with a pharmacy. Regarding R9, the DON stated vaccines would be recommended at end of her short-term stay. The DON stated the delay in R1 and R9 being offered to update their vaccine status while in short term stay, was due to billing. During an interview on 6/30/26 at 2:34 p.m., Doctor			F0883			08/11/2026

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F0883 SS = D	Continued from page 24 of Medicine (MD)-C had been informed some residents had not been offered pneumococcal vaccine updates on admission. MD-C stated pneumococcal would be important to have on admission and had been unaware of the process the facility utilized to determine which/when vaccines were offered. During an interview on 6/30/26 at 2:39 p.m., registered nurse (RN)-B who was also a nurse manager, stated her role in resident immunizations included looking up historical vaccinations, but did not assess vaccine status to determine if a resident was eligible for additional vaccines such as pneumococcal vaccines. RN-B stated that was handled by the DON and the pharmacy. RN-B stated immunization status was reviewed by pharmacy during vaccination clinics. Looking in the electronic medical record, RN-B stated both R1 and R9 had been eligible for PCV21 if a provider ordered it. Facility Standing Orders policy, undated, included per CDC guidelines, administer pneumococcal vaccines unless contraindicated. Facility Pneumococcal Vaccine Program policy dated 2024, indicated residents would be offered immunizations against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations. Pneumococcal disease was a serious illness that could cause sickness and even death. A physician order for all pneumococcal vaccines was required. Pneumococcal vaccination guidance for pneumococcal vaccination can be determined at CDC PneumoRecs VaxAdvisor.			F0883			08/11/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed			F0732	Observation of daily completion of nursing staffing hours of July, 2026 has 100% completion rate. Review of nursing staffing hours policy and redistribution to nurses emphasizing importance of completion done on June 30th, 2026. Check box reminder added to daily nursing notes/report sheet to complete census for old wing as that is where the census form is listed. An audit for observation of completion will be completed by DON and/or ADON 2x / week during August and September. Once weekly auditing to be completed in October and November. Twice monthly audit in December, then as needed beginning January 2027. During audits, if there is observed noncompletions		08/11/2026

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F0732 SS = C	Continued from page 25 nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure required and accurate nursing staffing information was posted for residents and visitors. This had the potential to affect all 47 residents residing in the facility and their visitors. Findings include:			F0732	Continued from page 25 for any shift, the DON will notify the nurse that was assigned as charge nurse on old wing and provide redirection and education. This deficiency was corrected on July 30, 2026. Observation of daily nursing staffing hours from 7-1-26 through 7-31-26 by DON have been reviewed and all shifts have completed their daily staffing hours to include the resident census for each shift and the staff assigned for each shift (RN, LPN, TMA, CNA) Written education was provided to all nurses again on August 7, 2026 with the below listed information. Please review the attached policy and procedure for the nursing staffing hours posted at Old Wing. It is the responsibility of the nurse on Old Wing each shift (Day, Eve, and NOC) to complete these hours listed on the form. I will be auditing this form as we need 100 % accuracy and will notify you if your shift was missed. If continued lack of completion is found it will be reflected upon your performance review. This email included the policy and procedure for the nursing staffing hours.		08/11/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245362		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
NAME OF PROVIDER OR SUPPLIER MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET SW , MAPLETON, Minnesota, 56065			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0732 SS = C	Continued from page 26 During an observation on 6/29/26 at 2:17 p.m., observed the daily nursing staffing posting for 6/29/26, in an acrylic holder on the countertop at the nurses station inside the main entrance. The posting included all of the required information, including the number of staff on duty: RN (registered nurse), LPN (licensed practical nurse), TMA (trained medication aide), and CNA (certified nursing assistant). Postings for April through June were requested for review. For April, from 4/1/26 through 4/30/26, 16 shifts had been left blank (all night shifts). Further, a registered nurse had not been identified as having been scheduled/working five of the dates: 4/1/26, 4/10/26, 4/15/26, 4/24/26, and 4/29/26. For May, from 5/1/26 through 5/31/26, 12 shifts had been left blank (16 night shifts and one evening shift). Further, on 5/27/26, one shift identified an RN in training, but no other RN had been identified. For June, from 6/1/26 through 6/28/26, 16 shifts had been left blank (12 night shifts, three evening shifts and one day shift). Further, a registered nurse had not been identified as having been scheduled/working on four of the dates: 6/6/26, 6/7/26, 6/10/26, and 6/24/26. During an interview on 6/29/26, at 3:37 p.m., the director of nursing (DON) stated it was the responsibility of charge nurses to complete the staffing posting sheet at the start of their shift. The DON stated a minimum of one registered nurse was scheduled for eight consecutive hours every day. In addition, a nurse leader was scheduled to work the day shift, Monday through Friday, either the DON, assistant DON or nurse manager. According to the DON, the shifts where an RN had not been identified as scheduled/working, were primarily shifts worked by agency nurses who likely did not know they needed to complete the form. In addition, for nine of the 10 dates, an RN nurse leader had worked 8 consecutive hours too, except for Saturday 6/6/26, when the RN was an agency nurse. The agency nurses time card had been reviewed for verification. The DON stated she did not monitor the process to ensure nurses completed the form each shift/each day. During an interview on 6/29/26 at 6:08 p.m., registered nurse (RN)-A who was the charge nurse stated she had never filled out a staffing posting for			F0732			08/11/2026

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F0732 SS = C	Continued from page 27 a shift she worked, adding it was usually already filled out. During an interview on 6/30/26 at 8:39 a.m., licensed practical nurse (LPN-A) stated the charge nurse completed the daily staffing posting for that shift. LPN-A stated she looked at the online electronic scheduling system to determine who was scheduled to work, added it to the sheet and made changes to it if someone called in (not able to work). LPN-A stated there was at least one RN scheduled to work every day. Facility Posting Nursing Staffing Hours policy, undated, indicated early in the shift, the charge nurse would obtain a staffing hours form from the bottom file drawer located in the nurses station. The form would be completed with date, census, the type of nursing staff scheduled to work, and their scheduled hours. This would be done by the charge nurse on each shift.			F0732			08/11/2026

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K0000 Bldg. 01	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on 06/30/2026 by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Mapleton Community Home 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			K0000			07/31/2026

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: 245362		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILD... B. WING		(X3) DATE SURVEY COMPLETED 06/30/2026	
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K0000 Bldg. 01	Continued from page 1 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. 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. Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction.			K0000			07/31/2026

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K0000 Bldg. 01	Continued from page 2 The 2011 nursing home addition, which included a link to an assisted living facility. The link incorporates a barber/beauty shop, storage rooms and staff office space. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 46 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			K0000			07/31/2026
K0346 SS = F Bldg. 01	Fire Alarm System - Out of Service CFR(s): NFPA 101 Fire Alarm - Out of Service Where required fire alarm system is out of services for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.6 This STANDARD is NOT MET as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement a fire alarm out-of-service policy per NFPA 101 (2012 edition), Life Safety Code, section 9.6.1.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include:			K0346	K0346 Fire Alarm Out of Service Documents were corrected on 7/7/26 to change the notification time for the fire alarm out of service policy from 10 hrs to the correct time of 4 hrs. Documents will be reviewed annually by the maintenance director.		07/07/2026

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K0346 SS = F Bldg. 01	Continued from page 3 On 06/30/2026 at 9:58 AM, it was revealed by review of available documentation that the fire alarm system out-of-service policy specified a 10-hour threshold for notification, which exceeds the required 4-hour timeframe for contacting the Deputy State Fire Marshal. An interview with the Maintenance Assistant verified this deficient finding at the time of discovery.			K0346			07/07/2026
K0226 SS = E Bldg. 01	Horizontal Exits CFR(s): NFPA 101 Horizontal Exits Horizontal exits, if used, are in accordance with 7.2.4 and the provisions of 18.2.2.5.1 through 18.2.2.5.7, or 19.2.2.5.1 through 19.2.2.5.4. 18.2.2.5, 19.2.2.5 This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to maintain fire barriers per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.2.5, 7.2.4.3.1, and 8.3.1.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 06/30/2026 at 11:43 AM, it was revealed by observation that above the ceiling at the 2-hour fire wall located near the South Nurses Station there were two unsealed penetrations. An interview with the Maintenance Assistant verified this deficient finding at the time of discovery.			K0226	K0226 Horizontal Exits Sheet rock was cut to cover penetrations, and fire caulk was applied to fill any gaps around pipes and wires. This was completed on 7/28/26. All other firewalls were inspected and any other penetrations found were repaired at that time. In the future firewalls will be inspected annually when fire door inspections are done, and any time work is done that could result in penetration in any firewalls.		07/28/2026
K0353 SS = E Bldg. 01	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked			K0353	K0353 Sprinkler System Maintenance and Testing 1. The wire zip tied to the sprinkler pipe in the south mechanical room was rerouted and removed from the sprinkler pipe on 7/6/26. We are watching to see if there are any more wires tied to sprinkler pipes anywhere and will monitor and inspect any areas that any work is done to ensure it isn't happening in the future. 2. Olympic Fire Protection has been contacted and were here to inspect the sprinkler heads. New heads have been ordered and are scheduled to be replaced on or before 9/7/26. Maintenance staff will visually inspect sprinkler heads annually at the time of our		09/07/2026

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K0353 SS = E Bldg. 01	Continued from page 4 b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is NOT MET as evidenced by: Based on observation, review of available documentation, and staff interview, the facility failed to maintain the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, section 9.7.5, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2(2)(5), and 5.2.2.2. These deficient finding could have a patterned impact on residents within the facility Findings include: 1. On 06/30/2026 at 11:13, it was revealed by observation that there were wires zip tied to the sprinkler pipe in the South Mechanical Room. 2. On 06/30/2026 at 11:20, it was revealed by observation that the sprinklers located in Furnace room 65 showing signs of corrosion. 3. On 06/30/2026 at 11:30, it was revealed by observation that there was a lint covered sprinkler located in the Kitchen. 4. On 06/30/2026 at 11:31, it was revealed by observation that the sprinklers located in the dishwashing room were showing signs of corrosion. An interview with the Maintenance Assistant verified these deficient findings at the time of discovery.			K0353	Continued from page 4 annual sprinkler system inspection. If any sprinkler heads show any corrosion, they will be scheduled to be replaced at that time. 3. On 7/14/26 and 7/15/26 all sprinkler heads were inspected and blown off to remove any dust or lint that was on them. Maintenance will blow off all sprinkler heads annually at the time of the annual sprinkler system inspection. 4. Olympic Fire Protection has been contacted and were here to inspect the sprinkler heads. New heads have been ordered and are scheduled to be replaced on or before 9/7/26. Maintenance staff will visually inspect sprinkler heads annually at the time of our annual sprinkler system inspection. If any sprinkler heads show any corrosion, they will be scheduled to be replaced at that time.		09/07/2026
K0923 SS = E Bldg. 01	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and			K0923	K0923 Oxygen containers have been rearranged in the storage room and clear signage has been put in place to identify where hospice and MCH tanks are to be stored. Also, signage has been placed to show where the full and empty tanks shall be stored keeping them separate. Staff have been notified of the new arrangement. The room will be inspected		07/31/2026

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K0923 SS = E Bldg. 01	Continued from page 5 ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and staff interview, the facility failed to store oxygen containers per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.5.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include On 06/30/2026 at 11:32 AM, it was revealed by observation that the oxygen containers in the Oxygen Storage Room were not segregated from full and empty. Although the containers were identified with paper tags indicating whether they were full or empty, both full and empty oxygen containers were stored together.			K0923	Continued from page 5 weekly to ensure that the tanks are being stored properly. A log has been placed on the door to sign off on the inspection. This was completed on or before 7/31/26		07/31/2026

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K0923 SS = E Bldg. 01	Continued from page 6 An interview with the Maintenance Assistant verified this deficient finding at the time of discovery.			K0923			07/31/2026



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
September 8, 2026

Administrator
MAPLETON COMMUNITY HOME
301 TROENDLE STREET SW
MAPLETON, MN 56065

RE: CCN: 245362
Cycle Start Date: June 30, 2026

Dear Administrator:

On September 8, 2026, the Minnesota Department(s) of Health and Public Safety, completed a revisit 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,

A handwritten signature in cursive script that reads 'Sarah Lane'.

Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697

Email: sarah.lane@state.mn.us

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E0000	Initial Comments On 6/29/26-6/30/26, 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				
F0000	INITIAL COMMENTS On 6/29/26-6/30/26, a standard recertification survey (S5362039) was completed at your facility by the Minnesota Department of Health to determine compliance with §42 CFR Part 483, Subpart B, Requirements for Long Term Care Facilities. Your facility was found to be NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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				
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.		F0641				

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
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245362	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/30/2026
NAME OF PROVIDER OR SUPPLIER MAPLETON COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET SW , MAPLETON, Minnesota, 56065	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 1 §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on interviews and document review the facility failed to ensure the Minimum Data Set (MDS) accurately reflected the resident's fall history for 2 of 3 residents (R2 and R10) reviewed for falls. Findings include: R2's significant change Minimum Data Set (MDS) assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play	F0641	Continued from page 1 completed on 3/6/26. However, there was a Quarterly completed on 2/17/26 that was not in compliance. The resident had one fall – injury except major on 1/7/26 (scratches to left shoulder blade). The Quarterly on 2/17/26 was coded as one fall – no injury. The prior assessment (OBRA or Scheduled PPS) was completed on 11/18/25, thus the fall on 11/17/25 would not be included on the Quarterly dated 2/17/26. The MDS Coordinator completed a Modification of Quarterly dated 2/17/26 on 7/31/26 to indicate one fall – injury except major. Resident R2: The MDS Coordinator reviewed this tag and identified there was not a Significant Change assessment completed on 4/30/26. However, there was a Significant Change completed on 4/15/26 that was not in compliance. The Significant Change indicated the resident had one fall – no injury, and one fall – injury except major. After review of progress notes, accident reports, and neurological assessments, the resident had falls on 3/29/26, 3/30/26, and 4/14/26 that would be included in the look back period. Of these falls, two were falls – no injury (3/29/26 and 3/30/26) and one fall – injury except major (abrasion to forehead on 4/14/26). The MDS Coordinator completed a Modification of Significant Change dated 4/15/26 on 7/31/26 to indicate two or more falls – no injury. There was no change to the one fall – injury except major, as that was in compliance. Resident R10: The MDS Coordinator reviewed progress notes and accident reports confirming the resident had falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26. The Quarterly completed on 4/29/26 was reviewed and determined was not in compliance. The resident had three falls during the look back period (2/14/26, 3/11/26, and 3/24/26). Of these falls, two were falls – no injury (2/14/26 and 3/11/26) and one fall – injury except major (pain requiring ED visit on 3/24/26). The fall on 4/30/26 would not be included in this MDS, as it was after the ARD of 4/29/26.	08/11/2026

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F0641 SS = D	Continued from page 2 cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. R2's quarterly MDS assessment dated 3/6/26, indicated falls since the prior assessment that included one fall with no injury. Review of R2's falls during that assessment period indicated two falls had occurred. R2's significant change MDS dated 4/30/26, indicated falls since the prior assessment that included one fall with no injury and one fall with minor injury. Review of R2's falls during that assessment period indicated three falls had occurred. During interview on 6/30/26 at 10:20 a.m., assistant director of nursing (ADON) stated she was the MDS nurse for the facility and completed R2's MDS assessments. ADON stated she did not think the facility used point click care (PCC- facility electronic health record) to its full potential, still had a lot of paper charting, and it was likely falls could be missed when reviewing for assessments. ADON reviewed R2's falls and confirmed some falls were missed on her assessments. R10's quarterly MDS assessment dated 4/29/26 indicated R10 had no cognitive impairment, utilized a walker, was independent with walking, and had diagnoses that included non-Alzheimer's dementia, repeated falls, and chronic pain. Section J indicated R10 had experienced falls since admission or the prior assessment and was coded as having one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, identified R10 as being at risk for falls related to poor balance and a history of falls. Interventions included anticipating and meeting R10's needs, keeping the call light within reach and encouraging its use for assistance as needed, and following the facility's fall protocol. Review of R10's Accident Reports indicated R10 sustained falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26. On 6/30/26 at 8:47 a.m., the ADON, who also served as the facility's MDS nurse, stated they completed R10's MDS fall coding on 5/13/26. The ADON confirmed R10 experienced falls on 2/14/26, 3/11/26, 3/24/26, and 4/30/26, including two falls			F0641	Continued from page 2 The MDS Coordinator completed a Modification of Quarterly dated 4/29/26 on 7/31/26 to indicate two or more falls – no injury. There was no change to the one fall – injury except major, as that was in compliance. MDS Coordinator will complete an audit on current residents with falls within the last year and review correlating MDS to assure accuracy. MDS Coordinator will thoroughly review progress notes and neurological assessments and cross reference with accident reports to assure all falls are accurately captured and coded accordingly. A random audit of five charts will be conducted quarterly on residents to cross reference accident reports, progress notes and neurological assessments to determine compliance. Audits will be completed quarterly for one year and then as needed thereafter. The deficiencies listed above were corrected on 7/31/26. The process for tracking falls has been updated so that either the DON or designee will update the care plan after a fall with the date of the fall and the intervention added related to that fall. The MDS Coordinator was educated on this new process on 8/6/26. The MDS Coordinator will be expected to review the care plan to identify dates of falls within the look back period then review progress notes, neurological assessments and accident reports to assure accurate documentation on the MDS to include both the amount of falls and the type of fall (no injury, injury – except major, injury – major).		08/11/2026

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F0641 SS = D	Continued from page 3 with injury (except major) and two falls with no injury during the applicable MDS look-back period. The ADON confirmed the MDS assessment was coded incorrectly and should have indicated two or more falls and two or more falls with injury (except major). On 6/30/26 at 11:18 a.m., the director of nursing (DON) stated they expected the MDS to accurately reflect residents' falls. Facility MDS Accuracy Policy, dated 3/2019, indicated the Resident Assessment Instrument (RAI) Manual would be followed to ensure accuracy in all coding areas.			F0641			08/11/2026
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:			F0657	Residents R10, R2 and R3 have had their care plans updated and modified to reflect new care plan layout for falls. New care plan layout as followed: Problem Goal Intervention Fall Date- specific intervention Fall Date- specific intervention DON will copy over all falls and interventions listed hand written binder log to the electronic care plan in the layout as listed above for fall interventions, including the fall date and specific intervention. All current residents that have sustained falls in the facility will have their care plans updated on 7/31/26 according to the layout listed above. Falls policy and procedure updated to reflect the updated policy with the new fall intervention layout. The DON and ADON will verify for any new falls that this layout is implemented into the fall section of the electronic care plan for all nursing staff to see. The ADON will observe at quarterly care conferences that the fall section of the care plan is completed and updated for any resident that has sustained a fall. Written education given to all nursing staff via OnShift with the following message: Nursing Staff: All resident fall interventions are listed in their care plan under the FALLS section. Please see me if you are having difficulty finding this. IDT Notes will have a new format in each wing's binder noting falls closer to the top. The handwritten binder is no longer utilized as the		08/11/2026

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F0657 SS = D	Continued from page 4 Based on interview, observation, and document review, the facility failed to revise and update the comprehensive care to include new fall interventions implemented for 3 of 3 residents (R2, R3, and R10) reviewed for falls. Findings include: R10's quarterly Minimum Data Set (MDS) Assessment dated 4/29/26, indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol. R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated: Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions: 12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor. 2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting. 3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care. 3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed.			F0657	Continued from page 4 only form for tracking falls and interventions. Each resident has a section in their electronic care plan listed for falls. In the fall section of the care plan, the date and intervention of each fall is listed. This allows all nursing staff (RN, LPN, TMA, CNA) access to the fall interventions. All residents that have sustained falls now have listed in their electronic care plan under the fall section the fall date and specific intervention for that fall.		08/11/2026

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F0657 SS = D	Continued from page 5 4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired. 6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education. Review of the comprehensive care plan failed to identify the interventions developed following the falls on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26. On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier because she lost her balance while walking without her walker. R10 stated staff reminded her to use her walker following the fall. On 6/29/26 at 2:41 p.m., licensed practical nurse (LPN)-B stated fall interventions were developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. LPN-A was observed to review R10's electronic medical record (EMR) and confirmed interventions form R10's most recent fall on 6/8/26, were not added to the care plan. On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a fall risk and relied on the care plan to identify current fall interventions. On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, known as the nurse manager, stated following a resident fall the nurse completes a fall report on paper and puts an immediate intervention in place and emails the nursing staff of the new interventions or writes a progress note. RN-B stated the the interdisciplinary team (IDT) meets and reviews the fall, and discusses interventions and the implemented interventions would be expected to appear in the resident's care plan. RN-B stated the IDT team consists of themselves, director of nursing (DON), assistant director of nursing (ADON), social worker, dietary, activities, business office, therapy and nursing floor staff. RN-B confirmed no new care plan interventions were documented following the 6/8/26, fall. RN-B stated DON or ADON updated			F0657			08/11/2026

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F0657 SS = D	Continued from page 6 resident care plans. On 6/29/26 at 3:09 p.m., the DON stated the IDT reviews each fall and attempts to implement a new intervention unless all appropriate interventions are already in place. The DON reviewed R10's fall investigation forms for the falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the comprehensive care plan. The DON stated the paper fall investigation forms containing the interventions were maintained in the DON's office and acknowledged staff would not be able to readily identify the interventions from the care plan. The DON confirmed the DON and ADON were responsible for updating resident care plans. On 6/29/26 at 5:03 p.m., an LPN-C stated fall interventions are communicated during report or by email but should also be included in the care plan because staff rely on the care plan to identify resident-specific interventions. 6/29/26 at 5:57 p.m., R10 was observed ambulating independently in the hallway using a two-wheeled walker. On 6/29/26 at 6:06 p.m., R10 was seated on a bench outside the facility smoking a cigarette. On 6/30/26 at 7:58 a.m., a NA-B stated new fall interventions were communicated during shift report and would also be expected to be documented in the care plan. On 6/30/26 at 8:08 a.m., a RN-C stated following a fall, interventions should be updated in the resident's care plan and confirmed the DON and ADON were responsible for revising and upateing the care plan. R2's significant change MDS assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in			F0657			08/11/2026

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F0657 SS = D	Continued from page 7 the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/17/25: Wide bed 1/7/26: Clip call light to chest for easier access 3/29/26: Fall mat at bedside 3/30/26: Hospice referral 4/14/26: Medication change 5/18/26: Remove or flip out foot pedal if wheeling self 5/23/26: Medication change 6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medication R3's significant change MDS assessment dated 6/17/26, indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture. R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at bedside and bed at knee height. R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26. Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/7/25: decreased medication 5/18/26: Remind to wear shoes in room and let staff get large items and carry for her			F0657			08/11/2026

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F0657 SS = D	Continued from page 8 5/28/26: Offer to move to room closer to nurses, discontinued medication During interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan. During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report. During interview on 6/30/26 at 10:20 a.m., DON stated she reviewed all fall investigations for R2 and R3 and confirmed those interventions were not added to the comprehensive care plan. DON stated interventions were shared in verbal report with staff. DON further stated the investigation forms were kept in her office and not always available to staff, and it would be important for all staff working with R2 and R3 to be aware of their fall interventions to prevent falls. The facility Care Planning and Care Conference policy dated 8/28/17, indicated; The care plan will be reviewed quarterly with the IDT, resident and/or resident representative and staff. Corrections will be made to the plan of care as needed. Care plans are an on-going process and will have updates made on PRN basis with any changes. Auding will be done weekly on two random care plan by the Director of Nursing to endsure that care plans are up to date. The facility Falls Policy and Procedure dated 9/23, indicated A plan of care will be developed to include measures to aid in prevention of falls. Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the			F0657			08/11/2026

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F0657 SS = D	Continued from page 9 fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI. Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference			F0657			08/11/2026
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. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess new bruises and abrasions for 1 of 2 residents (R3) reviewed for non-pressure skin conditions. Findings include: R3's significant change Minimum Data Set (MDS) assessment dated 6/17/26, indicated severely impaired cognition, no behaviors, diagnoses of arthritis, hip fracture, dementia, and use of anticoagulant (blood thinning medication). R3's care plan dated 11/23/24, indicated self-care performance deficit related to recent hip fracture and repair. Skin inspection: requires weekly skin inspection. Observe for redness, open areas, scratches, cuts, bruises and report changes to the nurse. During observation on 6/29/26 at 10:39 a.m., R3 was walking in the hallway independently with wheeled walker. R3 stated she fell about a month ago and broke her hip. R3's nursing admission/readmission evaluation completed by registered nurse (RN)-B dated 5/26/26, indicated skin issues present, right antecubital bruising from hospitalization, left antecubital bruising from hospitalization, coccyx			F0684	R3 bruise has healed. Facility procedure for skin impairments has been updated to include comprehensive data to be collected. This now includes the location, measurement, color and shape of the noted skin impairment. The procedure has been updated with steps to notify DON if a cause for the skin impairment can not be identified to determine if a Nursing Home Incident Report should be filed through MDH. Instructions added to incident report for skin impairment for nursing order to be placed into TAR (nursing order) by nurse finding skin impairment: Order to read- measure bruise weekly to (specific location) until healed. The DON and/or ADON will choose two skin impairment forms to audit each week during August and September to verify the following: Is the form completed? If not, query the nurse completing the form as to why the form was not completed. Is there an order in the TAR for weekly monitoring of skin impairment? Is the weekly skin assessment reflective of the incident report? Ongoing audits by DON and/or ADON will be completed as followed: October and November = 1x/week, December= 2x/month, then, as needed.This was corrected on 7/30/26. Written education sent to all nurses on 8/6/26 that included the policy update and new form. Email read receipt attached for this email that was sent. Email is as follows: Nurses, The Skin Incident Reports have been updated and		08/11/2026

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F0684 SS = D	Continued from page 10 blanchable redness, left hip known surgical incision covered with dressing, bruising present. There was no further information about the bruise sizes, shapes, dimensions, or coloring. The assessment indicated a care plan goal focus area: anticoagulation with goal of free from discomfort related to anticoagulant use and intervention of labs as ordered. There was no intervention to monitor/document/report signs or symptoms of anticoagulant complications, such as bruising. R3's nursing weekly skin check completed by licensed practical nurse (LPN)-B dated 5/29/26, indicated bruising related to fall, abrasion left forearm, redness to right knee from recent fall. See readmission assessment for skin concerns related to hospitalization/falls. New abrasion to left forearm and redness to right knee from fall sustained yesterday. No further information was on the assessment form. There was no further descriptive information about the new abrasion or knee redness. R3's nursing weekly skin check completed by RN-A dated 6/21/26, indicated new skin condition, injury or skin change noted. New bruise of unknown origin measuring three centimeters by two centimeters located on left knee (rear). No further information was on the assessment form. There was no further descriptive information about the new bruise. R3'S incident report for skin tears and bruises completed by RN-A dated 6/21/26, indicated new bruise to back of left leg below knee. No redness/warmth/swelling, pain with walking, scheduled Tylenol helps. Measurement three centimeters by two centimeters. There was no further description of the bruise. During interview on 6/30/26 at 2:06 p.m., RN-A stated she did not recall anything specific about R3's bruise, but she documented it in Point Click Care (PCC- facility electronic health record) and filled out the incident report provided by the facility. RN-A stated she was unsure if she should have done a focused assessment when finding the new bruise, and that she was unsure how other nurses would be able to tell if the bruise was worsening or healing. During interview on 6/30/26 at 10:12 a.m., director of nursing (DON) stated she was unaware nurses were not completing comprehensive, descriptive assessments of new non-pressure skin conditions. DON stated she thought the incident form they used covered everything. DON stated without comprehensive assessment of the skin conditions,			F0684	Continued from page 10 replaced on both New Wing and Old Wing. The new information that is included in this is as follows and must be completed to have a comprehensive assessment: Location, Color, Shape, Measurement IF INJURY IS OF UNKNOWN SOURCE IT MUST BE REPORTED TO DON IMMEDIATELY TO DETERMINE IF REPORTABLE TO MDH Order placed into TAR (NURSING ORDER) by nurse finding skin impairment: Order to read – measure bruise weekly to (specific location) until healed. Check box located as a reminder to place order into TAR. Please review the attached policy and procedure. There is also an attached copy of the incident report. Please see DON or ADON for any questions.		08/11/2026

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F0684 SS = D	Continued from page 11 other nurses would not be able to compare when monitoring for worsening of the skin condition and this could lead to something being missed for the resident. DON stated she expected comprehensive skin assessments with more detailed descriptions of bruises. Facility Skin Integrity Management Program provided 6/30/26, indicated the following: For new bruises, measure and document a skin progress note in PCC. Enter an order to measure bruises weekly until resolved into the treatment administration record (TAR) in PCC. Notify the family and provider within 24 hours. Complete an incident report and place in filing location at each nurse's station. For pre-existing bruises, measure bruise weekly and document a skin progress note in PCC until resolved. Notify provider if bruise worsens.			F0684			08/11/2026
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review the facility failed to ensure interventions developed following resident falls were implemented through a system that was available to staff to prevent further falls for 3 of 3 residents (R2, R3, R10) reviewed for accidents. Findings include: R10's quarterly Minimum Data Set (MDS) Assessment dated 4/29/26, indicated R10 had no cognitive impairment, utilized a walker, independent with walking, diagnoses included Non-Alzheimer's Dementia, repeated falls, chronic pain, had falls since admission or the prior assessment, one fall with no injury and one fall with injury (except major). R10's care plan dated 4/29/26, indicated R10 was at risk for falls r/t (related to) poor balance and history			F0689	Residents R10, R2 and R3 have had their care plans updated and modified to reflect new care plan layout for falls. New care plan lay out as followed: Problem Goal Intervention Fall Date- specific intervention Fall Date- specific intervention DON will copy over all falls and interventions listed hand written binder log to the electronic care plan in the layout as listed above for fall interventions, including the fall date and specific intervention. All current residents that have sustained falls in the facility will have their care plans updated on 7/31/26 according to the layout listed above. Falls policy and procedure updated to reflect the updated policy with the new fall intervention layout. The DON and ADON will verify for any new falls that this layout is implemented for all nursing staff to see. The ADON will observe at quarterly care conferences that the fall section of the care plan is completed and updated for any resident that has sustained a fall. F689 Weekly IDT minutes have been updated to reflect new format, with falls elevated to one of the top focuses.		08/11/2026

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F0689 SS = D	Continued from page 12 of falls and interventions included: anticipate and meet R10's needs, call light within reach and encourage her to use it for assistance as needed and follow facility fall protocol. R10's Accident Report documents which included interdisciplinary team review/investigation decision indicated: Review of R10's Accident Reports, including the interdisciplinary team (IDT) investigation and recommendations, identified the following falls and interventions: 12/5/25: Unwitnessed fall after bending to pick up a box of crackers. Intervention: remind R10 to have staff retrieve items from the floor. 2/14/26: Fell after attempting to sit on a walker without a seat. Intervention: use a chair when playing cards and move the walker aside before sitting. 3/11/26: Found sitting on the floor beside the bed. Intervention: call staff for assistance with transfers and incontinent care. 3/24/26: Found on the floor beside the bed with right hip and shoulder pain and transferred to the emergency department. Intervention: evaluate the need for a wider bed (determined not needed) and install a grab bar on the right side of the bed. 4/30/26: Fell while bending to pick up cigarette butts outside without her walker, resulting in a skin tear and superficial abrasions. Interventions: develop a smoking contract or revoke smoking privileges and have staff move her chair after smoking if desired. 6/8/26: Lost balance during dinner, fell backward, and struck the back of her head on another resident's chair before falling to the floor. Intervention: encourage R10 to slow down, stop and sit if feeling lightheaded, and provide smoking cessation education. Review of the interventions on 2/14/26, 3/24/26, 4/30/26, and 6/8/26, were not present on the care plan. On 6/29/26 at 10:33 a.m., R10 stated she had fallen approximately three weeks earlier after walking without her walker because she lost her balance. R10 stated staff reminded her to use her walker following the fall. On 6/29/26 at 2:41 p.m., licensed practical nurse			F0689	Continued from page 12 Updated Weekly IDT Minutes Agenda layout Written education given to all nursing staff via OnShift with the following message: Nursing Staff: All resident fall interventions are listed in their care plan under the FALLS section. Please see me if you are having difficulty finding this. IDT Notes will have a new format in each wing's binder noting falls closer to the top. The paper tracking of fall interventions has been updated to all residents care plans so that it is no longer tracked on just paper. All nursing staff have access to the electronic care plan.		08/11/2026

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F0689 SS = D	Continued from page 13 (LPN)-B stated fall interventions are developed by the interdisciplinary team following falls, documented in the care plan, communicated to staff, and implemented. After review of the electronic medical record, LPN-B confirmed interventions developed following the resident's 6/8/26 fall were not added to the care plan and stated she was not aware of all interventions in place to prevent R10's falls. On 6/29/26 at 2:48 p.m., nursing assistant (NA)-A stated R10 was a known fall risk and staff relied on the care plan to identify the resident's current fall prevention interventions and prevent further falls. On 6/29/26 at 2:59 p.m., registered nurse (RN)-B, the nurse manager, stated immediate interventions are implemented following a fall and later reviewed by the interdisciplinary team. RN-B stated IDT-developed interventions are expected to be incorporated into the care plan so staff were aware of and able to implement measures to prevent further falls. RN-B stated if fall interventions were not added to the care plan, staff may not be aware of interventions intended to prevent R10's falls. RN-B further stated she was not aware of all specific interventions in place following R10's falls. On 6/29/26 at 3:09 p.m., the director of nursing (DON) reviewed the post-fall investigations for R10's falls occurring on 2/14/26, 3/11/26, 3/24/26, 4/30/26, and 6/8/26 and confirmed the interventions developed following those falls had not been incorporated into the resident's comprehensive care plan. The DON stated the interventions remained on paper fall investigation forms maintained in the DON's office and acknowledged staff would not have a readily available method to identify the resident's current fall interventions to further prevent falls. On 6/29/26 at 5:03 p.m., LPN-C stated staff rely on the resident's care plan to identify current fall prevention interventions and, if the care plan is not updated, staff would not be aware of the interventions to prevent further falls. On 6/30/26 at 7:58 a.m., nursing assistant (NA)-B stated new fall interventions were communicated during shift report but are also expected to be documented in the care plan so all staff know what interventions to implement to prevent falls. On 6/30/26 at 8:08 a.m., registered nurse (RN)-C stated resident care plans should be updated following a fall to include new interventions to prevent further falls.			F0689			08/11/2026

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F0689 SS = D	Continued from page 14 R2's significant change MDS assessment dated 4/30/26, indicated impaired cognition, no behaviors or rejection of care, use of wheelchair, one fall with no injury, one fall with minor injury, and diagnoses of non-traumatic brain dysfunction, high blood pressure, and Alzheimer's disease. R2's care plan dated 11/2/23, indicated at risk for falls related to poor balance, assistive devices for mobility, psychotropic medication use, history of falls. Ensure non-slip footwear, follow facility fall protocol, if sitting on the edge of the bed to play cards, ensure that her bed is made or have her sit in the recliner. R2's facility progress notes reviewed on 6/29/26, indicated falls on 11/17/25, 1/7/26, 3/29/26, 3/30/26, 4/14/26, 4/18/26, 5/18/26, 5/23/26, and 6/15/26. Review of R2's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/17/25: Wide bed 1/7/26: Clip call light to chest for easier access 3/29/26: Fall mat at bedside 3/30/26: Hospice referral 4/14/26: Medication change 5/18/26: Remove or flip out foot pedal if wheeling self 5/23/26: Medication change 6/15/26: Reviewed with hospice concern for adverse effect post administration of anxiety medication and discontinued medication R3's significant change MDS assessment dated 6/17/26, indicated impaired cognition, no behaviors or rejection of care, independent with ambulation with wheeled walker, one fall with injury, and diagnoses of anemia, atrial fibrillation (irregular heartbeat), high blood pressure, and hip fracture. R3's care plan dated 11/23/24, indicated moderate risk for falls related to confusion, deconditioning, gait/balance problems. Be sure call light is within reach to encourage her to use it for assistance as needed. Ensure appropriate footwear. Fall mat at			F0689			08/11/2026

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F0689 SS = D	Continued from page 15 bedside and bed at knee height. R3's facility progress notes reviewed on 6/29/26, indicated falls on 11/7/25, 5/18/26, and 5/28/26. Review of R3's Accident Report documents which included interdisciplinary team review/investigation decision indicated the following interventions: 11/7/25: decreased medication 5/18/26: Remind to wear shoes in room and let staff get large items and carry for her 5/28/26: Offer to move to room closer to nurses, discontinued medication During interview on 6/29/26 at 3:45 p.m., NA-C stated she did not know specific interventions for R2 but knew they tried to keep her out in the main area to keep an eye on her. NA-C further stated she did not know where she would find interventions, but they were usually passed down in report. NA-C stated she did not work every day, so could have missed hearing some interventions. NA-C stated she was not sure if interventions were on R2's care plan. During interview on 6/29/26 at 4:02 p.m., NA-D stated she did not have a list of interventions on the care plan for R2 or R3 and did not know if interventions were documented anywhere. NA-D stated interventions were talked about in report. On 6/30/26 at 8:15 a.m., DON stated post-fall investigations had been completed and fall interventions had been decided for the above falls for R2 and R3. DON stated the interventions were passed on by word of mouth to the nurses in report. DON stated the interventions were not a part of the comprehensive care plan and were kept on paper in a binder in her office. DON further confirmed the interventions would not be available for staff if she were not there and it would be important for staff to know fall interventions to prevent future falls. Facility Falls Policy and Procedure dated 9/23, indicated; A plan of care will be developed to include measures to aid in prevention of falls. Post fall: an accident report is filled up by the charge nurse following a fall. The charge nurse of each wing brings this report to the daily interdisciplinary team meeting. The team reviews the			F0689			08/11/2026

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F0689 SS = D	Continued from page 16 fall and determines if the current plan is adequate or other interventions should be put in place. The reports given to the DON to log for QAPI.			F0689			08/11/2026
F0880 SS = D	Reassessment and reevaluation: residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at their resident care conference. Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a			F0880	R5 and R11 were placed on enhanced barrier precaution on 6/30/26. Both R5 and R11 remained on enhanced barrier precautions until removed when seen by wound care provider on site through shared clinical decision making and ruled skin injuries as healed. R11 returned to enhanced barrier precautions on 7/30/26 as new blisters formed on right leg. R58 was removed from precautions on 7/13/26 upon completion of antibiotic treatment. R58 completed planned discharge to long term memory care on 7/29/26. All residents screened for contact and droplet precautions; no new identified. All residents reviewed with DON and wound care nurse to identify any wounds that may require EBP. Facility wound care nurse and DON will review residents with wound care weekly to determine if appropriate residents are enrolled into EBP. Review of residents with new skin impairments will be reviewed upon identification to determine if EBP is required. DON and/or ADON will audit residents on EBP to observe staff for proper use and disposal of PPE (gown and gloves) 2x / week in August and September. Ongoing audits by DON and/or ADON will be completed as followed: October and November = 1x/week, December= 2x/month, then, as needed. Residents who admit to the facility and require contact or droplet precautions will follow the same auditing procedures. Staff who are audited and not found in compliance with proper use of PPE will be provided with on the spot re-education on use of PPE. Auditing may occur in direct observation or by means of camera footage review. This deficiency was corrected on 7/30/26. Written education provided to all nursing staff on 8/7/26 via OnShift message systems. The following		08/11/2026

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F0880 SS = D	Continued from page 17 resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review the facility failed to implement appropriate infection prevention and control practices by ensuring Enhanced Barrier Precautions (EBP), including gown and glove use during wound care, were implemented for 2 of 2 residents (R5 and R11) reviewed for skin conditions and by ensuring transmission-based contact precautions, including gown and glove use during direct personal care, were implemented for 1 of 1 resident (R58) reviewed for infection prevention. Findings include: R5's face sheet printed 6/30/26, indicated diagnoses of blister of left and right lower leg. R5's quarterly Minimum Data Set (MDS) assessment dated 6/25/26, indicated intact cognition, no			F0880	Continued from page 17 education was provided in writing: Nursing Staff: Enhanced Barrier Precautions are required to be followed when caring for residents under them. You will find an ORANGE SIGN outside the room and a 3 drawer cart with supplies. You MUST wear a GOWN and GLOVES when completing the following: dressing, bathing, transferring, changing linens, providing hygiene, toileting device use or wound care		08/11/2026

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F0880 SS = D	Continued from page 18 rejection of care, use of wheelchair, dependent for dressing and hygiene, and application of ointments/medications and nonsurgical dressings. R5's care plan dated 9/28/23, indicated potential for pressure ulcer development, goal of skin remaining intact through review dates, and interventions of administering treatments as ordered and checking skin when assisting with toileting and dressing daily and also weekly in the bath. R5's physician's order dated 6/6/26, indicated left lower extremity (LLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Right lower extremity (RLE) wound care: Cleanse leg, foot, toes, and between toes with normal saline or wound cleanser. Pat dry and dry well between toes. Moisturize intact skin, avoiding wounds and between toes. Apply skin prep to periwound skin and allow to dry. Apply a single layer cut-to-fit piece of foam over blisters. Cover with small pad, secure with wrap and tape from base of toes to just below the knee. R5's provider visit note dated 6/19/26 indicated RLE blister measuring 0.4 centimeters by 1.1 centimeters. Prep: cleansed with saline. Noted serosanguineous (thin fluid that is a mixture of water and blood) drainage. Surrounding skin noted to have tenderness. Patient tolerated procedure well. Moisturized and applied foam dressing. R5's progress note dated 6/29/26, indicated R5 had a hospice bath this shift. Wound continue to right lower extremity. Review of R5's treatment administration record (TAR) indicated licensed practical nurse (LPN)-A completed R5's RLE wound treatment on 6/29/26 and 6/30/26. During observation on 6/29/26 at 1:34 p.m., no enhanced barrier precaution (EBP) signs were noted on R5's room door. No personal protective equipment (PPE) for EBP was observed at his room entrance. During interview on 6/0/26 at 1:13 p.m., LPN-A state she completed R5's wound care for his RLE wound. LPN-A stated she did wear gloves but did not wear a gown. LPN-A stated she was not aware she needed to wear EBP PPE while taking care of R5's wound and he had not been placed on EBP as far as she knew.			F0880			08/11/2026

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F0880 SS = D	Continued from page 19 During interview on 6/30/26 at 11:20 a.m., director of nursing (DON) also known as the infection preventionist, stated EBP should be used for R5 during cares and wound treatments due to his RLE wound with drainage. R11's significant change in status MDS assessment dated 6/19/26, indicated no cognitive impairment, independent with personal cares and transfers, and diagnoses included non-Alzheimer's dementia and cellulitis (bacterial infection of the skin) of left lower limb. R11's care plan dated 5/19/26, indicated impairment to skin integrity r/t (related to) cellulitis and monitor/document location, size and treatment of skin injury. R11's wound care provider note dated 6/19/26, identified two open ulcers to the left lower extremity requiring daily wound care, including cleansing, application of topical treatments, Xeroform (sterile, non-adherent medical dressing) dressing, ABD (absorbent medical dressing) pad, and Kerlix (gauze bandage) wrap. On 6/29/26 at 2:39 p.m., R11 was seated in a recliner in their room with a dressing to the left lower leg. R11 stated nursing staff performed daily dressing changes and wore gloves during wound care but did not wear gowns. R11's room identified no EBP signage or PPE cart outside or outside the room. On 6/30/26 at 10:00 a.m., RN-C performed R11's wound care, including removal of the dressing, cleansing the wound, application of prescribed treatments, and placement of a new dressing. RN-C performed hand hygiene and wore gloves throughout the dressing change; however, a gown was not worn. RN-C stated R11 would be expected to be on enhanced barrier precautions because of the wound requiring dressing changes. RN-C stated the director of nursing (DON) determined which residents were placed on EBP and was responsible for EBP signage and PPE carts. On 6/30/26 at 11:18 a.m., the DON stated residents with wounds requiring dressing changes would be expected to be on enhanced barrier precautions with gown and glove use during wound care. The DON stated she believed R11 only had a scratch and was unaware the resident had active wound care orders. The DON confirmed R11 should have been on EBP			F0880			08/11/2026

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F0880 SS = D	Continued from page 20 and stated any nurse could initiate EBP by posting signage and placing a PPE cart outside the resident's room. R58's entry MDS assessment dated 6/22/26, indicated reentry from short term hospital on 6/22/26. R58's treatment administration record (TAR) dated 6/1/26-6/30/26, indicated start date 6/22/26, contact precautions used as directed per CMS guidelines every shift for VRE in urine (Vancomycin-Resistant Enterococci- bacteria primarily spread through direct contact with contaminated hands or surfaces). R58's After Visit Summary dated 6/22/26, indicated skin care/pressure management instructions wound care: buttocks; pressure injury. R58's care plan dated revised on 6/22/26, indicated at risk of transmitting an infection, contact isolation: wear gowns and gloves when entering room. On 6/29/26 at 12:23 p.m., observation identified a PPE cart containing gowns and gloves and contact precaution signage posted outside R58's room. On 6/29/26 at 12:26 p.m. trained medication aide (TMA)-A was observed providing toileting assistance to R58 while wearing gloves but no gown. TMA-A exited the resident's bathroom without having a gown. TMA-A confirmed R11 was on contact precautions for VRE in the urine, and confirmed a gown and gloves were required during care, and stated they forgot to put on the gown. On 6/29/26 at 4:51 p.m., the DON confirmed R58 was on contact precautions for VRE in urine and stated staff should know to use gown and gloves when providing toileting assistance, due to the signage posted and the PPE cart outside of R58's room. Facility Infection Prevention and Control Manual Policy dated 2024, indicated; Enhanced Barrier Precautions: "refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident			F0880			08/11/2026

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F0880 SS = D	Continued from page 21 care activities that provide opportunities for transfer of MDROs to staff hands and clothing. EBP are indicated for residents with any of the following: •Infection or colonization with a CDC-targeted MDRO when Contact Precautions do not otherwise apply; or •Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.			F0880			08/11/2026
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and			F0883	F883 How corrective action will be accomplished for those residents found to have been affected by deficient practice R1 and R9 were reviewed by DON using PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they were eligible for. Consent obtained from each family and approved vaccine administration. Vaccine ordered from pharmacy and will be administered on 8/3/26 (or sooner, pending arrival from pharmacy). 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 deficient practice will not occur. All current residents screened by DON with PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they were eligible for. New spreadsheet built to track eligibility and need for all residents with pneumonia vaccine status. Residents that were identified as eligible, regardless of Medicare A stay status, were offered pneumonia vaccines. Four residents were identified and offered. Of the four, one deferred and three refused. How the facility will monitor its corrective action to ensure that the deficient practice is being corrected and will not reoccur. When a new resident admits to the facility, the DON will reference the PneumoRecs VaxAdvisor app to determine which pneumonia vaccines they are eligible for or if they are up to date. By the scheduled care conference (within three weeks of admission) the DON will notify the ADON of which pneumonia vaccines the resident is eligible for and seek consent and provide Vaccine Information Statement. Decision from resident and or residents		08/11/2026

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F0883 SS = D	Continued from page 22 potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on interview and document review, the facility failed to offer the recommended update for pneumococcal immunizations for 2 of 5 residents (R1, R9), reviewed for immunizations. Findings include: R1's face sheet printed on 6/30/26, included diagnoses of dementia, chronic kidney disease, congestive heart failure (when the heart does not pump as well as it should) and chronic obstructive pulmonary disease (lung condition that obstructs airflow and causes breathing difficulty). R1's admission Minimum Data Set (MDS) assessment dated 2/27/26, indicated intact cognition, clear speech, could understand and be understood. R1 was dependent upon staff for activities of daily living (ADLs). R1's physician orders did not include vaccinations. R1's vaccine history indicated pneumococcal 23-valent vaccine was received in 2011. PneumoRecs VaxAdvisor application, a product created by the CDC (Centers for Disease Control and Prevention) for healthcare providers to determine which pneumococcal vaccines were needed,			F0883	Continued from page 22 responsible party will be documented in the resident immunization tab (administered or declined). A routine audit, twice yearly by Thrifty White Pharmacy will be completed to determine eligibility for pneumonia vaccines during bi-annual clinics that Thrifty White Pharmacy hosts at Mapleton Community Home.		08/11/2026

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F0883 SS = D	Continued from page 23 recommended to give one dose of PCV15, PCV20, PCV21 at least one year after the last dose of PPSV23. During an interview on 6/30/26 at 2:30 p.m., R1 had been sleeping in bed; family member FM-A stated she could not recall if the facility had talked to them about R1 receiving additional vaccinations, but stated if one were recommended, R1 would take it. FM-A stated she knew R1 had received pneumococcal, influenza and covid vaccines, but gave up trying to keep track. R9's face sheet received on 6/30/26, included primary and secondary diagnoses of hepatic encephalopathy (brain dysfunction caused by liver disease) and nonalcoholic steatohepatitis (aggressive form of fatty liver disease). R9's admission MDS assessment dated 6/11/26, indicated moderately impaired cognition, clear speech, could understand and be understood. R9 required substantial assistance or was dependent upon staff for ADLs. R9's physician orders did not include vaccines. R9's vaccine history indicated pneumococcal 23-valent vaccine in 2017, and PCV13 in 2020. PneumoRecs VaxAdvisor recommended to give one dose of PCV20 or PCV21 at least 5 years after the last pneumococcal vaccine dose. During an interview on 6/30/26 on 3:13 p.m., R9 stated if vaccines were recommended and offered, she would take them. R9 stated no vaccines had been offered or received since admission. During an interview on 6/30/26 at 12:44 p.m., the director of nursing (DON) who was also the infection preventionist, stated R1 had been admitted on 2/13/26, for short term rehabilitation, which was Medicare part A, so the facility would not automatically update any vaccines. Then on 4/17/26, R1 moved to long term care status, and missed the vaccine clinic held on 4/20/26. The next vaccine clinic would be held at the end of July. The DON stated the facility conducted quarterly vaccine clinics in conjunction with a pharmacy. Regarding R9, the DON stated vaccines would be recommended at end of her short-term stay. The DON stated the delay in R1 and R9 being offered to update their vaccine status while in short term stay, was due to billing. During an interview on 6/30/26 at 2:34 p.m., Doctor			F0883			08/11/2026

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F0883 SS = D	Continued from page 24 of Medicine (MD)-C had been informed some residents had not been offered pneumococcal vaccine updates on admission. MD-C stated pneumococcal would be important to have on admission and had been unaware of the process the facility utilized to determine which/when vaccines were offered. During an interview on 6/30/26 at 2:39 p.m., registered nurse (RN)-B who was also a nurse manager, stated her role in resident immunizations included looking up historical vaccinations, but did not assess vaccine status to determine if a resident was eligible for additional vaccines such as pneumococcal vaccines. RN-B stated that was handled by the DON and the pharmacy. RN-B stated immunization status was reviewed by pharmacy during vaccination clinics. Looking in the electronic medical record, RN-B stated both R1 and R9 had been eligible for PCV21 if a provider ordered it. Facility Standing Orders policy, undated, included per CDC guidelines, administer pneumococcal vaccines unless contraindicated. Facility Pneumococcal Vaccine Program policy dated 2024, indicated residents would be offered immunizations against pneumococcal disease in accordance with Advisory Committee on Immunization Practices (ACIP) recommendations. Pneumococcal disease was a serious illness that could cause sickness and even death. A physician order for all pneumococcal vaccines was required. Pneumococcal vaccination guidance for pneumococcal vaccination can be determined at CDC PneumoRecs VaxAdvisor.			F0883			08/11/2026
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed			F0732	Observation of daily completion of nursing staffing hours of July, 2026 has 100% completion rate. Review of nursing staffing hours policy and redistribution to nurses emphasizing importance of completion done on June 30th, 2026. Check box reminder added to daily nursing notes/report sheet to complete census for old wing as that is where the census form is listed. An audit for observation of completion will be completed by DON and/or ADON 2x / week during August and September. Once weekly auditing to be completed in October and November. Twice monthly audit in December, then as needed beginning January 2027. During audits, if there is observed noncompletions		08/11/2026

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F0732 SS = C	Continued from page 25 nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure required and accurate nursing staffing information was posted for residents and visitors. This had the potential to affect all 47 residents residing in the facility and their visitors. Findings include:			F0732	Continued from page 25 for any shift, the DON will notify the nurse that was assigned as charge nurse on old wing and provide redirection and education. This deficiency was corrected on July 30, 2026. Observation of daily nursing staffing hours from 7-1-26 through 7-31-26 by DON have been reviewed and all shifts have completed their daily staffing hours to include the resident census for each shift and the staff assigned for each shift (RN, LPN, TMA, CNA) Written education was provided to all nurses again on August 7, 2026 with the below listed information. Please review the attached policy and procedure for the nursing staffing hours posted at Old Wing. It is the responsibility of the nurse on Old Wing each shift (Day, Eve, and NOC) to complete these hours listed on the form. I will be auditing this form as we need 100 % accuracy and will notify you if your shift was missed. If continued lack of completion is found it will be reflected upon your performance review. This email included the policy and procedure for the nursing staffing hours.		08/11/2026

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F0732 SS = C	Continued from page 26 During an observation on 6/29/26 at 2:17 p.m., observed the daily nursing staffing posting for 6/29/26, in an acrylic holder on the countertop at the nurses station inside the main entrance. The posting included all of the required information, including the number of staff on duty: RN (registered nurse), LPN (licensed practical nurse), TMA (trained medication aide), and CNA (certified nursing assistant). Postings for April through June were requested for review. For April, from 4/1/26 through 4/30/26, 16 shifts had been left blank (all night shifts). Further, a registered nurse had not been identified as having been scheduled/working five of the dates: 4/1/26, 4/10/26, 4/15/26, 4/24/26, and 4/29/26. For May, from 5/1/26 through 5/31/26, 12 shifts had been left blank (16 night shifts and one evening shift). Further, on 5/27/26, one shift identified an RN in training, but no other RN had been identified. For June, from 6/1/26 through 6/28/26, 16 shifts had been left blank (12 night shifts, three evening shifts and one day shift). Further, a registered nurse had not been identified as having been scheduled/working on four of the dates: 6/6/26, 6/7/26, 6/10/26, and 6/24/26. During an interview on 6/29/26, at 3:37 p.m., the director of nursing (DON) stated it was the responsibility of charge nurses to complete the staffing posting sheet at the start of their shift. The DON stated a minimum of one registered nurse was scheduled for eight consecutive hours every day. In addition, a nurse leader was scheduled to work the day shift, Monday through Friday, either the DON, assistant DON or nurse manager. According to the DON, the shifts where an RN had not been identified as scheduled/working, were primarily shifts worked by agency nurses who likely did not know they needed to complete the form. In addition, for nine of the 10 dates, an RN nurse leader had worked 8 consecutive hours too, except for Saturday 6/6/26, when the RN was an agency nurse. The agency nurses time card had been reviewed for verification. The DON stated she did not monitor the process to ensure nurses completed the form each shift/each day. During an interview on 6/29/26 at 6:08 p.m., registered nurse (RN)-A who was the charge nurse stated she had never filled out a staffing posting for			F0732			08/11/2026

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F0732 SS = C	Continued from page 27 a shift she worked, adding it was usually already filled out. During an interview on 6/30/26 at 8:39 a.m., licensed practical nurse (LPN-A) stated the charge nurse completed the daily staffing posting for that shift. LPN-A stated she looked at the online electronic scheduling system to determine who was scheduled to work, added it to the sheet and made changes to it if someone called in (not able to work). LPN-A stated there was at least one RN scheduled to work every day. Facility Posting Nursing Staffing Hours policy, undated, indicated early in the shift, the charge nurse would obtain a staffing hours form from the bottom file drawer located in the nurses station. The form would be completed with date, census, the type of nursing staff scheduled to work, and their scheduled hours. This would be done by the charge nurse on each shift.			F0732			08/11/2026