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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2QJM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

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

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/01/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Kathy Hahn, HFE NE II 06/12/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske, Enforcement Specialist 06/12/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245362
June 12, 2018

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

Dear Ms. Gosson:

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

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

Effective May 25, 2018 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
June 12, 2018

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

RE: Project Number S5362026

Dear Ms. Gosson:

On May 9, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 14, 2018. (42 CFR 488.422)

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective July 9, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on April 20, 2018. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On June 1, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 8, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 20, 2018, as of May 25, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 25, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of May 9, 2018:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions be rescinded as of May 25, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies, and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2QJM

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Facility ID: 00037

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(L5) **MAPLETON, MN** (L6) **56065**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/20/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
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11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date:
Connie Brady, HFE NE II 05/30/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/31/2018 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 9, 2018

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

RE: Project Number S5362026

Dear Ms. Gosson:

On April 20, 2018, a standard 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Appeal Rights - the facility rights to appeal imposed remedies;

Potential Consequences - the consequences of not attaining substantial compliance 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Holly Kranz, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: holly.kranz@state.mn.us
Phone: (507) 344-2742
Fax: (507) 344-2723

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective May 14, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective July 9, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 9, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 9, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Mapleton Community Home is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective July 9, 2018. This prohibition is not subject to appeal.
Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved

and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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 July 9, 2018 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 20, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING _____ B. WING _____	04/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey with CMS Appendix Z Emergency Preparedness Requirements, was conducted on April 16-20, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On April 16, 17, 18, 19 and 20, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=G	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	F 689		5/17/18

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

Electronically Signed | 05/18/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING _____ B. WING _____	04/20/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 1 by: Based on observation, interview and document review, the facility failed to comprehensively re-evaluate and supervise residents who experienced reoccurring falls for 3 of 7 residents (R40, R50 & R15), reviewed for accidents. R40 sustained actual harm, a right femur fracture as the result of a fall on 4/3/18. Findings include: The most current diagnosis list for R40, obtained from the electronic medical record (EMR) included: Anemia, hypertension, chronic kidney disease stage III, chronic obstructive pulmonary disease with dependence on supplemental oxygen, and fractures to the right hip/femur. R40's Brief Interview for Mental Status (BIMS, a cognitive assessment), indicated flucating cognition. On 12/11/17, R40's BIMS score was identified as 11/15 (moderate impairment). A BIMS score was identified as 15/15 on 3/6/18 (fully intact cognition). The most recent quarterly Minnimum Data Set (MDS) assessment dated 3/30/18, indicated a BIMS score of 9/15 (moderate cognitive impairment). According to a comprehensive Care Area Assessment (CAA), completed 1/2/18, R40 was identified as at risk for falls, requiring interventions. R40's care plan identified a focus area including: R40 had an actual fall with serious injury, poor balance, unsteady gait. The goal was identified to include: will resolve without complication by review date. Interventions for falls included: 1.) Encourage/remind R40 to call for assistance	F 689	MDH Corrections 2018 F689 Corrective action for R40 is as follows: Prior to survey referred to a facility with a smaller setting in which staff could observe her impulsive behavior. Resident transferred on May 2, 2018. Corrective action for R50 is as follows: Staff member O-F(UA) is no longer employed at Mapleton Community Home. (TMA)-A was educated on answering residents when they call out for help and assisting if able or calling on her walkie-talkie for staff to provide assistance and remaining with resident until another staff member is able to assist. Review of call lights for April 18, 2018 shows that R50 did not have his call light on during the time of question and did not turn his call light on until 11:30 on April 18, 2018. Corrective action for R15 is as follows: Room rearranged and oxygen concentrator filler stored in a different location to reduce noise and clutter in room. Mapleton Community Home continues to work with Mayo Hospice to provide cares for R15 and we continue to discuss falls and fall interventions with hospice team and hospice team also reviews falls of R15 at their meetings. In order to ensure that deficient practice does not occur on admission/readmission, residents will be screened for fall history on the safety risk assessment form. If a fall has occurred in the past three months the new resident will have hourly visual checks initiated for seven days in order for staff to observe resident actions, routine	

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F 689	Continued From page 2 before she transfers. 2.) Keep call light within reach. 3.) Sign placed to remind to call for assistance before getting up; 4.) Physical therapy (PT) consult for strength and mobility. Additional care plan focus areas included: Activities of Daily Living (ADL) self care performance deficit related to (r/t) confusion, does not remember to use wheelchair brakes; short of breath and becomes entangled in the tubing when transferring self with the oxygen on; Often forgets to call for assistance with transfers. Interventions included: 1.) Physical Therapy(PT)/Occupational Therapy (OT) evaluation and treatment as per MD (medical doctor) orders; 2.) Encourage to use the call light for assistance with all transfers; 3.) EZ stand lift (mechanical lift device) and 2 staff assist with transfers. Review of R40's incident reports and progress notes since December 2017, indicated R40 had a history of frequent falls, including a fracture of her right hip (femur) fracture 12/12/17 with surgical intervention, and a subsequent inoperable fracture of the right femur 4/3/18. The facility failed to comprehensively assess the falls in order to identify predisposing/causative factors so individualized preventative interventions could be developed. Falls included: 12/11/17, 3:30 p.m. R40 was in the bathroom and fell to the floor and was lying on her right side. Abrasions/skin tears to right (Rt) arm, and Rt lower extremity, c/o of rt hip pain. The nursing progress note from 12/11/17 included: "Resident in the bathroom changing her jeans; slippers off, jeans off and pushed the door open and fell. Skin tears down the right arm, a bruise on her right	F 689	and anticipate the needs of the resident. If a fall occurs after admission interdisciplinary team will review the admission fall risk assessment form and determined if a specialized risk test would need to be completed such as a pain assessment, mood assessment, Tinetti or individualized interventions will be initiated per nurse discretion at the time of the fall and/or at interdisciplinary team review. We will monitor our performance weekly at our fall meetings and continue to review our falls at our QAA/QAPI quarterly meetings. Fall policy and procedure is being updated by DON and was completed by May 16, 2018. Updates are being made to the worksheet that the nurse completes when a fall occurs and was completed by falls committee by May 16, 2018. A committee is being formed on May 17, 2018 to focus on falls, fall prevention, fall interventions and communication between staff to keep all staff aware of the interventions put into place. All staff are being trained in a mandatory meeting on May 17, 2018 on our new falls policy and procedure. This team will meet weekly for an hour until goals are met and will then meet bi-monthly to ensure that goals are being followed through. Mapleton Community Home has applied for a PIPP project to work on fall prevention. QAA/QAPI team was updated on new policy and procedure and new fall prevention program on May 17, 2018. A laptop will be brought to the daily IDT meeting and DON or ADON will record focused notes on any falls that occur and	

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F 689	Continued From page 3 forearm and write wrist skin tear with a bruise. Range of motion to all extremities with moderate to severe pain in righ thip. A the same time, [physician] called in regards to her recent left back and left abdomen pain. orders received to send to [local hospital] for eval (evaluation) and treat (treatment) of both issues." A follow up nursing progress note indicated, "Called [local hospital] at 2040 (8:40 p.m.) for update on resident. Resident had a CT (computed X-ray Tomography) scan from head to toe and impression was normall. All blood work was fine. Resident was up walking, felt dizzy then retried and felt fine. She will be returning to the facility via ambulance." Incident Report follow up included: Measures/Interventions to Prevent Further Accidents: Continue current plan of care. 12/12/17, 2:50 p.m. R40 found lying on the floor of her room. Resident was complaining of right hip pain rated at 10/10 (10 being most severe pain). R40 was transferred to the emergency room (ER) where X-ray revealed a right hip fracture and the need for surgical repair. The corresponding nursing progress note from 12/12/17 at 3:22 p.m. included: "Notified taht resident had self transferred and was hoyered from floor. Resident c/o (complained) tailbone, butt and right hip and leg hurting. Resident has hand holding her lower back and abdomen while laying in bed. C/o pain 10/10. Rec'd (received) orders to send to [local emergency room] for eval/treatment via ambulance." An additional progress note indicated the local hospital had been contacted for an update, and staff were informed the reisdent had a right hip fracture with surgery requqired. Subsequent notes indicated R40 returned to the facility on 12/19/17, and care plan interventions were updated to include	F 689	immediately put the interventions into the careplan. If the intervention is something to be monitored staff will be given the informational tools and explanation of why the monitoring is taking place. IDT will review the interventions for effectiveness within timeframe stated at initial IDT meeting. This began May 15, 2018. Falls IDT will meet weekly to review interventions put in place from falls that occurred that week and if interventions are working. Quarterly care conference IDT will review with family interventions from fall prevention. Falls Policy and Procedure Policy: It is the desire of Mapleton Community Home to keep residents free from falls. Procedure: 1. If a resident has just fallen or is found on the floor without a witness to the event the person finding the resident will immediately notify nursing staff. 2. Nursing staff will remain with resident while the LPN or RN working with that resident is notified of the event and arrives at the scene. 3. The nurse will record vital signs and assess for further injuries of the head, neck, spine and extremities. a. If there is evidence of significant injury such as fracture or bleeding or any signs of abuse or neglect nursing staff will provide appropriate first aid to the resident. i. A physician will be notified and determine if transition to the emergency	

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F 689	Continued From page 4 reminding R40 to use her call light and to ask for assistance. No additional monitoring and/or interventions were indicated. 1/2/18, 6:30 p.m. R40 was heard yelling for help and found sitting on the floor in front of her recliner. The resident indicated she was self transferring and didn't know what had happened. The call light was in reach, but had not been activated. No injury was noted. An interdisciplinary (IDT) meeting was held on 1/3/18, with an intervention identified to "increase frequency of visual checks to every hour." However, there was no documentation initiated to confirm the hourly visual checks were conducted. 1/7/18, 5:20 a.m. A nursing progress note indicated R40 was seated on the floor and indicated she was going to her closet for clothes, and slid out of her wheelchair. R40 had further stated she had decided to attempt to get to the door after she realized she could not get back up. The incident report indicated an IDT meeting was conducted 1/8/18, and indicated the team had spoken with the resident to remind her about asking for assistance before walking out of room. In addition, the IDT recommended a new intervention to conduct every 15 minute visual checks. Documentation was provided of visual checks from 1/8/18 at 2:00 p.m. until 1/10/18, at 2:15 p.m. The resident's record indicated the resident was hospitalized for an elevated Troponin (a cardiac enzympe which could indicate a cardiac issue) level and influenza B on 1/10/18. Upon return to the facility on 1/14/18, the frequent visual checks were no longer in place, and no additional monitoring for falls was instituted. In addition, no	F 689	room is appropriate. ii. Family will be notified of fall, suspected injury and physician recommendation at this time. iii. Administrator will be notified immediately. b. Once an assessment rules out significant injury nursing staff will assist resident from place of fall(floor) with the mechanical lift(hoyer) and two staff. i. Nursing staff will notify residents physician in an appropriate time frame by fax the next business day. ii. Nursing staff will notify residents family in an appropriate time frame. 1. If the fall with no injury occurs during the night the night nurse will inform the day nurse to call the family to update them. 4. 24-hour vital signs will be initiated and a neuro assessment will be completed if there is a head injury or an unwitnessed fall. a. Documentation will be completed by the nurse and will include any signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility and any changes in level of consciousness/responsivenss and overall function. It will note the presence or absence of significant findings. 5. An accident report sheet will be filled out by the nurse working with the resident immediately after the residents needs have been met. a. The nurse will institute an appropriate and immediate intervention to be placed on the resident to reduce the risk of another fall by:	

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F 689	Continued From page 5 fall assessment was completed after the hospitalization. 2/2/18, 5:15 p.m. R40 was observed sitting on the floor next to her recliner and stated, "she was just getting up and her legs didn't hold". The nursing progress note indicated the residetn was complaining of pain in her right hip rated as 5/10 (10 greatest pain). The notes indicated R40 was transfered from the floor to a recliner by a hoyer lift. A call was placed to the on-call physician who ordered a transfer to the local hospital for evaluation. The progress notes indicated the resident was returned to teh facility that same evening, and that no fracture or injury was identified in the emergency room. A post fall IDT meeting 2/5/18 indicated Measures/Interventions to prevent Further Accidents: Continue current plan of care. A nursing progress note, dated 2/5/18 indicated R40's niece called expressing concerns about repeated falls, and a sign was placed in R40's room to remind R40 to ask for help before trying to transfer herself. 2/12/18, at 10:10 p.m. staff heard a loud noise, after which R40 was heard yelling and was found sitting on her bottom on the floor in front of her recliner. R40 stated she wsa trying to get a Kleenex from her nightstand. Documentation on the report with rspect to contributing factors for the fall indicated: Unaware of safety, transfers self and does not use call light, she was given a touch pad call light (one that is more easily activated). A subsequent IDT meeting was held on 2/13/18, team discussion notes indicated: impulsive, forgetful about recent fracture and repair, PT/OT completed. Interventions: Continue frequent visual checks-offer assistance if looking restless.	F 689	i. interviewing the staff working with the resident at the time of occurrence. ii. gathering information to determine the residents current condition, condition prior to fall and general demeanor after the fall. iii. make notes of the condition of the area that the fall occurred and the residents attire including footwear at the time of the incident. b. The interdisciplinary team will discuss and review on the next business day. 6. A complete interdisciplinary team that includes staff from departments including nursing, administration, dietary, social services, medical records, therapeutic recreation, MDS and therapy will meet every business morning to discuss significant issues with the residents. a. Director of Nursing or Assistant Director of Nursing will bring a laptop to each meeting. b. This team will review any falls that occurred in the last 24 hours or falls that occurred during weekends and holidays. c. Team will review the fall, the immediate intervention to determine its appropriateness and further interventions along with medical conditions, environmental factors or change of status that may have contributed to the fall. Some examples include: i. Time of day of the fall ii. Time of last meal iii. What the resident was doing iv. What the resident was trying to do at the time of the fall v. Was the resident alone or among other people vi. Was the resident attempting to get to	

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F 689	Continued From page 6 2/16/18, at 8:15 p.m. R40 was heard yelling, "help, I fell," and was found lying on her back on the floor. The call light had not been activated. R40 was not able to recall what she was doing that resulted in the fall and was not able to recall if she had hit her head. The subsequent IDT meeting, held on 2/19/18 team discussion notes indicated: cares being met; impulsive. Measures/Interventions put into place included: hourly checks. Documentation in R40's medical record indicated hourly visual checks were completed from 2/16/18 at 11:15 p.m. - 2/20/18, at 8:20 a.m., then discontinued. 3/1/18, at 8:45 p.m. R40 was heard yelling, "help me," and was found sitting on the floor but did not know what she needed or why she had fallen. Immediate actions indicated to prevent falls on the accident report indicated: ever hour safety checks started. Review of R40's medical record indicated the hourly checks were documented as starting 3/1/18, at 9:00 p.m. - 3/3/18, at 7:00 p.m., then discontinued. An IDT meeting related to this fall dated 3/2/18 indicated under team discussion notes: history of falls, working with PT/OT; forgetful. Interventions to prevent further accidents included: Continue current plan of care. 3/9/18, at 10:30 a.m. R40 was witnessed attempting to stand from recliner. R40 stated her oxygen tubing caught on the foot rest and she fell to a sitting position on the floor. R40's call light had not been activated and R40 was unaware of why she had stood or where she was attempting to go. The subsequent IDT meeting on 3/12/18 indicated measures/interventions to prevent falls indicated: Continue current plan of care.	F 689	the toilet vii. Was an environmental risk factor involved viii. Is there a pattern of falls for the resident ix. Medication changes x. Staff to resident ratio xi. Call light reports d. Staff will collect all data through date determined at initial interdisciplinary meeting and review in a separate fall meeting weekly. i. ADON will consult with the primary care physician or attendee to determine if contributing factors to the fall were medically related and if any further testing must be conducted ii. if resident continues to fall after interventions in place and all other areas have been exhausted social worker will consult with family for input and preference on if they wish to transfer resident to another care facility. Mapleton Community Home Accident Report Date_____ Time_____ Resident Name/Cs#_____ Location_____ _____ Witnessed by_____ Nurse reporting Accident_____	

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F 689	Continued From page 7 3/13/18, at 8:00 p.m. R40 was witnessed by a nurse (unidentified) standing up from recliner and attempting to transfer to her wheelchair, her breaks on the wheelchair were not locked resulting in the chair rolling away from R40, and fell to the floor. A subsequent IDT meeting held on 3/14/18 indicated interventions to prevent further accidents included: Moving to room closer to desk and anti-rollback breaks on w/c. 4/3/18, at 3:50 p.m. R40 was heard yelling, "help me," and was found sitting on the floor. R40's call light was indicating second request (indicating it was the second time the light had been activated for assistance) when NA (unknown) entered the room. R40 was not sure why she had stood up or where she was attempting to go. R40 was complaining of right arm and elbow pain in addition to right hip pain rated at 10/10. A nursing progress note, dated 4/3/18 indicated R40 was transported to ER for evaluation at 6:51 p.m., and on 4/6/18, nursing progress notes indicated she returned to the facility at 3:32 p.m. The note further indicated, "Resident is to be toe touch weight bearing as fracture could not be fixed; non-displaced fracture of the right acetabular fracture." Documentation of an IDT meeting on 4/4/18 indicated: call light on-assistance provided between first and second request. Interventions to prevent further accidents included: Continue to toilet frequently and work with therapy. Visually monitor resident for restlessness. 4/7/18, at 2:05 p.m. R40 heard yelling and was found lying on her left hip on the floor. R40 stated she was trying to reach for her tranfer belt which was on her bed and way out of reach. R40's call	F 689	CNA Assigned to resident_____ Last time toileted_____ Details of the Event: Describe exactly what happened. Include description of surroundings and resident attire including footwear. _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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light had not been activated. New bruising was noted on the underside of her left wrist. Documentation of an IDT meeting held on 4/9/18 indicated: frequent fall history; recent hospital stay, was recently viewed in chair by nurse. Interventions to prevent further accidents included: Discuss with family potential referral to a memory care unit, and the possibility of use of a recliner in the hallway instead of in R40's room to keep less secluded.

During observation on 4/16/18, at 3:14 p.m., R40 was seated in her recliner with the foot rest elevated and was c/o feeling tired. R40 was located beside the window and the privacy curtain was pulled between her bed and the resident in the bed closest to the door. Therefore R40 was not visible from the hallway.

During observation on 4/17/18, at 8:39 a.m. R40 was observed seated in her wheelchair being transported from the dining room to her room, where two staff utilized an EZ stand lift to transfer R40 from her w/c into the recliner located in her room. At 10:15 a.m., R40 remained in her recliner, wrapped in a blanket sleeping.

During an observation 4/17/18, at 12:30 p.m. R40 was in her room and was speaking with a visitor. The visitor was overheard telling R40 she had to wait and have help with transfers. The privacy curtain between R40, on the window side of the room, and her roommate was pulled so that only R40's lower legs were visible from the door.

On 4/18/18 at 11:30 a.m., R40 was transferred from the recliner to w/c with the assist of two and the EZ stand lift and transported to the dining room for the noon meal.

Were Interventions in place?

Detailed Description of any Injury:

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F 689	Continued From page 9 During observation on 4/19/18 at 7:30 a.m., R40 was sleeping in her recliner in her room, with both feet resting on the floor. At 8:30 a.m. two staff transferred R40 from the recliner to her wheelchair and transported her to the dining room for breakfast. At 9:00 a.m., R40 was back in her room seated in the recliner sleeping. During observation from 9:00 a.m. - 10:15 a.m., R40 remained in her recliner in the room with feet elevated and the room curtain partially pulled. R40's feet were visible from the door of the room however, the privacy curtain blocked any view of the resident's chair from the hall. During interview on 4/18/18 at 1:32 p.m., the director of nursing (DON) verified the only Safety Risk Assessment (facility assessment used to determine falls risk and appropriate strategies to manage falls) completed for R40 was dated 1/2/17. The DON verified this assessment was only completed at the time of initial admission to the facility. At the time of R40's original admission when the 1/2/17 assessment was completed, R40 did not have a history of falls. During an interview on 4/18/18 at 3:02 p.m., registered nurse (RN)-A and RN-B stated R40 was transferred with the use of an EZ stand and her call light was kept within reach. However, they said R40 frequently called out for assistance rather than using the call light. Both RN-A and RN-B stated staff frequently walked by R40's room, but there was no specific time frequency for safety checks. They also verified R40 was able to be heard from the nursing station when she called out and staff looked in on her when they were passing by in the hall. RN-A indicated R40 would yell "help, help" and not know what	F 689	IMMEDIATE ACTION and INTERVENTION TAKEN: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ Vitals: Temp_____Pulse_____Resp _____ BP_____ O2_____ Neuros: Yes_____ No_____ NA_____ C/O Pain Yes_____ No_____ Location_____	

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she wanted, or even realize she had been yelling out. RN-A stated R40 had been transferred to her current room on 3/15/18, and confirmed R40 had become increasingly confused since the move. RN-A indicated that since R40 had fallen and obtained the most recent fracture on 4/3/18, R40 had not been observed attempting to self transfer.

NA-A was interviewed on 4/18/18 at 3:34 p.m., and indicated R40 required use of an EZ stand lift for transfers and required staff assist with transportation from one location to another. NA-A stated R40 would call out at times and other times would use her call light. NA-A indicated R40 was on an every two-hour toileting schedule, but there was no specified time period for visual checks, and the time varied depending on what was happening with other residents. NA-A further confirmed she was unaware of any process to document visual checks when they were completed.

During an interview on 4/19/18, at 7:33 a.m. NA-B also stated she was unaware of any scheduled frequency for visual checks of R40, only that staff checked in as they walked by her room. NA-B stated sometimes R40 would yell out for help. NA-B said when staff responded, R40 didn't know what she was yelling for or if she needed assistance. NA-B indicated that since R40 had fallen on 4/3/18, she no longer attempted to self transfer.

During a follow up interview on 4/19/18 at 10:05 a.m., RN-A verifed if there was a program for safety checks, there should be a form with documentation of when the checks were completed. RN-A also she was not aware of any

__
If yes 1-10 pain scale_____
Accucheck (if applicable)_____

THIS AREA MAY NOT BE LEFT BLANK
Nurse/CNA input: List any behavior, medical conditions and environmental factors that may have been occurring at this time.

_____
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Physician Notified:
Family Notified:

Name_____
Name_____
_____

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F 689	Continued From page 11	F 689		

ongoing monitoring or if/when routine checks, either 15 minute or hourly, were implemented. RN-A stated the safety checks would have been short term, and she was unaware of any specific time frame used when monitoring occurred.

During interview on 4/19/18, at 10:16 a.m. both the director of nursing (DON) and assistant director of nursing (ADON) confirmed no specific monitoring was in place for R40 because she was already in a room close to the desk and staff frequently went by her room.

The certified occupational therapy assistant (COTA)-A was interviewed on 4/19/18, at 1:51 p.m. and confirmed R40 had experienced multiple falls due to self transfer attempts. COTA-A further indicated R40 didn't use her call light-"at all," and would call out for help. COTA-A indicated R40 had been moved closer to the nursing station, which helped.

During an interview on 4/19/18 at 2:01 p.m., NA-B and NA-C stated they felt R40 was confused most of the time. They also stated they would give R40 her call light, but frequently had to explain how to use it. They said she didn't use the call light most of the time. The NAs stated if a staff person was in the hall, R40 was able to be heard, but if they were in assisting another resident's room, R40 could not be heard.

The director of health information was interviewed on 4/19/18, at 2:30 p.m.. She stated the facility's Safety Committee Meetings were held monthly, but falls were addressed at the Quality Assurance (QA) meetings and those were held quarterly.

The assistant director of nursing (ADON) was

Date/Time_____
Date/Time_____
_____

ks

Interdisciplinary Team
Review/Investigation Decision

Team Discussion Notes: (discuss interventions, note more interviews or further investigation if needed,
note possible causes, potential abuse, risk factors, medications and referrals)

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F 689	Continued From page 12 interviewed on 4/19/18, at 2:38 p.m., and stated a daily report meeting in addition to the Interdisciplinary Team meeting was held Monday - Friday with each wing's nurse bringing incident reports for discussion. The ADON stated a log of incidents was completed for each wing and brought to the QA meetings. During a group interview on 4/20/18, at 9:47 a.m. including the administrator, DON, ADON, and MDS coordinator, the staff present confirmed IDT meetings were the facility's primary method of discussing interventions to prevent falls and incidents, and confirmed the IDT meeting notes would be reflective of any documented analysis and investigation of R40's incidents. R50 R50's diagnoses, according to the diagnosis list dated 12/19/17 included: vascular dementia with behavioral disturbance, other Alzheimer's disease, anxiety disorder, and Major Depressive Disorder. R50's admission Minimum Data Set (MDS) dated 12/27/17, identified R50's cognition as moderately impaired. R50 required extensive assistance for mobility, toileting, transfers, and most activities of daily living (ADLs) and identified as occasionally incontinent of urine with no toileting program. R50 was identified as having fallen within one month prior to admission and 2 or more falls since admission, one with injury (except major), and no falls with major injury since admission. R50's balance was unsteady and required assistance for stability.	F 689	Team Rationales: Decision to Notify OHFC Yes_____ No_____ Rationale Summary_____ _____ _____ _____ _____ _____ _____ _____ _____ Measures/Interventions to Prevent Further Accidents: _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____ _____	

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F 689	Continued From page 13 R50's Care Area Assessment (CAA) dated 12/27/17, indicated physical therapy (PT) was initiated 12/27/17, with a goal to improve strength, balance, and independence, and decrease the risk of falls. The CAA also indicated to increase visual checks on R50 to ensure safety. The quarterly MDS dated 3/30/18, identified no changes in residents mobility or functional care areas. Review of R50's safety risk evaluation, dated 12/19/17, indicated R50 had a history of multiple falls prior to admission. Internal risk factors for falls (underlying health problem) included: pacemaker, decline in functional impairment, cerebral vascular accident (CVA), dizziness, vertigo, high blood pressure (antihypertensive prescribed) and a history of hip fracture. It indicated these factors were to be care planned. R50's care plan dated 12/26/17, indicated R50 was a high risk for falls related to confusion, gait and balance problems, poor communication and comprehension, and unawareness of safety needs. The goal listed identified: will not sustain serious injury. Interventions included: (1) ensure call light is within reach, (2) prompt response to all requests for assistance (3) educate, family and care givers about safety reminders and what to do if a fall occurs, (4) R50 needs a safe environment with even floors, free from spills, and or clutter, a working reachable call light, and to have personal items within reach, (5) physical therapy (PT) to evaluate and treat as ordered or as needed, and (6) utilize activities that minimize the potential for falls while providing diversion and distraction. R50's care plan was revised on 4/16/18 with the	F 689	Interdisciplinary Team Involved: Fall Committee Review Follow-up Charge Nurses_____ _ _____ _____ 1._____ MDS_____ _____ 2._____ Director of Nursing_____ 3._____ ADON_____ _____ 4._____ Social Service_____ ___ 5._____ Dietary_____ _____ Therapeutic Rec_____ Administrator_____ _____ Date of Discussion_____ _ Date of Discussion_____	

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F 689	Continued From page 14 following interventions: (1) resident requires assistance with all toileting tasks to use toilet, (2) to encourage to use call light for assistance, (3) resident is able to turn and reposition self independently, (4) resident requires stand by assist of 1 to ensure safety in and out of bed, (5) requires one staff participation to dress upper and lower body, and (6) requires contact guard, stand by assistance with transferring. Review of R50's accident reports dated since admission 12/19/17, were as noted: (1) dated 12/20/17, at 8:15 a.m.- found in bathroom on the floor; no injuries noted and no pain. Interdisciplinary team (IDT) post-fall review dated 12/21/17, Interdisciplinary team (IDT) fall review identified that staff were to stay with R50 when on the toilet, and to anticipate needs, and assist as necessary. (2) dated 12/22/17, at 7:45 a.m.- fall witnessed by roommate reported it to staff. Found lying on the floor at the entrance to room 203. Injuries included a left elbow skin tear, bruise, and left hip pain. No signs of fracture. An IDT fall review indicated R50 was a new admission who lived at home and had frequent falls. Staff encouraged to keep close eye on resident, continue current plan of care, obtain and order for physical (PT) and occupational therapy (OT). (3) dated 12/27/17, at 4:55 a.m. - found lying on floor on back next to bed. No injuries indicated. An IDT fall review on 12/27/17, indicated R50 is a new admit, with dementia. Immediate interventions indicated to monitor resident every 15 minutes. No documentation provided to indicate completion of 15 minute checks. No	F 689	Resident Name/Cs#_____ _	

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measures to prevent further falls indicated.

(4) dated 12/29/17, at 4:00 p.m. - found lying on floor. Resident assessed for injury, no injury noted. IDT fall review not indicated on accident report, and no measures to prevent further falls indicated.

(5) dated 1/20/18, at 11:30 a.m. - found on the floor in the bathroom in room 203. Injuries were an abrasion to the left thigh and pain on R50's tailbone. An IDT review indicated R50 was impulsive, forgetful, had a history of falls prior to and after admission. Resident was receiving physical therapy (PT). R50 obtained an x-ray to rule out fracture. No measures to prevent further falls indicated.

(6) dated 3/16/18, at 8:10 a.m. R50 fell , landed on stomach. Fall resulted in a small abrasion to R50's head. IDT fall review indicated R50 was received therapy, and had a recent hospital stay. No measures to prevent further falls indicated.

(7) dated 4/10/18, at 5:00 p.m. -fell in the activity room, which resulted in a skin tear on left pinky finger, a scratch by left eye, and a new bruise on left elbow. An IDT fall review indicated OT/PT recently completed, resident was impulsive, forgetful, and free to move in w/c from room to activity room. No measures indicated to prevent further falls.

R50's physical therapy (PT) notes indicated R50 was referred to PT/OT for history of falls. PT started on 12/27/17, and ended 1/24/18. PT identified R50 had deficits in strength and balance. R50 was treated three times per week for six weeks for history of falls. R50's PT

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discharge summary dated 1/24/18, indicated resident had fair progress in therapy mostly limited by cognitive deficits, required a lot of redirection to stay on task, and required one assist for transfers and ambulation. According to the PT discharge summary, R50 was placed on nursing walk program, however, R50's current care plan indicated no walking program was in place.

R50 was treated again by PT from 3/2/18, to 4/10/18, following hospitalization for pneumonia, for decreased strength and balance, and low endurance. R50's PT discharge summary on 4/10/18 indicated R50 did not progress as anticipated, maximized level of improvement was reached, and placed R50 on a walk program. OT treated R50 from 3/3/18, to 4/12/18. R50's OT discharge summary, dated 4/12/18 indicated Resident plateaued and required stand by assist with ambulating, ADLs and transfers to remain safe due to limited cognition and impulsiveness.

During observation on 04/18/18, at 8:30 a.m., R50 was in room 203 sitting in a wheelchair after breakfast. R50 was asking for help to use the bathroom, and the call light was on/activated. R50 stated it was ok, he could do it alone and wheeled himself towards the bathroom. The surveyor again encouraged R50 to wait, and R50 stated he would wait, but not for much longer. The surveyor approached unit assistant (UA) O-F and asked for assistance for R50. O-F, replied "It's not my job," and continued walking towards dining room. Surveyor reapproached O-F and asked if it was possible to call for help with the walkie talkie clipped to O-F's uniform. O-F sighed, radioed for assistance, and continued to the dining room.

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On 04/18/18, at 8:35 a.m., trained medication aide (TMA)-A was observed to walk past room 203 from the direction of the dining area to the nurse station holding a med cup and white plastic spoon. A few minutes later, TMA-A walked past room 203 from the direction of the nurse station, towards the dining room. R50 resident called out "Nurse," from the doorway as TMA-A briskly walked past room 203, stated she was busy, and continued walking towards the dining room. At 8:40 a.m., R50 stated he could not wait any longer, and pedaled towards the bathroom. R50 entered the bathroom to transfer self onto toilet. The surveyor got assistance from RN-A at the nurses station by room 203, who finished assisting R50 onto the toilet.

During interview on 04/18/18, at 8:40 a.m. RN-A indicated R50 required one person assist to transfer on and off the toilet. RN-A stated R50 had a history of falls and fell about 2 weeks ago and required an x-ray to rule out injury. RN-A described R50 as impatient, not safety aware, and attempts transfers self to toilet frequently. Staff are frequently reminded to assist resident and to remind resident no to try transfer without help.

During interview on 04/18/18, 8:42 a.m. with TMA-A indicated the resident needs assistance to the toilet and had fallen recently, but was not sure when.

R15

R15's currrent diagnosis listing included: dementia, vascular dementia, atrial fibrillation,

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congestive hear failure, diabetes, Major depressive disorder, and kidney disease, chronic respiratory failure with hypoxia, hypoxemia, chronic obstructive pulmonary disease, enlarged prostrate with lower urinary tract symptoms, vocal cord disease, anemia, low back pain, constipation, weakness, urine retention, irritable bowel syndrome, joint pain, pulmonary hypertension, abdominal pain, cataracts, feeling of incomplete bladder emptying, anxiety disorder, and dysuria.

Review of R19's Quarterly MDS dated 1/23/18, indicated resident had severely impaired memory, and a depression score of two. R19 required extensive assist of two for bed mobility, transfers, toileting, and dressing, and requires supervision of one for eating. R19 is frequently incontinent of bladder and bowel, short of breath, and has had two or more falls since the last MDS assessment without major injury.

Review of R19's care plan, dated 1/22/18, indicated R19 was a fall risk. Interventions included: (1) to ensure oxygen tubing is above feet, (2) educate R19 about safe transferring, (3) scoop mattress on bed, (4) maintain bed in low position with a fall mat and motion sensor while in bed, (5) uses a Broda chair maintained in lowest position with a seat alarm, (7) R19 required assist of one with toileting tasks, (8) two assistance when tired /weak with EZ stand (9) able to move and repo self in bed, (10) sit up independently when alert, and (11) staff assist required when fatigued.

Review of R19's accident reports indicated the following:

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(1) On 10/14/17, at 3:22 p.m. resident found on floor in room fall was unwitnessed. No injury. An IDT fall review on 10/16/17, indicated R19 was on hospice, had frequent falls, had alarms and fall mat, continue current plan of care. No measures to prevent further falls were indicated.

(2) On 10/20/17, at 21:20 p.m. R19 found on floor with no injury noted. An IDT fall review dated 10/21/18, indicated R19 had a history of back pain, hypoxemia, weakness, anxiety disorder, hypertension, chronic respiratory failure and was on hospice. No measures to prevent further falls were listed.

(3) On 11/6/17, at 7:55 am R19 observed crawling on hands and knees on floor in room. No injury. An IDT fall review dated 11/17/17, indicated resident has history of falls, had alarms and fall mat in place. Measures to prevent falls included to "attempt to toilet more frequently."

(4) On 11/16/17 at 4:40 p.m. R19 was found on the floor in their room, and resulted in a bruise to fifth finger knuckle and skin tear to left top hand. An IDT fall review on 11/17/17, indicated the fall alarm did not sound, the facility was working to become an alarm free community, and R19 had frequent falls, R19 had frequent staff checks. Fall alarm replaced. Frequency of checks not indicated, no documentation provided to indicate frequent checks. No measures to prevent further falls were noted. Frequent checks not indicated in plan of care.

(5) On 11/25/17, at 6:45 a.m. - found sitting on floor without injury. IDT fall review on 11/27/17, indicated R19 had a history of falls, fall mat in place low bed, low Broda chair, alarms in place.

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Measures to prevent further falls indicated to increase visual checks and toileting. Continue current plan of care, and "no new interventions". No revised goal or interventions for frequency of visual checks or toileting indicated in plan of care.

(6) On 1/14/18, at 8:37a.m. -found on floor resident stated hit head on oxygen but unable to recall why he stood up. Injury included a 0.5 cm round open area to back of right side of head with minimal bloody drainage. An IDT fall review on 1/15/18, indicated med review and diagnoses review completed. R19 had oxygen depravation, bad judgement, frequent checks, frequent falls and is on hospice. Review indicated to continue current plan of care. No measures to prevent further falls indicated, no frequent checks or frequency indicated on plan of care. No documentation of frequent checks available.

(7) On 3/4/18, at 9:15 p.m. R19 yelling for help, found on floor, and stated, hit head on the wheels of bedside table. Injuries included a 3.2 x 2.3 centimeter (cm) bruise on top of a goose egg on right side of the forehead, and a 5.5 x 3 cm bruise and abrasion to the right shoulder. An IDT fall review on 3/5/18, indicated resident on hospice, had oxygen deprivation, and to continue current plan of care. No measures to prevent further falls indicated.

During interview on 04/18/18, at 1:46 p.m. RN-A indicated R19 no longer used call light, and used to call out for help when needed the bathroom. R19 had a history of trying to self transfer, but does not try to self transfer as much anymore because of declining health, and also does not call for help as much as used to. Staff monitored R19 by looking into the room when passing in

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hallway to ensure safety, and R19 used a motion sensor while in bed and sensor pad when in wheelchair. R19 required an EZ stand and two assist for transfers. R19 was unaware of safety limitations, and had fallen out of both his bed and his wheelchair.

During interview on 04/18/18, at 4:03 p.m., the DON and ADON indicated when a fall occurs, staff complete an accident report that includes immediate actions to prevent falls. Falls are reviewed on a daily basis at IDT. IDT determines whether further interventions are needed. New measures to prevent falls are recorded on the accident report. After IDT, care plans are updated with interventions determined by IDT. The DON and ADON stated after a fall, new interventions are expected to be put into place, and the plan of care updated to reflect current interventions after IDT. The charge nurse communicates any care plan changes to the staff and also during change of shift report. The most current care plans are located in the electronic medical records. DON expected care plans to reflect current fall interventions. Staff were expected to follow care plans and respond to resident's needs according to the care plans. R19 and R50's fall history and observations were reviewed at this time with the DON and ADON. When asked about what facility had done to prevent further falls, the DON indicated that R50 has had fewer falls, and had physical therapy in the past. R50 was impulsive and forgot his abilities. R19 was on hospice and had declining health, which had caused him to have fewer falls. No further interventions were implemented. Staff were expected to respond promptly and anticipate R50's needs to prevent falls. All staff were aware of residents with falls risk and were expected to respond to resident

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F 689	Continued From page 22 request for help in a timely manner, and had radios to communicate with other staff for assistance. The facility policy and procedure entitled Falls Policy and Procedure, last updated 3/15/11 indicated: Policy: Each resident at risk for falls will be identified. A plan of care will be developed to include measures to aid in prevention of falls. Procedure: Resident falls assessment process: A fall risk assessment will be completed on admission. If the resident is at risk for falls on admission the admitting charge nurse and RCC [Resident Care Coordinator] determine which interventions need to be put into place to aid in the prevention of falls. This information is entered on the temporary care plan. Reassessment and Re-evaluation: Residents who are at risk for falls will have their plan of care reassessed with each MDS assessment and reviewed at the resident care conference.	F 689		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that---	F 758		4/20/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 23 §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to monitor behaviors with the use of an antipsychotic medication for 1 of 5 resident (R10) reviewed for unnecessary	F 758	F758 R10 mood and behavior sheet corrected on April 18, 2018. Upon admission, if resident is using an	

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	245362	A. BUILDING _____ B. WING _____	04/20/2018

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F 758	Continued From page 24 medications. Findings include: A quarterly Minimum Data Set (MDS) assessment dated 1/12/18, indicated no behaviors, hallucinations or delusions were observed during the assessment reference period. Review of an Order Summary Report dated 4/1/18-4/30/18, identified R10 had diagnoses including Parkinson's with hallucinations and delusional disorder. The Order Summary Report also identified R10 received the antipsychotic medication Nuplazid 17 milligrams (mg) daily. Review of R10's medical record revealed no behavior monitoring was recorded. During interview on 4/18/18, at 2:47 p.m. the director of nursing (DON) stated R10 should have had a behavior sheet started to monitor for behaviors related to the use of the antipsychotic medication. The DON stated she'd had staff look for a behavior monitoring sheet, and stated, "one was never started."	F 758	antipsychotic, anti-anxiety, hypnotic or psychotropic medication mood and behaviors will be monitored for 3 weeks through progress notes and staff communication to determine if target behaviors are present. If no mood and behaviors present MDS coordinator will research the medication and use the standards for medication use on the mood and behavior sheet. Coordinate with MDS to have a mood and behavior sheet in place by initial care conference. Family and physician will also provide target mood and behaviors if history is known to them. ADON attends and leads care conferences. ADON will coordinate with MDS coordinator if they notice that a mood and behavior sheet has not been put into place.	

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	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/18/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/18/2018**

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K 000	Continued From page 1 St. Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction.	K 000		

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K 000	Continued From page 2 The 5th Addition was constructed in 201, is a one-story , 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 has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 60 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=E	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 _____ b) Who provided system test _____ c) Water system supply source _____	K 353		5/16/18

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K 353	Continued From page 3 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 REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 70 out of 70 residents. 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 _____ 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 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 8/16/2017, during inspection and observation, it was noted that the fire sprinkler gauges had not	K 353	The gauge was replaced by Olympic Fire Protection on 5/16/18. Environmental Service Director will be responsible to make sure the gauge is replaced every 5 years.	

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K 353	Continued From page 4 been been replace every 5 years. The last replacement date was conducted on 11-2-12. Based on observation and interview, the Facility failed to maintain the automatic sprinkler system in accordance with 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could affect 42 out of 42 residents.	K 353		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire	K 363		4/24/18

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K 363	Continued From page 5 window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain portable fire extinguishers in accordance with NFPA 80. The deficient practice could affect 70 out of 70 residents. Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted.	K 363	The Environmental Service Director will be responsible to make sure the Fire doors are inspected and documented annually. This work was completed on 4/24/18 and will be done annually.	

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K 363	Continued From page 6 Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/18/2018, documentation review revealed that not all the required required fire/smoke doors are being documented during the Annual Fire and Smoke Door Inspection per NFPA 80. This deficient practice was verified by the Facility Maintenance Director.	K 363		
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6,	K 914		5/25/18

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K 914	Continued From page 7 which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to maintain electrical recepatacles in accordance with NFPA 99. The deficient practice could affect 70 out of 70 residents. Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99).	K 914	The Environmental Service Director will ensure that the receptacles will be inspected, tested, documented and repairs made as needed annually as required. This work will be completed no later than 5/25/18.	

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K 914	Continued From page 8 FINDINGS INCLUDE: On facility tour between 9:00 AM and 12:00 PM on 04/18/2018, it was revealed that not all of the testing procedures were being conducted during the electric receptacle testing. The electrical receptacles must receive the following inspections: 1.The physical integrity of each receptacle shall be confirmed by visual inspection. 2. The continuity of the grounding circuit in each electrical receptacle shall be verified. 3. Correct polarity of the hot and neutral connections in each electrical receptacle shall be confirmed. 4. The retention force of the grounding blade of each electrical receptacle (except locking-type receptacles) shall be not less than 115 g (4 oz). This deficient practice was verified by the Facility Maintenance Director.	K 914		