DEPARTMENT OF HEALTH	I AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION	AND TRANSMITTAL	ID: 99X8
	PART I -	TO BE COMPI	LETED BY T	THE STA	TE SURVEY AGENCY	Facility ID: 00396
1. MEDICARE/MEDICAID PROVIDE (L1) 245570		3. NAME AND AI (L3) <b>MAPLE LA</b>	WN NURSING			4. TYPE OF ACTION: <u>7 (</u> L8)         1. Initial       2. Recertification
2.STATE VENDOR OR MEDICAID N (L2) 235842500	0.	(L4) 400 SEVEN (L5) FULDA, MN			(L6) <b>56131</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF C (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEC 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY 10/14 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	<b>4/2014</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30
11LTC PERIOD OF CERTIFICATION	ſ	10.THE FACILITY	IS CERTIFIED	AS		1
From (a):		X A. In Complia			And/Or Approved Waivers Of	The Following Requirements:
To (b):		Program R	equirements		2. Technical Personnel	6. Scope of Services Limit
	(110)		e Based On:		3. 24 Hour RN	7. Medical Director
12.Total Facility Beds	<b>62</b> (L18)	l. A	cceptable POC		4. 7-Day RN (Rural SN 5. Life Safety Code	VF)8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	<b>62</b> (L17)		npliance with Prog ents and/or Appli			(L12)
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS	
18 SNF 18/19 SNF 62	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Mary Whitlo	ck, HFE NE II	1	0/22/2014	(L19)	K <u>amala Fiske-Downing.</u>	Enforcement Specialist 10/22/2014 (L20)
PAR	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONA	L OFFICE OR SINGLE S	TATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILI</li> <li>_X_ 1. Facility is Eligible to Particular Statement</li> </ol>			IPLIANCE WITI ITS ACT:	H CIVIL		ncial Solvency (HCFA-2572) ol Interest Disclosure Stmt (HCFA-1513) e :
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	
OF PARTICIPATION <b>08/01/1991</b>	BEGINNING	<b>J</b> DATE	ENDING DA	ΓE	VOLUNTARY         00           01-Merger, Closure         00	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER
	A. Suspensio	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	B. Rescind S	uspension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL	DATE		
	(L32)	10/02/2014		(L33)	DETERMINATION APP	ROVAL



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245570

October 22, 2014

Mr. Arlan Swanson, Administrator Maple Lawn Nursing Home 400 Seventh Street Fulda, Minnesota 56131

Dear Mr. Swanson:

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 October 10, 2014 the above facility is certified for:

62 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 62 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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Maple Lawn Nursing Home October 22, 2014 Page 2

Division of Compliance Monitoring Minnesota Department of Health Telephone: (651) 201-4112 Fax: (651) 215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 22, 2014

Mr. Arlan Swanson, Administrator Maple Lawn Nursing Home 400 Seventh Street Fulda, Minnesota 56131

RE: Project Number S5570024

Dear Mr. Swanson:

On September 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 4, 2014. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On October 14, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 17, 2014 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 September 4, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 4, 2014, effective October 14, 2014 and therefore remedies outlined in our letter to you dated September 18, 2014, will not be imposed.

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,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Maple Lawn Nursing Home October 22, 2014 Page 2

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245570	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/14/2014
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLE LAWN NURSING HOME		400 SEVENTH STREET FULDA, MN 56131	

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

(Y4) Item	(Y5	i) Date	(Y4) Item	(Y5	5) Date	(Y4) Item	(Y5)	Date
	F0329 483.25(I)	Correction Completed 10/14/2014		F0428 483.60(c)	Correction Completed 10/14/2014	ID Prefix Reg. # LSC		
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed 	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed			Correction Completed 	ID Prefix Reg. # LSC		Correction Completed
Reg. #			Reg. #		Correction Completed 	ID Prefix Reg. # LSC		Correction Completed
			_			ID Prefix Reg. # LSC		
Reviewed I			Date:	Signature of St	•		Date:	
State Agen Reviewed I CMS RO	cy KS/H By Reviewed		10/22/20 Date:	Signature of Su		588	Date:	10/24/2014
Followup t	o Survey Completed of 9/4/2014	n:	 			iencies. Was a Sumn S-2567) Sent to the Fa		NO

#### **Post-Certification Revisit Report**

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(Y1)	Provider / Supplier / CLIA / Identification Number 245570	(Y2) Multiple Con A. Building B. Wing	IN BUILDING 01	(Y3) Date of Revisit 10/17/2014
Name	e of Facility		Street Address, City, State, Zip Code	
MA	APLE LAWN NURSING HOME		400 SEVENTH STREET	
			FULDA, MN 56131	

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

(Y4) Item		(Y5) Date	(Y4) Item		(Y5) Date	(Y4) Item	(Y5)	Date
ID Prefix		Correction Completed 09/19/2014	ID Prefix		Correction Completed 10/10/2014	ID Prefix		Correction Completed
-	NFPA 101		0	NFPA 101		Reg. #		
LSC	K0038		LSC	K0144				
		Correction			Correction			Correction
ID Drofin		Completed	ID Drofiv		Completed	ID Drafin		Completed
ID Prefix						ID Prefix		
Reg. # LSC			Reg. # LSC			Reg. # 		
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #			Reg. #					
		Correction			Correction			Correction
		Completed			Completed			Completed
ID Prefix			ID Prefix			ID Prefix		
Reg. #			Reg. #			Reg. #		
LSC			LSC					
		Correction			Correction			Correction
ID Prefix		Completed	ID Prefix		Completed	ID Prefix		Completed
Reg. #						D		
LSC			LSC			LSC		
Reviewed E	By Rev	iewed By	Date:	Signature	of Surveyor:		Date:	
State Agen	cy P	S/KFD	10/22/201	4	34	764		10/17/2014
Reviewed E CMS RO	3y Rev	iewed By	Date:	Signature	of Surveyor:		Date:	
Followup t	o Survey Comple 9/8/2014					ciencies. Was a Sumn IS-2567) Sent to the Fa		NO

#### **Post-Certification Revisit Report**

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

(Y1)	Provider / Supplier / CLIA / Identification Number 245570	(Y2) Multiple Construction A. Building B. Wing 02 - ACT		ΤΙVΙΤΥ ROOM Α	(Y3) Date of Revisit 10/17/2014
Name	e of Facility			Street Address, City, State, Zip Code	
MA	APLE LAWN NURSING HOME			400 SEVENTH STREET	
				FULDA, MN 56131	

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

(Y4) Item		(Y5) Dat	e (Y4	4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		Correc	tion				Correction					Correction
ID Prefix		Compl 09/19/2		ID Prefix			Completed 09/29/2014		ID Prefix			Completed 10/10/2014
-	NFPA 101			0	NFPA 101				0	NFPA 101		
LSC	K0038			LSC	K0141				LSC	K0144		
		Correc	tion				Correction					Correction
ID Des fiss		Compl	eted	ID Des fes			Completed		ID Des fee			Completed
ID Prefix												
Reg. # LSC				Reg. # LSC					Reg. # LSC			
						,						
		Correc	tion				Correction					Correction
ID Prefix		Compl	eted	ID Brofiv			Completed		ID Brofiv			Completed
Reg. # LSC				Reg. # LSC					Reg. # LSC			
		Correc	tion				Correction					Correction
ID Prefix		Compl	eted	ID Prefix			Completed		ID Prefix			Completed
Reg. #												
				LSC					LSC			
		Correc	tion				Correction					Correction
		Compl					Completed					Completed
				ID Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
				LSC					LSC			
Reviewed B	By Rev	iewed By	D	Date:	Signature	of Sur	veyor:				Date:	
State Agen	cy PS	S/KFD	1	10/22/20	14			34	764			10/17/2014
Reviewed E CMS RO	3y Rev	iewed By	D	Date:	Signature	of Sur	veyor:				Date:	
Followup t	o Survey Comple	ted on:			Check for any						1	
	9/8/2014				Uncorrecte	d Defic	iencies (CM	S-2567	7) Sent to	the Facility?	YES	NO

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID SERV	VICES
					AND TRANSMITTAL	ID: 99X8	
	PART I -	TO BE COMPI	LETED BY 1	THE STA	TE SURVEY AGENCY	Facility ID: 00	396
1. MEDICARE/MEDICAID PROVIDE	ER NO.	3. NAME AND AI (L3) MAPLE LA				4. TYPE OF ACTION: $2(L8)$	
(L1) <b>245570</b> 2.STATE VENDOR OR MEDICAID N	NO.	(L4) 400 SEVEN		o nome		1. Initial 2. Recerting	
(L2) <b>235842500</b>		(L5) FULDA, MN			(L6) <b>56131</b>	3. Termination     4. CHOW       5. Validation     6. Compla       7. On-Site Visit     9. Other	
5. EFFECTIVE DATE CHANGE OF ( (L9)	OWNERSHIP	7. PROVIDER/SU			<u>02</u> (L7)	8. Full Survey After Complaint	
	4/2014 (L34)	01 Hospital 02 SNF/NF/Dual	05 HHA 06 PRTF	09 ESRD 10 NF	13 PTIP 22 CLIA		
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/II	14 CORF D 15 ASC	FISCAL YEAR ENDING DATE:	(L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_ ( ''	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	09/30	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:	
To (b):			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit	
12.Total Facility Beds	62 (L18)	-	cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SN	<ul> <li>7. Medical Director</li> <li>F)8. Patient Room Size</li> </ul>	
5	0_ ( )				5. Life Safety Code	9. Beds/Room	
13.Total Certified Beds	<b>62</b> (L17)	X B. Not in Con Requirem	npliance with Pro ents and/or Appl		: * Code: <b>B</b>	(L12)	
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
62 (L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:	
Mary Whitlock, HF	E NE II	0	09/30/2014	(L19)	Kamala Fiske-Downing.	Enforcement Specialist 10/02	2/2014 (L20)
PAI	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONA	L OFFICE OR SINGLE S	FATE AGENCY	(===*)
19. DETERMINATION OF ELIGIBIL	JTY	20. COM	IPLIANCE WIT	H CIVIL	21. 1. Statement of Finar	cial Solvency (HCFA-2572)	
<ol> <li>Facility is Eligible to P</li> </ol>	Participate	RIGI	HTS ACT:			l Interest Disclosure Stmt (HCFA-1513)	
2. Facility is not Eligible	;				5. Dour of the Above		
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)	
OF PARTICIPATION	BEGINNING	<b>B</b> DATE	ENDING DA	TE	<u>VOLUNTARY</u> 00	INVOLUNTARY	
08/01/1991					01-Merger, Closure	05-Fail to Meet Health/Sa	afety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	··· · ··· ··· ··· ··· ··· ··· ··· ···	nt
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	OTHER	
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Chan	ige
(L27)	B Rescind St	spension Date:	(L44)			00-Active	
	D. Resenid 5	ispension Date.	(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	· ·		30. REMARKS		
		03001					
	(L28)	00001		(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	I OF APPROVAI	LDATE			
	(L32)			(L33)	DETERMINATION APPE	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 2873

September 18, 2014

Mr. Arlan Swanson, Administrator Maple Lawn Nursing Home 400 Seventh Street Fulda, Minnesota 56131

RE: Project Number S5570024

Dear Mr. Swanson:

On September 4, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

# <u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

# <u>Informal Dispute Resolution</u> - 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), i.e., the plan of correction should be directed to:

Pat Halverson Patricia.Halverson@state.mn.us Minnesota Department of Health Duluth Technology Village 11 East Superior Street, Suite 290 Duluth, Minnesota 55802 Telephone: (218) 723-4637 Fax: (218) 723-2359

# **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by October 14, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 14, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

### PLAN OF CORRECTION (PoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Include signature of provider and date.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

Maple Lawn Nursing Home September 18, 2014 Page 4

### VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) 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 remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

#### Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

#### Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

#### Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

# 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 December 4, 2014 (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

Maple Lawn Nursing Home September 18, 2014 Page 5

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 March 4, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

# **INFORMAL DISPUTE RESOLUTION**

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm">http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</a>

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Telephone: (651) 201-7205 Fax: (651) 215-0525 Maple Lawn Nursing Home September 18, 2014 Page 6

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

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

Enclosure

cc: Licensing and Certification File

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245570	B. WING _		09/	04/2014	
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C 400 SEVENTH STREET	ODE		
	AWN NURSING HON	E		FULDA, MN 56131			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 000	The facility's plan of as your allegation of Department's acceled bottom of the first p be used as verifica Upon receipt of an revisit of your facility validate that substate regulations has been	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will	FO	The following provid responses are neither an admission of nor agreement with the herein alleged deficiencies, and the should not be read to construed as such.	<u>er</u> EV nor		
F 329 SS=D	UNNECESSARY D Each resident's dru unnecessary drugs drug when used in duplicate therapy); without adequate n indications for its u adverse conseque should be reduced combinations of the Based on a compri- resident, the facility who have not used given these drugs therapy is necessa as diagnosed and record; and resided drugs receive grad behavioral interver	ig regimen must be free from a An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of nces which indicate the dose or discontinued; or any	F 3	29	F 19 1-25-19 BLH		
1 <b>- 1 - 1 - 1 - 1 - 1 - 1</b> - 1 - 1 - 1 - 1						1 (X6) DATE	

Any deficiency statement ending with an asterist (\*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CONSTRUCTION		E SURVEY
ID PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG		PLEIEU
		245570	B. WING_		09/	04/2014
AME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 400 SEVENTH STREET		
APLE L	AWN NURSING HOM	1E		FULDA, MN 56131		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIC DATE
F 329	Continued From pa	age 1	F 32	29 <b>F 329</b>		
		NT is not met as evidenced		Action Pian Appropriate lab orders for R were obtained.	47 & R8	
	facility failed to mo	w and document review, the nitor routine laboratory levels a, (R47, R8) who were reviewed edications.		Other Residents Any residents that have been discharged from Hospice has their orders checked to asso	ive had ire	
	Findings include:			proper resumption of lab or	Jers.	
		nedication Depakote (mood blood testing related to		An audit will be completed of current residents with drug that require lab work, to ass all required orders are issue	orders ure that	
	Depakote 125 mill for mood disorder, dose was increase for a Depakote lev	orders dated 10/14/13, included igrams (mg) twice daily (bid) , On 8/19/14, the Depakote ed to 250 mg bid. No lab test rel was documented.		Changes/Monitoring A procedure for checking ar resident who discharges fro Hospice care will be establi assume proper resumption	ny m shed to	
	at 3:51 p.m. indica been ordered by the pharmacist, intervised that since F mood disorder, the been tested at lea R8's physician ord	stered nurse (RN)-A on 9/3/14, ated the lab testing had never he physician. The consulting iewed on 9/4/14, at 11:03 a.m., R47 was on Depakote for a e Depakote level should have ist yearly for toxicity reasons. ders dated 4/16/14, included othyroidisn, 88 micrograms		for routine lab work. In consultation with our pha consultant, we will establish revised process for docume orders. Director of Nurses is respor Date of Action Plan Comp	rmacy a nting lab nsible.	
	blood tests for thy when the Thyroid and Thyroid Func within normal limi	ord identified the most recent vroid levels were on 4/24/12, Stimulating Hormone (TSH) tion Test (T4) indicated levels ts. There was no evidence of ests related to hypothyroidism.		October 10, 2014	NCLIOII	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:99X811

Facility ID: 00396

If continuation sheet Page 2 of 5

		AND HUMAN SERVICES				FORM /	09/16/2014 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY
		245570	B. WING			09/0	4/2014
NAME OF F	PROVIDER OR SUPPLIER	Annorad a gun an anno an ann an Annorad an An	·	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	AWN NURSING HON	AE ·····			0 SEVENTH STREET		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES			JLDA, MN 56131 PROVIDER'S PLAN OF CORRECTION	v I	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 329	Continued From pa	age 2	F3	29		4 (A)	
F 428 SS=D	9/3/14, at 6:00 p.m laboratory monitorii stated R8 had rece 11/19/12, thru 7/1/1 11/6/12, indicated, DON indicated was on hospice. The D tests were usually admitted to hospica related to treatmen resumed since R8 on 7/1/13. 483.60(c) DRUG F IRREGULAR, ACT The drug regimen reviewed at least of pharmacist. The pharmacist muthe attending physi	ses (DON), interviewed on , verified that annual ng was the norm. The DON ived hospice services from 13. Physician orders dated "No further labs," which the s a result of R8 being placed ION verified that laboratory stopped when a resident was e. The orders for blood tests it of hypothyroidism were not was discharged from hospice REGIMEN REVIEW, REPORT ON of each resident must be ince a month by a licensed ust report any irregularities to lician, and the director of reports must be acted upon.	F4	128			
	by: Based on interview consulting pharma routine laboratory	INT is not met as evidenced w and document review the cist failed to identify the lack of monitoring for 2 of 5 residents				ţ	
	(R8, R47) reviewe	d for unnecessary medications.					
	Findings include:						
FORM CMS-2	567(02-99) Previous Version	s Obsolete Event ID:99X8	  1	Fac	cility ID: 00396 If contin	uation she	et Page 3 of 5

|

	OF DEFICIENCIES	& MEDICAID SERVICES			1	. 0938-039 E SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:				PLETED
		245570	B. WING		09/	/04/2014
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	AWN NURSING HO	AE	1	100 SEVENTH STREET FULDA, MN 56131		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 428	Continued From pa	age 3	F 428	► F 428		
	R47's monthly con not address the lac	sultant pharmacy reports did ck of annual laboratory testing y related to Depakote (mood	=-	Action Plan Appropriate lab orders for R4 were obtained.	7 & R8	
	Depakote 125 mill for mood disorder. dose was increase results for a Depa	orders dated 10/14/13, included grams (mg) twice daily (bid) On 8/19/14, the Depakote id to 250 mg bid. No lab kote level were documented. stered nurse (RN)-A on 9/3/14,		Other Residents Any residents that have been discharged from Hospice have their orders checked to assure proper resumption of lab orde	e had e	
	at 3:51 p.m. indica been ordered by th pharmacist, intervi verified the lack of	ted the lab testing had never he physician. The consulting ewed on 9/4/14, at 11:03 a.m., pharmacy recommendations should have been done		An audit will be completed on current residents with drug or that require lab work, to assur all required orders are issued	ders e that	
	R8's consultant ph	armacy reviews did not identify esting related to the use of at hypothyroidism.		Changes/Monitoring A procedure for checking any resident who discharges from Hospice care will be establish assume proper resumption of	ed to	
	reviews from July were reviewed. R8 services on 7/1/13 medications that in QD for hypothyroid included blood tes	armacist monthly drug regimen 2013 through August 2014 3 was discharged from hospice 4, with physician ordered ncluded Synthroid 88mcg PO dism. R8's medical record t results dated 4/24/12, that		for routine lab work. In consultation with our pharm consultant, we will establish a revised process for document orders.	nacy	
	and Thyroid Funct normal limits. The	oid Stimulating Hormone (TSH) ion Test (T4) levels were within re was no evidence of ests related to hypothyroidism.		Director of Nurses is responsi Date of Action Plan Comple October 10, 2014		
	9/3/14, at 6:00 p.n laboratory monitor	rses (DON), interviewed on n., verified that annual ring was the norm. The DON eived hospice services from				

		AND HUMAN SERVICES				FORM	: 09/16/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		PLE CONSTRUCTION G	(X3) DAT	TE SURVEY MPLETED
		245570	B. WING	G		09	/04/2014
NAME OF F	PROVIDER OR SUPPLIER	and a second		Τ	STREET ADDRESS, CITY, STATE, ZIP COD		
MAPLE L	AWN NURSING HOM	1E			400 SEVENTH STREET FULDA, MN 56131		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF	FIX		OULD BE	COMPLETION DATE
F 428	11/6/12, indicated, DON indicated was on hospice. The D tests were usually s admitted to hospice related to treatmen resumed since R8 on 7/1/13. On 09/4/14, at 11:0 pharmacist was int not aware R8 was services. The cons that she would exp yearly basis unless	age 4 3. Physician orders dated "No further labs," which the s a result of R8 being placed ON verified that laboratory stopped when a resident was be. The orders for blood tests t of hypothyroidism were not was discharged from hospice 00 a.m. the consultant erviewed and stated she was no longer receiving hospice sultant pharmacist also stated ect labs to be rechecked on a there were other conditions ed for more frequent	F	42			
EORM CMS-2	2567(02-99) Previous Version	s Obsolete Event ID:99X8	11		Facility ID: 00396 If	continuation s	neet Page 5 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245570	B. WING		09/08/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE L	AWN NURSING HOM	E		100 SEVENTH STREET FULDA, MN 56131		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTIO	N (X	
PREFIX		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		
K 000	INITIAL COMMENT	S	K 000			
	FIRE SAFETY			pocok		
1-14-	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S-2567 FORM WILL BE ATION OF COMPLIANCE.		POCOR P3 9-30-14		
Se: 10	ONSITE REVISIT O CONDUCTED TO V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE IS BEEN ATTAINED IN TH YOUR VERIFICATION.				
,-14 (	Minnesota Departm Fire Marshal Divisio the time of this surv Nursing Home was compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F (NFPA) Standard 10	Survey was conducted by the ent of Public Safety, State in, on September 8, 2014. At ey, Building 01 of Maple Lawn found not to be in substantial requirements for participation id at 42 CFR, Subpart ty from Fire, and the 2000 Fire Protection Association D1 Life Safety Code (LSC),		HECEIVED		
5-6 12	PLEASE RETURN CORRECTION FOI DEFICIENCIES (K-	R THE FIRE SAFETY TAGS) TO:		SEP 2 9 2014 MM DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION		
EXI	Health Care Fire Ins State Fire Marshal I 445 Minnesota St., St. Paul, MN 55101 Facsimile: 691-215	Division Suite 145 -5145		TITLE . /	(X6) DAT	

Any deficiency statement anding 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 tollowing 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.

PRINTED: 09/18/2014 FORM APPROVED OMB NO: 0938-0391

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION - Main Building 01	(X3) DATE SURVEY COMPLETED		
		245570	B. WING			09/	08/2014	
NAME OF PROVIDER OR SUPPLIER  MAPLE LAWN NURSING HOME  SUMMARY STATEMENT OF DEFICIENCIES				STREET ADDRESS, CITY, STATE, ZIP CODE 400 SEVENTH STREET FULDA, MN 56131				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION S		LD BE	(X5) COMPLETIO DATE	
K 000	Continued From pa	age 1	кo	00				
	By e-mail to: Marian.Whitney@state.mn.us							
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:						
	1. A description of to correct the defici	what has been, or will be, done iency.						
	2. The actual, or pr	oposed, completion date.						
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.	×					
	follows: The original buildin one-story, has a pa sprinkler protected construction; The 1st Addition wa one-story, has no b protected and is of The 2nd Addition w one-story, has no b protected and is of The 3rd Addition w one-story, has a pa	ng Home was constructed as g was constructed in 1964, is artial basement, is fully fire and is of Type II(111) as constructed in 1991, is basement, is fully fire sprinkler Type II(000) construction; vas constructed in 2001, is basement, is fully fire sprinkler Type II(111) construction; as constructed in 2004, is artial basement, is fully fire and is of Type II(111)						
	Building 01 consist	s of the original 1964 building, 2001 building additions.						
	The facility has a fi detection in the cor	re alarm system with smoke ridors and spaces open to the						

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 09/18/ FORM APPRC MB NO. 0938-	OVED
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION 6 01 - MAIN BUILDING 01	(X3) DATE SURVE COMPLETED	
		245570	B. WING		09/08/201	4
	PROVIDER OR SUPPLIER	IE		STREET ADDRESS, CITY, STATE, ZIP CODE 400 SEVENTH STREET FULDA, MN 56131		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLE	
K 000 K 038 SS=F	Corridors which is n department notifical capacity of 62 beds time of the survey. The requirement at NOT MET as evide NFPA 101 LIFE SA Exit access is arran accessible at all tim 7.1. 19.2.1 This STANDARD is NFPA 101 (2000) L REGULATION - Exits are readily acc accordance with se This STANDARD is Based on observati maintain the means the requirements at Section 19.2.2.2.1 a This deficient practio of 52 residents, stat FINDINGS INCLUE On 09/08/2014 at 1 observation revealed	and had a census of 52 at 42 CFR, Subpart 483.70(a) is need by: FETY CODE STANDARD aged so that exits are readily res in accordance with section s not met as evidenced by: IFE SAFETY CODE SURVEY it access is arranged so that cessible at all times in ction 7.1. 19.2.1 not met as evidenced by: on, the facility failed to a of egress in accordance with NFPA 101 (2000) Chapter 19, and Chapter 7, Section 7.2. ce could adversely affect 52 ff or visitors.	K 000		fied as	
		ce was confirmed with the			ution sheet Pass	3.01.4
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:99X821	Fa	adlity 1D: 00396 If continu	ation sheet Page	0014

		AND HUMAN SERVICES			FORM	09/18/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE COM	E SURVEY PLETED
		245570	B. WING		09/0	08/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLE	AWN NURSING HON	ΙE		100 SEVENTH STREET FULDA, MN 56131		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
K 038 K 144 SS=F	chief building engin discovery. NFPA 101 LIFE SA Generators are insp under load for 30 m accordance with NF Based on document interview, the facility emergency generat requirements of 200 NFPA 110 Chapter could affect all 52 m Findings include: On facility tour betw 9/8/2014, document inspection logs (Se 2014) for the diesel revealed that the with were missed for the	eer (MM) at the time of FETY CODE STANDARD bected weekly and exercised hinutes per month in FPA 99. 3.4.4.1.	K 038			
FORM CMS-25	67(02-99) Previous Versions	Obsolete Event ID:99X821	Fe	acliity ID: 00396 If continu	uation she	et Page 4 of 4

		AND HUMAN SERVICES		-	755100000	FORM	APPROVED		
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION 02 - ACTIVITY ROOM A	(X3) DATE	SURVEY		
		245570	B. WING			09/0	08/2014		
NAME OF F	PROVIDER OR SUPPLIER			I s	STREET ADDRESS, CITY, STATE, ZIP CODE	00/1			
					100 SEVENTH STREET				
MAPLEL	AWN NURSING HON	16		F	FULDA, MN 56131				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)		
PRÉFIX		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		DATE		
TAG	HEGULATORY ON L	SCIDENTIFTING INFORMATION	IAG	1	DEFICIENCY)				
K 000	INITIAL COMMENT	rs	K	000					
	Swenson, Kimberly	y					D: 09/18/2014 M APPROVED <u>0. 0938-0391</u> ATE SURVEY DMPLETED 9/08/2014 COMPLETION DATE		
	FIRE SAFETY				DACEA				
	THE EACH ITVIS D	OC WILL SERVE AS YOUR			Po				
		COMPLIANCE UPON THE			0 10-11				
	DEPARTMENT'S A	CCEPTANCE, YOUR			POC 01 9-30-14				
		E BOTTOM OF THE FIRST			281.				
		S-2567 FORM WILL BE			3:				
	USED AS VERIFIC	ATION OF COMPLIANCE.							
	UPON RECEIPT O	F AN ACCEPTABLE POC, AN							
	ONSITE REVISIT (	OF YOUR FACILITY MAY BE							
	CONDUCTED TO								
		MPLIANCE WITH THE AS BEEN ATTAINED IN							
		TH YOUR VERIFICATION.							
	A Life Safety Code	Survey was conducted by the							
	Minnesota Departm	nent of Public Safety, State							
		on, on September 8, 2014. At vey, Building 01 of Maple Lawn							
		found not to be in substantial							
	compliance with the	e requirements for participation							
	in Medicare/Medica	aid at 42 CFR, Subpart			RECEIVED				
	483.70(a), Life Safe	ety from Fire, and the 2000 Fire Protection Association			Amer				
		01 Life Safety Code (LSC),							
	Chapter 19 Existing	Health Care Occupancies.			SEP 2 9 2014				
	PLEASE RETURN								
	CORRECTION FO	R THE FIRE SAFETY			MN DI PT. OF PUBLIC SAFETY				
		1,40,10.			STATE MARSHAL DIVISION				
	Health Care Fire In								
	State Fire Marshal								
	445 Minnesota St.,								
	St. Paul, MN 55101	10140							
LABORATORY	Y DIRECTOR'S OF PROVID	DER/SUPPLIER AEPRESENTATIVE'S SIGN	NATURE		TITLE				
	Ada	Ananen			Alministrator		19/2014		
Any deficient	cy statement inding with	an asterisk (*) denotes a deficiency wh	ich the in	stitu	tion may be excused from correcting providing	it is dete a disclosa	mined that ble 90 days		

Any deficiency statement inding with an asterisi (\*) 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

PRINTED: 09/18/2014 FORM APPROVED OMB NO. 0938-0391

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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·		E CONSTRUCTION 22 - ACTIVITY ROOM A		E SURVEY		
		245570	B. WING			09/08/20			
	PROVIDER OR SUPPLIER	IE	STREET ADDRESS, CITY, STATE, ZIP CODE 400 SEVENTH STREET FULDA, MN 56131						
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	Facsimile: 651-215 By e-mail to: Marian.Whitney@s THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of w to correct the defici 2. The actual, or pro- 3. The name and/o responsible for corr prevent a reoccurre Maple Lawn Nursin follows: The original building one-story, has a pa sprinkler protected construction; The 1st Addition wa one-story, has no b protected and is of The 2nd Addition wa one-story, has a pa	5-0525, or tate.mn.us RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done ency. oposed, completion date.	KC	000					
	Building 01 consists and, the 1991 and 2	s of the original 1964 building, 2001 building additions.							
	The facility has a fi	e alarm system with smoke							

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OMB NO. 0938-0391 **CENTERS FOR MEDICARE & MEDICAID SERVICES** (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - ACTIVITY ROOM A 245570 B. WING 09/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 SEVENTH STREET** MAPLE LAWN NURSING HOME FULDA, MN 56131 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION 1D (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 Continued From page 2 K 000 detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 62 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 038 K 038 ► K 038 \$S=F Exit access is arranged so that exits are readily **Action Plan** accessible at all times in accordance with section The panic bar valences were 7.1. 18.2.1 removed from the two exit doors that were affected and a third door that was not an exit. This STANDARD is not met as evidenced by: The nursing department was notified NFPA 101 (2000) LIFE SAFETY CODE SURVEY that valences were unacceptable as REGULATION - Exit access is arranged so that a solution. exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Maintenance Supervisor is responsible. This STANDARD is not met as evidenced by: Based on observation, the facility failed to **Date of Action Plan Completion** maintain the means of egress in accordance with the requirements at NFPA 101 (2000) Chapter 19, September 19, 2014 Section 19.2.2.2.1 and Chapter 7, Section 7.2. This deficient practice could adversely affect 52 of 52 residents, staff or visitors. FINDINGS INCLUDE: On 09/08/2014 at 1:00 PM to 3:30 PM . observation revealed that the entire facility had valances on the panic hardware of the exit doors. This deficient practice was confirmed with the If continuation sheet Page 3 of 5 Facility ID: 00396 Event ID:99X821 FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2014

FORM APPROVED

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - ACTIVITY ROOM A **B. WING** 245570 09/08/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **400 SEVENTH STREET** MAPLE LAWN NURSING HOME **FULDA, MN 56131** SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (X5) COMPLETION ID. (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) K 038 Continued From page 3 K 038 chief building engineer (MM) at the time of discovery. NFPA 101 LIFE SAFETY CODE STANDARD K 141 K 141 ► K 141 SS=F Non-smoking and no smoking signs in areas Action Plan where oxygen is used or stored are in accordance An appropriate oxygen caution sign with 18.3.2.4, NFPA 99, 8.6.4.2. has been installed on the door to this room where empty oxygen tanks are stored. This STANDARD is not met as evidenced by: Maintenance Supervisor is Observations revealed and an Interview with responsible. staff confirmed that the use of oxygen within the facility is not in accordance with NFPA 99 Standard for Health Care Facilities (1999 edition) **Date of Action Plan Completion** section 8-6.4.2, which requires signs that are September 29, 2014 readable from 5 feet that state CAUTION OXYGEN IN USE NO SMOKING, NO OPEN FLAMES. This deficient practices could negatively impact the individual residents of each Individual room, the staff and the emergency responders to the facility if they are unaware of were oxygen enriched atmospheres are. Findings include: During the facility tour on September 8,2014, between 1:00 PM and 3:30PM, it was observed that oxygen tanks were stored in the air exchange room, however the room did not have signs on the doors Indicating oxygen was in there. An interview with the Director of Maintenance revealed that the tanks were placed there when empty. This finding was verified by the Director of Maintenance during the facility tour and during the exit conference. K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144

Facility ID: 00396

Event ID: 99X821

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/18/2014

If continuation sheet Page 4 of 5

FORM APPROVED

	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION 3 02 - ACTIVITY ROOM A	COM	PLETED
245570		B. WING		09/0	08/2014
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AWN NURSING HOM	1E		400 SEVENTH STREET FULDA, MN 56131		
(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	O BE	(X5) COMPLETIC DATE
Continued From pa	age 4	K 144	4 ► K 144		
			Action Plan		
under load for 30 m	ninutes per month in			in 🗌	
accordance with M	FFA 99. 3.4.4.1.				
			weekly operational inspections.	it.	
	÷		Maintenance Supervisor is responsible.		
Based on docume interview, the facilit generators in accor of 2000 NFPA 101	ntation review and staff y failed to test the emergency rdance with the requirements - 9.1.3 and 1999 NFPA 110		Date of Action Plan Completio October 10, 2014	on	
Findings include:					
09/08/2014, the do weekly inspection is September 2014) for generator revealed	cumentation review of the ogs (September 2013 to or the diesel emergency that a weekly operational				
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	(EACH DEFICIENC' REGULATORY OR L Continued From pa Generators are ins under load for 30 m accordance with NI This STANDARD i Based on docume interview, the facilit generators in accord of 2000 NFPA 101 Chapter 6-4.1. The all 52 residents. Findings include: On facility tour betw 09/08/2014, the do weekly inspection I September 2014) f generator revealed inspections were m 2014. This deficient pract Director of Mainten discovery.	Findings include: On facility tour between 1:00 PM and 3:30 PM on 09/08/2014, the documentation review of the weekly inspection logs (September 2013 to September 2014) for the diesel emergency generator revealed that a weekly operational inspections were missed for the month of January 2014. This deficient practice was confirmed by the Director of Maintenance (MM) at the time of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG         Continued From page 4       K 144         Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.       K 144         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 52 residents.         Findings include:       On facility tour between 1:00 PM and 3:30 PM on 09/08/2014, the documentation review of the weekly inspection logs (September 2013 to September 2014) for the diesel emergency generator revealed that a weekly operational inspections were missed for the month of January 2014.         This deficient practice was confirmed by the Director of Maintenance (MM) at the time of	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDEN'S PLAN OF CORRECTIC (EACH CORRECTIR ACTION SHOLL) OROSS-REFERENCED TO THE APPROID DEFICIENCY)         Continued From page 4       K 144       K 144         Generators are inspected weekly and exercised under load for 30 minutes per mointh in accordance with NFPA 99. 3.4.4.1.       K 144       K 144         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 52 residents.       Date of Action Plan Completic October 10, 2014         Findings include:       On facility tour between 1:00 PM and 3:30 PM on 09/08/2014, the documentation review of the weekly inspection logs (September 2013) to September 2014) for the diseal emergency generator revealed that a weekly operational inspections were missed for the month of January 2014.       Date of Action Plan Complexity of the time of discovery.	SUMMARY STATEMENT OF DEFICIENCIES ((EACH DEFICIENCY MUST BE PRECEDED BY PLL REGULATORY OR LSC IDENTIFYING INFORMATION)       ID PREFIX TAG       PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)         Continued From page 4       K 144       K 144         Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.       K 144       K 144         This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to test the emergency generators in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 52 residents.       Date of Action Plan Completion October 10, 2014         Provident State       On facility tour between 1:00 PM and 3:30 PM on 09(08/2014, the documentation review of the weekly inspection logs (September 2013 to September 2014) for the diesel emergency generator revealed that a weekly operational inspections were missed for the month of January 2014.