*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
February 15, 2023

Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, MN  56131

RE: CCN: 245570
Cycle Start Date: January 25, 2023

Dear Administrator:

On January 25, 2023, a survey was completed at your facility by the Minnesota Department(s) 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 no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition.  The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective April 25, 2023.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective April 25, 2023.  They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 25, 2023.

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.

This Department is also recommending that CMS impose:

• Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

## NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by April 25, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Maple Lawn Senior Care will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 25, 2023. You will receive further information regarding this from the State agency. 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.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

## ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

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

## DEPARTMENT CONTACT

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

Nicole Osterloh, RN, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230  Mobile: (507) 251-6264

## 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 - Health Regulation Division 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 Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 25, 2023 if your facility does not achieve substantial compliance.  This action is mandated by the Social Security Act at § 1819(h)(2)(C) and

1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

## 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:

Steven.Delich@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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

## INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 245570 | A. BUILDING _____ B. WING _____ | C 01/25/2023 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| E 000 | Initial Comments<br><br>On 1/23/23 through 1/25/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance.<br><br>The facility is enrolled in the electronic Plan of Correction (ePoC) and therefore a signature is not required at the bottom of the first page of the State form. Although no plan of correction is required, it is required that you acknowledge receipt of the electronic documents. | E 000 | | |
| F 000 | INITIAL COMMENTS<br><br>On 1/23/23 through 1/25/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.<br><br>The following complaints were found to be UNSUBSTANTIATED: H55707742C (MN87272), H55707645C (MN86651), H55707646C (MN87526) and H55707647C (MN84864).<br><br>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.<br><br>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted | F 000 | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| Electronically Signed | | 02/24/2023 |

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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| F 000 | Continued From page 1<br>to validate substantial compliance with the regulations has been attained. | F 000 | | |
| F 868 SS=D | QAA Committee<br>CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c)<br><br>§483.75(g) Quality assessment and assurance.<br>§483.75(g) Quality assessment and assurance.<br>§483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of:<br>(i) The director of nursing services;<br>(ii) The Medical Director or his/her designee;<br>(iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and<br>(iv) The infection preventionist.<br><br>§483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:<br>(i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary.<br><br>§483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality | F 868 | | 3/9/23 |

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| F 868 | Continued From page 2<br>assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is not met as evidenced by:<br>Based on document review and interview, the facility failed to document the absence or presence of 1 of 1 consultant pharmacist required to be in attendance quarterly at Quality Assurance Performance Improvement (QAPI) meetings.<br><br>Findings include:<br><br>Review of the quarterly QAPI Meeting Minutes and Agenda identified in July 2022, (third quarter), the consultant pharmacist was not documented as having attended.<br><br>Review of the 2022 Quality Assurance & Performance Improvement Plan identified the committee would meet at least quarterly and record minutes of the meetings to be shared with staff. The policy failed to identify required member attendance at the quarterly meetings as identified in the CMS guidelines.<br><br>Interview on 1/25/23 at 4:01 p.m., with the director of nursing (DON), reported the consultant pharmacist had failed to attend a QAPI meeting during the 3rd quarter (July, August, September). As a result the facility was not in compliance with required quarterly QAPI meeting requirements. | F 868 | 1. QAPI meetings as of Nov 2022 are now being coordinated by the ADON & MDS coordinator taking the lead<br>2. Jessica Larson RN has completed the QAPI Program Education. QAPI Design and Scope for Skilled Nursing Facilities offered by American Association of Post-Acute Care Nursing dated May 5, 2022.<br>3. Communication via email on Jan 27, 2023 with consulting pharmacist from Lewis Drug of Windom, MN explaining the concern at survey exit meeting regarding the attendance of the consulting pharmacist. Discussed the option for real-time alternative methods of participation, such as videoconferencing and teleconference calls.<br>4. QAPI meetings will be held the second Thursday of each month. Medical Director & Consulting Pharmacist have been educated and understand the requirement of quarterly attendance.<br>5. Outlook email meeting invitations are sent out the first week of the month.<br>6. QAPI Plan was reviewed by QAPI committee. Continues to be appropriate.<br>7. Administrator, DON, ADON & MDS coordinator reviewed the QAPI Critical Element Pathway.<br>8. Administrator, DON, ADON & MDS reviewed F868-QAA committee, F882-Infection Preventionist Qualification/Role, F755-Pharmacy | |

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| F 868 | Continued From page 3 | F 868 | Services<br>9. All staff meeting on Jan 31, 2023, ADON presented annual QAPI training.<br>10. All staff are required on hire and annually to complete online training regarding QAPI.<br>11. The POC will be monitored by the QAA committee monthly at QAPI meeting. | |
| F 885 SS=D | Reporting-Residents,Representatives&Families<br>CFR(s): 483.80(g)(3)(i)-(iii)<br><br>§483.80(g) COVID-19 reporting. The facility must—<br><br>§483.80(g)(3) Inform residents, their representatives, and families of those residing in facilities by 5 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—<br><br>(i) Not include personally identifiable information;<br>(ii) Include information on mitigating actions implemented to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and<br>(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either: each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.<br>This REQUIREMENT is not met as evidenced by: | F 885 | | 3/9/23 |

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| F 885 | Continued From page 4<br>Based on interview and document review the facility failed to appropriately inform residents, their representatives, and families of those residing in facility by 5 p.m. the next calendar day following the occurrence of a single confirmed infection or when 3 or more residents or staff had new-onset of respiratory symptoms occurring within 72 hours of each other prior to and during facility's COVID-19 outbreak. That had the potential to affect the 39 residents, their families, and resident representatives.<br><br>Findings include:<br><br>Interview on 1/23/23 at 10:30 a.m., assistant director of nursing (ADON), identified the facility had one resident who had tested positive for COVID-19 and was on transmission based precautions (TBP).<br><br>Observation on 1/23/23 at 10:35 a.m., of R5's room entrance identified he had personal protective equipment (PPE) stored outside of his room in a cart. R5 had a sign on his door identifying staff were to put on full PPE prior to entering his room.<br><br>Review of the facility staff testing logs identified on 1/21/23, licensed practical nurse (LPN)-A tested positive for COVID-19.<br><br>Interview on 1/23/23 at 3:45 p.m., with family member (FM)-A revealed they had been notified earlier that day of the positive COVID-19 case that occurred on 1/21/23.<br><br>Interview on 1/23/23 at 4:00 p.m., with FM-B revealed he had never been notified of a positive | F 885 | COVID-19 – Documenting and Reporting Policy was reviewed and timeframe for notification was updated to comply with COVID-19 reporting requirements. Policy now reads; “Administrator or delegated staff member will inform residents, their representatives, and families of those residing in the facility by 5pm the next calendar date following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other.”.<br>Established a new communication system that allows facility to access platform from anywhere, update at any time, and deliver more efficiently.<br>Template was created to send out each time communication is made following a positive case that includes;<br>A) Mitigation measures that facility is taking to prevent the spread of infection.<br>B) Any part of operations that will be altered.<br>C) The number of staff and residents currently positive.<br>All positive case notifications will now stream through this online system.<br>Administrator and DON have access to this communication platform.<br>ADON and DON will audit notifications to families, representatives, and families daily x 1 week, weekly x4, and monthly x 3 months.<br>Reporting process will be added to QAPI meeting agenda to review audit and ensure compliance. | |

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| F 885 | Continued From page 5<br>COVID-19 case at the facility since the beginning of COVID-19 in 2020.<br><br>Interview on 1/23/23 at 4:30 p.m., with FM-C revealed he had received a facility generated notification only 2 hours ago regarding the newly identified 1/21/23, COVID-19 positive case.<br><br>Review of the undated, facility Automated Broadcasting Summary identified the notification to families and representatives of a COVID-19 had been newly created on 1/23/23 at 1:17 p.m.<br><br>Interview on 1/25/23 at 3:22 p.m., with administrator identified she confirmed notifications to families and representatives had not been completed by 5:00 p.m., the next calendar day following a single occurrence of a confirmed positive COVID-19 case. The administrator revealed she was responsible to ensure notifications were sent out to families and representatives by 5:00 p.m. the next calendar day.<br><br>Review of the 5/23/22, Coronavirus Disease (COVID-19)-Documenting and Reporting COVID-19 Testing policy identified the facility was responsible to report identified COVID-19 cases in the facility to residents, families, and representatives according to requirements. The policy lacked identification of a time frame for reporting positive COVID-19 cases. | F 885 | | |

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| | 245570 | A. BUILDING **01 - MAIN BUILDING 01**<br>B. WING _____ | **01/24/2023** |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| **MAPLE LAWN SENIOR CARE** | **400 SEVENTH STREET**<br>**FULDA, MN 56131** |

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| K 000 | INITIAL COMMENTS<br><br>FIRE SAFETY<br><br>An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 01/24/2023. At the time of this survey, Maple Lawn Senior Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code.<br><br>This one-story with partial basement facility was built in 1964, with building additions constructed in 1991 and 2001. All are fully sprinklered. The 1991 addition was determined to be of Type II (000) construction. The 1964 and 2001 buildings were determined to be of Type II (111) construction.<br><br>BLDG 02 was constructed in 2004, as an addition to the existing nursing home. It is one-story, has a partial basement and is fully sprinklered, and was determined to be of Type II (111) construction. It consists of a new activities room, new entrance and an elevator/elevator lobbies. There are no patient sleeping or treatment areas in Building 02.<br><br>The facility had a capcity of 46 beds and had a census of 39 at time of the survey.<br><br>The requirements at 42 CFR, Subpart 483.70(a), are MET. | K 000 | | |

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

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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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **MAPLE LAWN SENIOR CARE** | **400 SEVENTH STREET**<br>**FULDA, MN 56131** |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|---|---|---|---|---|
| | | | | |

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
March 22, 2023

CMS Certification Number (CCN): 245570

Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, MN  56131

Dear Administrator:

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 March 9, 2023 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 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/or 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
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112  Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

*Protecting, Maintaining and Improving the Health of All Minnesotans*

Electronically delivered
March 22, 2023

Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, MN  56131

RE: CCN: 245570
Cycle Start Date: January 25, 2023

Dear Administrator:

On February 15, 2023, we notified you a remedy was imposed. On March 13, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of March 9, 2023.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 25, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 15, 2023, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from April 25, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on March 9, 2023, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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