### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QPBP

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I - TO BE COMPLETED BY THE					STATE SURVEY AGENCY Facility ID: 00037			
MEDICARE/MEDICAID PROVIDER N     (L1) 245362     2.STATE VENDOR OR MEDICAID NO.     (L2) 106540800	NO.	3. NAME AND ADDRESS OF FACILITY (L3) MAPLETON COMMUNITY HOME (L4) 301 TROENDLE STREET (L5) MAPLETON, MN				56065	4. TYPE OF AC  1. Initial  3. Termination  5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visi 8. Full Survey	t 9. Other After Complaint
6. DATE OF SURVEY 10/22/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	C015 (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 E	NDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	<ul><li>60 (L18)</li><li>60 (L17)</li></ul>	Compliance  1. Ac  B. Not in Com		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	7. Medica	of Services Limit 1 Director Room Size
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY M	IEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	RVEY AGENCY	APPROVAL	Date:
Joseph Garvey, HFE NE II		1	0/28/2015	(L19)	Kamala Fiske	-Downing, I	Enforcement Sp	pecialist 10/28/2015 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OF	R SINGLE S'	TATE AGENCY	<i>Y</i>
DETERMINATION OF ELIGIBILITY			IPLIANCE WITH	H CIVIL	<ol> <li>Statement of Financial Solvency (HCFA-2572)</li> <li>Ownership/Control Interest Disclosure Stmt (HCFA-1513)</li> <li>Both of the Above :</li> </ol>			
22. ORIGINAL DATE 2:	3. LTC AGREEI	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Clos		05-Fa	DLUNTARY il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involu			il to Meet Agreement
25. LTC EXTENSION DATE: 27. (L27)	A. Suspension	VE SANCTIONS n of Admissions: aspension Date:	(L44) (L45)		04-Other Reason	•	OTH	ovider Status Change
28. TERMINATION DATE:	29	). INTERMEDIARY/			30. REMARKS			
		03001						
	(L28)	35001		(L31)				
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	DATE				
	(L32)			(L33)	DETERMIN.	ATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245362

October 28, 2015

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

Dear Ms. Gosson:

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

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

Effective October 5, 2015 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

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



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 28, 2015

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

RE: Project Number S5362023

Dear Ms. Gosson:

On September 11, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 27, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On October 22, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 7, 2015 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 August 27, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 5, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 27, 2015, effective October 5, 2015 and therefore remedies outlined in our letter to you dated September 11, 2015, 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,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

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

### Form Approved OMB NO. 0938-0390

#### **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 245362	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2015
Nam	e of Facility		Street Address, City, State, Zip Code	
M	APLETON COMMUNITY HOME		301 TROENDLE STREET MAPLETON, MN 56065	

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) D	ate	(Y4)	Item	(Y5)	Date	
ID Prefix	F0221	Correction Completed 10/05/2015	ID Prefix	F0248	Co	rrection mpleted 05/2015		ID Prefix	F0279	Correction Complete 10/05/201	ed
	483.13(a)			483.15(f)(1)					483.20(d), 483.20(k		
	F0282 483.20(k)(3)(ii)	Correction Completed 10/05/2015	ID Prefix Reg. # LSC	F0309 483.25	Co	rrection mpleted (05/2015			F0325 483.25(i)	Correction Complete 10/05/201	ed
ID Prefix Reg. # LSC	F0431 483.60(b), (d), (e)	Correction Completed 10/05/2015			Co	rrection mpleted					
Reg. #			Reg. #			rrection mpleted					
Reg. #			Reg. #		Co	rrection mpleted		ъ "			
Reviewed E	By Revi	ewed By	Date:	Signature	of Survey	or:			Date	<b>)</b> :	
State Agen	10/1		10/28/201	15		2211	3			11/22/20	15
Reviewed E	By Revi	ewed By	Date:	Signature	of Survey	or:			Date	<b>):</b>	
Followup t	o Survey Complet 8/27/2015			Check for any Uncorrecte					Summary of the Facility? YES	S NO	

### Form Approved OMB NO. 0938-0390

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

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(Y1) Provider / Supplier / CLIA / Identification Number 245362	(Y2) Multiple Construction A. Building B. Wing 01 - MAI		IN BUILDING 01	(Y3) Date of Revisit 10/7/2015
Name of Facility			Street Address, City, State, Zip Code	
MAPLETON COMMUNITY HOME			301 TROENDLE STREET	
			MAPLETON MN 56065	

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	(Yt	i) Date	(Y4)	Item	(Y5)	Date
ID Prefix		Correction Completed 08/25/2015	ID Prefix		Correction Completed 08/25/2015		ID Prefix		Correction Completed
	NFPA 101			NFPA 101			- "		
LSC	K0029		LSC	K0144	<del>-</del> -		LSC		
		Correction			Correction				Correction
ID Dueffy		Completed	ID Duefic		Completed		ID Duefis		Completed
Reg. # LSC			Reg. # LSC		<u> </u>		Reg. # LSC		
		Correction			Correction				Correction
ID D ('		Completed	15.5 "		Completed		15.5 °		Completed
	-				_				
Reg. #			Reg. #		_		Reg. #		
			130		_				
		Correction			Correction				Correction
ID Prefix		Completed	ID Profix		Completed		ID Profix		Completed
					_				
Reg. # LSC			Reg. # LSC		<del>-</del>		Reg. # _ LSC _		
		Correction			Correction				Correction
ID D ('		Completed	15.5 "		Completed		15.5 °		Completed
					_				
Reg. # LSC			Reg. # LSC		<del>-</del>		Reg. # _ LSC _		 
Reviewed I	By Re	eviewed By	Date:	Signature of St	ırveyor:			Date	
State Agen	cy G	S/kfd	10/28/201	5			10/	07/2015	
Reviewed I	Ву Re	eviewed By	Date:	Signature of Su	ırveyor:			Date	
CMS RO									
Followup t	to Survey Comp 8/25/20			Check for any Uncourected Def					NO
	0/23/20	710	Ì		(		,	, 159	NO

### Form Approved OMB NO. 0938-0390

#### **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 245362	(Y2) Multiple Construction A. Building B. Wing 02 - 2	011 ADDITION	(Y3) Date of Revisit 10/7/2015
Name of Facility		Street Address, City, State, Zip Code	
MAPLETON COMMUNITY HOME		301 TROENDLE STREET	
		MAPLETON MN 56065	

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 08/25/2015	ID Prefix		Correction Completed 08/25/2015		ID Prefix		Correction Completed
	NFPA 101			NFPA 101			<b>-</b> "		
LSC	K0011		LSC	K0144			LSC		
		Correction			Correction				Correction
ID Dorth		Completed	ID Doctor		Completed		ID Destin		Completed
Reg. # LSC			Reg. # LSC				Reg. # LSC		
		Correction			Correction				Correction
ID Dorfo		Completed	ID Doctor		Completed		ID Destin		Completed
Reg. # LSC			Reg. # LSC				Reg. # LSC		<u></u>
		Correction			Correction				Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix		Completed
Reg. #			Reg. #						
LSC							LSC		
		Correction			Correction				Correction
ID Profix		Completed	ID Profix		Completed		ID Profix		Completed
Reg. #									
			LSC				LSC		
Reviewed E	By Ro	eviewed By	Date:	Signature	e of Surveyor:			Date	
State Agen	cy G	S/kfd	10/28/201	5	35482		10/	/07/2015	
Reviewed E	3y R	eviewed By	Date:	Signature	e of Surveyor:			Date	
CMS RO									
Followup t	o Survey Comp 8/25/20				y Uncorrected Def ed Deficiencies (Cl				NO



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered October 28, 2015

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

Re: Reinspection Results - Project Number S5362023

Dear Ms. Gosson:

On October 22, 2015 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 22, 2015. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Riske. Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

	State Form: Revisit Report								
(Y1)	Provider / Supplier / CLIA / Identification Number 00037	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 10/22/2015					
Name	of Facility		Street Address, City, State, Zip Code						
MA	PLETON COMMUNITY HOME		301 TROENDLE STREET MAPLETON, MN 56065						

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

D Prefix   20505	rection npleted 15/2015 ID Pre Reg L: rection npleted ID Pre Reg		Correction Completed 10/05/2015 Subp.  Correction Completed	
Reg. # LSC	rection npleted 15/2015 ID Pre Reg L: rection npleted ID Pre	efix 21435 MN Rule 4658.0405  MN Rule 4658.0405  MN Rule 4658.0900  efix 4  ef	Correction Completed 10/05/2015 Subp.  Correction Completed	
Completed   10/05/2015   ID Prefix   20965   10/05   2016     2016   2	npleted 05/2015  ID Pre  Reg L  rection npleted  ID Pre  Reg	mN Rule 4658.0900 SC  efix	Completed 10/05/2015 Subp.  Correction Completed	
Correction   Correction   Correction   Corpleted   Correction   Corr	rection npleted ID Pre	efix 	Correction Completed	
Completed   Completed   Completed   Completed   Completed   ID Prefix   Reg. # LSC   LSC   Correction   Cor	L	SC		
	rection npleted ID Pre Reç L			
Completed ID Prefix ID Prefix Reg. # LSC LSC LSC	Reg	efix g. # SC		
Reviewed By	or: 22113	Date:	10/22/2015	
	Signature of Surveyor:			
	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?			

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: QPBP

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

PART I - TO BE COMPLETED BY TH					STATE SURVEY AGENCY Facility ID: 00037			
MEDICARE/MEDICAID PROVIDER     (L1) 245362     2.STATE VENDOR OR MEDICAID NO     (L2) 106540800		3. NAME AND ADDRESS OF FACILITY (L3) MAPLETON COMMUNITY HOME (L4) 301 TROENDLE STREET (L5) MAPLETON, MN			(L6) <b>56065</b>		4. TYPE OF A  1. Initial  3. Terminatio  5. Validation	2. Recertification a. CHOW b. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)		7. PROVIDER/SU	05 HHA	09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Site Visit 9. Other  8. Full Survey After Complaint	
6. DATE OF SURVEY 08/27  8. ACCREDITATION STATUS:  0 Unaccredited 1 TJC 2 AOA 3 Other	<b>7/2015</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 E	ENDING DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b):  12.Total Facility Beds  13.Total Certified Beds	60 (L18) 60 (L17)	Complianc  X 1. A  B. Not in Con		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	nical Personnel	7. Medic	of Services Limit al Director Room Size
14. LTC CERTIFIED BED BREAKDOV	VN				15. FACILITY M	IEETS		
18 SNF 18/19 SNF	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 1	DATE):				
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	RVEY AGENCY	APPROVAL	Date:
Wendy Buckholz, HFE NE II 10/12/2015				(L19)	Kamala Fiske	-Downing, I	Enforcement S	pecialist 10/15/2015 (L20)
PAR	T II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	L OFFICE OF	R SINGLE S'	TATE AGENC	Y
DETERMINATION OF ELIGIBILE			IPLIANCE WITH HTS ACT:	H CIVIL	21. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above :			
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	4. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATION 12/01/1986	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 01-Merger, Clos		05-Fa	DLUNTARY ail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction 03-Risk of Involu			nil to Meet Agreement
25. LTC EXTENSION DATE: (L27)	_	VE SANCTIONS n of Admissions: uspension Date:	(L44) (L45)		04-Other Reason	•	07-P	ER rovider Status Change ctive
28. TERMINATION DATE:	29	). INTERMEDIARY/			30. REMARKS			
	27	03001						
	(L28)	00001		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMIN.	ATION APPI	ROVAL	



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 11, 2015

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

RE: Project Number S5362023

Dear Ms. Gosson:

On August 27, 2015, 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. In addition, at the time of the August 27, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D) a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the August 27, 2015 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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>Electronic 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:

Gail Anderson, Unit Supervisor Fergus Falls Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: gail.anderson@state.mn.us

Phone: (218) 332-5140 Fax: (218) 332-5196

### **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 6, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- 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 ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 ePoC

must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, 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 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.

### 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 November 27, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new

admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 27, 2016 (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 Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable 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. Gary Schroeder, Interim Supervisor Health Care Fire Inspections State Fire Marshal Division Email: gary.schroeder@state.mn.us

**Telephone: (651) 201-7205** 

Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

PRINTED: 10/12/2015 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION ()	(3) DATE SURVEY COMPLETED
		245362	B. WING		08/27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO	МЕ		STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENT	-S	F 000		
		cation survey was completed . Deficiencies were found. 567 form.			
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve f compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 lic submission of the POC will ion of compliance.			
F 221 SS=D	on-site revisit of you validate that substate regulations has been your verification.		F 22 <sup>-</sup>		10/5/15
	physical restraints i	e right to be free from any mposed for purposes of lience, and not required to medical symptoms.			
	by: Based on observate review the facility factoric for least amount assessment for 1 controls ample who was observed.	ion, interview and document alled to use the least restrictive bount of time based on an of 1 resident (R22) in the eserved to have restraints that m of movement in wheelchair		This Plan of Correction constitutes in written allegation of compliance for the deficiencies cited. However, submiss of this Plan of Correction is not an admission that a deficiency exists or one was cited correctly. This Plan of Correction is submitted to meet requirements established by state an federal law.	ne sion that
ABORATORY	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 

09/21/2015

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		E SURVEY PLETED	
		245362	B. WING		08/:	27/2015
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MADLET	ON OOM !!!			301 TROENDLE STREET		
MAPLEI	ON COMMUNITY HO	ME		MAPLETON, MN 56065		
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F 221	Continued From pa	age 1	F 2	21		
	assessment, dated diagnoses which ir kidney disease and MDS identified R22 cognition and requistaff for bed mobility in MDS identified R22 staff with mobility in R22's admission Codated 8/6/15, ident dementia, weakne cognitive impairment activities of daily live transfer and utilize CAA identified R22 and go recliner about herapy goal of R2	Minimum Data Set (MDS) 17/31/15, identified R22 had included dementia, chronic d behavioral disturbance. The 2 had severe impaired ired extensive assist of two ty and to transfer. Further, the 2 required extensive assist of 1 in the wheelchair.  Fare Area Assessment (CAA), ified R22 had diagnoses of ss, knee pain, had severe ent, required assistance with all ring, was not able to stand and d a mechanical lift. Further, the 2 was able to move the rock but 10 feet on his own, with a 2 being able to move his imately 50 feet. The CAA		Immediate re-education was with nursing staff through was written resources. R22 will body pillow in room and chatilted for ¿safety¿. Neither as a restrictive device. As be available in room for repaid will only be used for consumption of Nursing staff were interviewd Director of Nursing, to determine the process of the	rerbal and no longer have air will not be will be utilized mall pillow will cositioning and nfort.  wed by the ermine other restrictive other concerns and the Director of the visual audits	
	identified R22 was stand independent transfers, alarms, I at bedside, and roo R22's admission or identified R22 required grooming, use of a use of a motion seand directed staff thowever, R22's carisks, goals or interest.	at risk for falls, not able to ly, used a mechanical lift for ow bed, sided mattress, matt ck and go wheelchair for safety.  are plan, dated 7/25/15, lired assistance with dressing, mechanical lift for transfers, nsor on the floor at bedside o anticipate his needs. The plan did not include any eventions for the use of the		inappropriate use of restrict and/or practice. If restrictiv necessary, it will be proper evaluated, documented, Rand Procedure will be followed plan will be written with appropriate and interventions. Not to be held September 28, 20 meeting to be held Octobe address all deficient nursing.	etive devices e devise is ly identified, estraint Policy wed and care propriate risks, urse's Meeting 2015 and NAR r 1, 2015 to g practices.	
	p.m. to 7:30 p.m. F	lined wheelchair.  of R22 on 8/24/15, from 1:30 R22 was observed seated in his ir in front of the nurses station		conduct 6 monthly audits w specific to R22 for 3 month findings will be reported at and will be monitored until consistent substantial com been met.	ns. The audit the QA meeting such time	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245362	B. WING	<del> </del>	08	/27/2015
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F 221	into his room for permeals. R22 was obpositioned in his rewhere the chair was to attempt to sit for wheelchair when reso.  During observation a.m. R22 was obseroom and placed in nurses station. Nur observed to recline that he was in a newas noted to have cord, between the shirt.  During interview on NA-E stated R22's keep R22 from beinthe chair. NA-E stated rechair but he was not stated, "When the cotton get out of the whole the shirt.  During observation p.m. NA-E and NA-attached R22 to a recomplete the chair but he was not stated, "When the cotton get out of the whole side in bed. During on 8/25/15, at 1:50 not try to get out of because they put a in bed. The opposition was side in bed. The	inge 2 iods when he was wheeled ersonal cares or attended served multiple times clining wheelchair in a manner is reclined. R22 was observed ward in his reclining eclined but was unable to do of cares on 8/25/15, at 10:09 erved to be wheeled from his the hallway in front of the sing assistant (NA)-E was R22 back in his recliner so ar back lying position. R22 a safety alarm, attached with a back of his wheelchair and his wheelchair was leaned back to hig able to self-transfer from the ted R22 could try to get out of of steady or safe. NA-E further hair is reclined [R22] is unable eelchair without assistance.  of cares on 8/25/15, at 1:40 on entered R22's room and mechanical lift. NA-E and lift. NA-E and lift interview with NA-E and NA-D p.m. the staff stated R22 did bed as much as he used to body pillow beside him when e side of R22's bed was m wall. NA-E and NA-D further	F 2	Completion date October 5,	2015	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 301 TROENDLE STREET MAPLETON, MN 56065		
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F 221	wheelchair when it impeded his ability R22 lying in his bed pillow holding him i During observation p.m. R22 was obseside with a body pil his right side. A ser the floor beside the other side of the bed On 8/25/15, at 3:34 his bed with a body him in a right sided have a sensor alar R22 was observed back while lying in I remove the pillow funable to remove it he was unable to mis positioning.  During review of R2 notes identified R23 times and did atternand bed at times. Twas identified in the room where he had was noted to be sless Staff were alerted by resident yelling "he on his footrests and	attempt to get out of his was leaned back as it to do so. NA-E and NA-D left don his right side with a body in that position.  of cares on 8/25/15, at 2:34 erved lying in bed on his right low behind him holding him on a sor monitor was observed on egress side of his bed and do was against the wall.  p.m. R22 remained lying in pillow beside him supporting position. R22 was noted to m on the floor beside his bed. attempting to turn onto his bed and reaching to attempt to rom behind him but was attempted and reaching to attempt to rom behind him but was attempted and reaching to attempt to rom behind him but was attempted and reaching to attempt to rom behind him but was attempted and reaching to attempt to rom behind him but was attempted and reaching to attempt to rom behind him but was attempted and change attempted to wheel himself at the pillowing documentation.	F 22			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY MPLETED
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F 221	of 3 staff back to his room where range of completed and vital he was changed to -On 8/2/2015, at 9:20 of bed at 9 p.m. set -On 8/6/2015, at 12 climb out of recliner kicking at writer who cream on his lower his lower legs.  -On 8/15/2015, at 4 himself to Old Wing -On 8/20/2015, at 3 (pounding on wall, cout for help). Call ligposition, floor alarm. The progress notes capable of wheeling in bed and capable out of his wheelchat a.m. NA-A stated set R22 in his wheelchat transfer out of it and utilized when he was from attempting to stated she knew R2 and set and s	vas than hoyered with assist is wheelchair and taken to his of motion (ROM) was signs (VS) taken. At this time a rock-n-go chair for safety.  29 p.m. resident sat up on side ting off his motion sensor.  19 p.m. resident trying to this morning. Resident en she was putting eucerin extremities and ace wrapping  33 p.m. resident wheeled staff brought him back.  43 a.m. resident restless crawling out of bed and yelling ght in reach, bed in low on.  demonstrated R22 was ghimself, capable of sitting up of attempting to transfer self ir.  h NA-A on 8/26/15 at 10:17 taff were directed to recline air to keep him from trying to distated the body pillow in bed was to keep R22 self transfer from bed. NA-A capable of sittimes attempted to get not observed him attempting to	F 22	1		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	FIPLE CONSTRUCTION  NG		TE SURVEY MPLETED
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F 221	a.m. NA-C stated his bed and the boout. NA-C stated shis chair but stated wheelchair reclined transfer and fall.  During interview w (DNS) and registe 11:02 a.m. they conot been develope pillow or reclining wheelchair restrictive native had not been reclining wheelchair restrictive native utilized as restrictive native was not aware reclined position in aware of the use of the restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not assess how they not seem to be utilized as restrictive had been not seem to b	ith NA-C on 8/26/15, at 10:53 R22 did attempt to get out of dy pillow kept him from getting he had not seen him get out of d she had been told to keep his d so he did not attempt to self  ith the director of nursing red nurse (RN)-C on 8/26/15, at nfirmed R22's care plan had d to identify the use of the body wheelchair. The DNS stated in an assessment of the ir or the body pillow to assess ure as neither were intended to aints. The DNS further stated the staff were locking R22 in a his wheelchair and was not f body pillows. RN-C verified assessment of the devices to night restrict R22  with access to his body and icted by the use of the body g chair. R22 was observed to wheel himself around in his ne wheelchair was not reclined	F 2	,		
	whether safe or not Further, R22 was in his bed when the behind him. R2 was observed to not be behind him and re comfortable lying p	ity of getting out of the chair, ot, when it was not reclined. The stricted from free movement the body pillow was placed as visibly agitated when the able to remove the pillow from position himself to a more position.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  IG	` /	E SURVEY IPLETED
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F 221	staff how to utilize of R22 was not restrict R22 was not restrict. The facility's policy identified residents physical restraints i discipline or staff coassess the restraint possible for resident. Staff will identify unsafe. (frequent factor injury to self). Attorner on the effect of the interdisciplinary attempt by making Make sure all falls as 2. The resident care evaluate use of alter appropriate charting 3. The RCC will conassessment, which have been tried and 4. Obtain a physicia restraint, the reason the restraint will be 5. A safety assessment at care conferences	develop a care plan to direct devices and failed to ensure ted by the interventions used.  Physical restraints, undated, have a right to be free of imposed for the purpose of onvenience. Staff would at for the least restrictive devise at scomfort and safety.  If the following procedures-resident's behavior that is alls, improper body alignment, empt different alternatives, of the alternative. Make sure team (IDT) is aware of an inote on 24-hour report sheet. The coordinator (RCC) will ematives and make sure g is in residents chart. Implete a physical restraint will include alternatives that diffailed.  In order which include, type of in for the restraint, and when	F 22	.1		
F 248 SS=D	483.15(f)(1) ACTIV INTERESTS/NEED  The facility must pro		F 24	8		10/5/15
		assessment, the interests and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		245362	B. WING		08/2	7/2015	
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F 248	the physical, menta of each resident.  This REQUIREMEI by: Based on observareview the facility factivity needs base assessment for 2 of the sample who we findings include: R14's annual Mininassessment dated diagnoses that includementia, anemia a identified R22 requione staff for mobiliti was somewhat impactivities with other favorite activities and music she likes and R14's quarterly Act 6/26/15, identified R3-5 times a week. The eded reminders activities and identifies and identif	NT is not met as evidenced tion, interview and document ailed to provide the necessary d on comprehensive if 3 residents (R14 and R22) in the reviewed for activities.  Thum Data Set (MDS) 6/25/15 identified R14 had added major depression, and atrial fibrillation. The MDS ired extensive assistance of the interviewed for R14 to do group so, keep up with news, do her and very important to listen to digoing outside.  The assessment, dated R14 participated in activities The assessment identified R14 and assistance to attend fied she demonstrated	F 248	Immediate re-education was comp with all Therapeutic Recreation Sta regards to activity needs, socializat documentation. Care Plans of R22 R18 were reviewed and updated to include in room activities, radio and television. A "Textile" activity was introduced to all residents, including & R18. R22 has increased 1:1 visits scheduled. Reminders and invitation be given to both R22 and R18 for gactivity events.  If TR staff note any decline in activinattendance, they will immediately in Therapeutic Recreation Director. Recreation care plans and program be reviewed for all residents.  TRD will review and revise care plate monthly and with significant changes Dementia specific activities will be introduced for appropriate residents including but not limited to ¿Textiles	ff in ion and and and d/or g R22 s ons will group dify ans will ans e.		
	R14's Care Plan fo identified R14 had which she has been identified R14 had sleeping more. The R14's interest in ac	r activities, dated 7/6/15, liked to read romance novels, n not doing. The care plan been watching TV and care plan further identified tivities as:		Awareness of activity in room will be ducated to all staff, to include but limited to television, reading materizadio, CD players, and books on tal TRD will complete weekly audits of activity participation logs for complete documentation and activity level.  Re-education for TR staff socialization.	not als, pe. the ete		

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F 248	she finds in them.  2. Going to and enj program, where sh week.  3. Going to exercise  4. Going to music p  5. Wheeling around afternoons.  6. Reading out loud working well for hel reading but due to she declined book  R14's care plan go activities at least 3-for activity were ide activity schedule, Ir attend activities of i programs), assist to socialization, and comaterials for independent of the second	oying Music and Motion e is participating 3-5 days a e program on occasion. orograms as well. d the halls in the late d program, which has been r. R14 has always enjoyed sight she hasn't been able to.	F 248	interests met and proper com documentation. The audit find reported at the QA meeting a monitored until such time con substantial compliance has b Completion date October 5, 2	dings will be nd will be asistent een met.	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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F 248	front of her recliner and television off. F wheelchair until las she remained seate with no stimulus in During observation was observed in the dining room table in placed at the table the table was at the observed sleeping 8/25/14 R14 was w to her room and lef front of her recliner television off. There observed until 11:30 out of her room and noon meal at 11:30 dining room until as she was wheeled b transferred from he her room. R14 was out and no stimulus 8/25/15 R14 remain her recliner in her room other than he which is out of her observed through 3 remained in her reactivity occurring.  During phone intered on 8/25/15, at 9:56	in her room and left seated in in her room with the light off R22 remained seated in her tobserved at 7:45 p.m. when ed in her room in her recliner	F 24	8		
	facility environment R14 was frequently	The family member stated in her room in her wheelchair g offered to her for activities or				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
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	PROVIDER OR SUPPLIER ON COMMUNITY HO	ME		STREET ADDRESS, CITY, STATE, ZIP COI 301 TROENDLE STREET MAPLETON, MN 56065		,,_
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 248	a.m. R14 was obset wheelchair with eye television was on be 8/26/15, at 7:30 a.m. her w/c in her room wheelchair with no On 8/26/15 at 8:24 seated in her wheeleft with eyes close at 8:40 a.m. R14 wof her room to the at the dining room wheeled out of the then transferred intrecliner with no stime remained in her recapproximately 12:1 of her recliner and wheeled to the dinible served her noor eating by staff plac spoon. R14 was not the table. At 1:20 p wheeled out of the was transferred into Again R14 was left no stimulus occurrion. The activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity schedules: 2:00 p.m., happy here was transpersed in the activity s	of cares on 8/26/15, at 6:40 erved in her room in her es closed. Roommates out out of the view of R14. On m. R14 was observed seated in a leaning to her left in her activity occurring in the room. a.m. R14 was observed elchair in her room leaning to d. No stimulus noted in room. as observed to be wheeled out main dining room and placed table. At 9:38 a.m. R14 was dining room and into her room to her recliner. R14 was left in mulus in the room. R14 cliner until the noon meal. At 0 pm. R14 was transferred out into her wheelchair then and room. R14 was observed to meal and be assisted with ing food in her mouth with a observed to be dining room to her room and to her recliner in her room. In the room with light off and	F 24	8		
	9:30 a.m., Exercise a.m., Bible study; 1	es; 10:00 a.m. Trivia; 10:30 1:00 a.m., Techniques; 11:30 otion: 2:00 p.m., craft: 3:30				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION  IG		TE SURVEY MPLETED
		245362	B. WING _		08	/27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 248	9:30 a.m., Exercise 11:00 a.m., Technic	le for 8/25/15 was as follows: s; 10:00 a.m. Brain games; ques; 11:30 a.m., music and social; 2:15 p.m. Bingo; 4:00	F 24	48		
	months of May, Jur revealed R22 had of in activities consisted R14's activity log id activities such as rehalls and watching revealed at times F the logs did not inclusted activities	tivity attendance logs for the ne, July and August 2015 documentation of attendance ently less than 2 times a week. entified R14 had independent esting, wheeling/walking in television. The documentation 114 refused a activity, however, ude why R14 was not when she did not attend nor that had been offered.				
	revealed a note on one to one visit whe her kids and activiti	ne to One Activity Log 8/2015 identified R14 had (1) ere staff visited with her about es she would do with the kids. ation of one to one visits was ility.				
	(AD) was interviewed be in one to one actimprovement and the discontinued. The Ademonstrated a deshould be reassess again. The AD conflongs and stated sto attend moves an	0:25 a.m. the activity director ed. The AD stated R14 used to tivities but had demonstrated ne one to ones were AD stated R14 had recently cline in activity attendance and sed for need for one to ones irmed the monthly attendance aff ask R14 frequently for her d motion and R22 often rified R14 was not involved in				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	1		E SURVEY PLETED
		245362	B. WING _			08/	27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HOI	МЕ		STREET ADDRESS, CITY, STATE, ZIP C 301 TROENDLE STREET MAPLETON, MN 56065	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD I	BE	(X5) COMPLETION DATE
F 248	spent the majority of AD verified R14 nere encouraged to partie enjoyed.  The facility failed to needs for R14 as exprovide services as one to one and group encourage R14 to a identified as importance. The facility did needs when they idented and attendance has the three days of ok 8/26/14, during time being conducted at observed to be encactively involved in observed to spend time in her room wistimulus (I.e televicinteraction).  R22's admission Massessment, dated diagnoses which including disease and MDS identified R22 cognition and requistaff for bed mobility MDS identified R22 staff with mobility in the staff with mobility with the staff with mobility with the staff with mobility with the staff with with the staff with with with the staff with with the staff wi	provide the necessary activity videnced by their failure to directed by their failure to directed by the care plan for up activities and failed to attend activities which she ant or somewhat important to not reassess R14's activities entified her activity preference is significantly changed. During oservation 8/24/15 through es when formal activities were the facility, R14 was not ouraged to attend or be any formal activities. R14 was the majority of the observation that he lights out and no sion, radio, or staff  Inimum Data Set (MDS) 7/31/15, identified R22 had cluded dementia, chronic behavioral disturbance. The had severe impaired red extensive assist of two y and to transfer. Further, the required extensive assist of 1 in the wheelchair.	F 24	48			
	R22's Activity asses	ssment dated 8/10/15					

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY MPLETED
		245362	B. WING _		08	/27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065	•	
(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 APPR DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 248	interests that include exercises, reading shopping, outdoors gardening and kee Further, the assess attending activities	past and current activity ded: cards, games, crafts, , music, sports, religion, s, watching television, ping current with news. sment identified R22 enjoyed both morning and afternoon, njoyed watching ball games on	F 24	8		
	R22 as dependent stimulation and sod disease process at further identified R focused for long peridentified as a milit singing and watchi. The care plan identified as a milit singing and watchi. The care plan identified attend/participate is weekly. Intervention 1. assist/escort to a 2. Invite to activitie 3. R22 is to have 1 and activities if unatevents.  4. R22 prefers actionary demanding simple, structured Motion 5. When R22 chools are for the structured motion and simple in the structured Motion 5. When R22 chools are forced in the structured motion and simple in the structured motion 5. When R22 chools are forced in the structured motion and structured motion are structured motion and structured motion and structured motion are structured motion.	to 1 bedside/in-room visits able to attend out of room vities which do not involve cognitive tasks. Engage in activities such as Music & eses not to participate in s, turn on TV, music in room to				
	p.m. to 7:30 p.m. F reclining wheelcha except for brief per	of R22 on 8/24/15, from 1:30 R22 was observed seated in his ir in front of the nurses station riods when he was wheeled ersonal cares and meal times.				

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		245362	B. WING		08/	/27/2015	
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 248	at 8:40 a.m. R14 whereakfast after bein R22 consumed his to wander around the near the dining room wheelchair. At 9:43 the dining room and nurses station recli approximately 10:00 room for a short pethe hallway in front a.m. R22 remained wheelchair until 11: wheeled into the dinat approximately 12 out of the dining rool left beside his bed 1:40 p.m. NA-E and and with the use of him into bed. At 2:3 R22 was not obserparticipate or attend R22 remained in him were occurring.  During observation 6:47 a.m. R22 was his back with eyes a.m. R22 was transof a mechanical lift R22 was wheeled is served his breakfast dining room until 9: wheeled out of the in front of the nurse was wheeled to his	of morning cares on 8/25/15, vas observed to be served ag assisted out of bed;. After breakfast R22 was observed he dining room and hallways in by wheeling himself in his a.m. staff wheeled R22 out of diplaced him in front of the ned in his wheelchair. At 0 a.m. R22 was wheeled to his riod then wheeled back to the of the nurses station at 10:09 diseated in his reclining 35 a.m. at which time he was ning room. After the noon meal 2:50 p.m. R22 was wheeled om and into his room. R22 was in the room with no activity. At di NA-D entered R22's room a mechanical lift transferred as p.m. R22 remained in bed. Wed to be encouraged to diany activities. At 3:37 p.m. as bed while group activities  of cares on 08/26/2015 at observed lying in his bed on closed. At approximately 8:05 aftered out of bed with the use and two staff. At 8:20 a.m. not the dining room and at meal. R22 remained in the 43 a.m. at which time he was dining room and to the hallway as station. At 9:49 a.m. R22 room by staff to change his illy soiled with breakfast foods	F 24	8			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245362	B. WING		08	/27/2015	
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP C 301 TROENDLE STREET MAPLETON, MN 56065			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 248	and liquids. At 9:55 seated in his wheel bed. There was no An activity note dat identified a care co interdisciplinary tea The note identified activities, cognitive interaction.  The activity schedu 9:30 a.m., Exercise a.m., Techniques; 12:00 p.m., happy ho The activity schedu 9:30 a.m., Exercise a.m., Bible study; 1 a.m. music and mo p.m., Rosary. The activity schedu 9:30 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Exercise 11:00 a.m., Techniques; 10:00 a.m., Exercise 11:00 a.m., Exerc	a.m. R22 was observed to be chair in his room beside his activity occurring in the room.  ed 8/12/2015, at 11:53 a.m. Inference was held with the mand R22's family member. R22 as dependent on staff for stimulation and social  le for 8/24/15 was as follows: s; 10:00 a.m. Trivia; 11:00 1:30 a.m., music and motion; our; 4:00 p.m., men's group. le for 8/25/15 was as follows: s; 10:00 a.m. Trivia; 10:30 1:00 a.m., Techniques; 11:30 tion; 2:00 p.m., craft; 3:30  le for 8/25/15 was as follows: s; 10:00 a.m. Brain games; ques; 11:30 a.m., music and social; 2:15 p.m. Bingo; 4:00	F 2	,			
	environment and sp his room or position	not involved in the facility bent the majority of his time in ned outside the nurses station. dance logs for the past month,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245362	B. WING _		08/	27/2015
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 248	since admission, id activities less than incomplete to ident activities when he coccasionally indicated dates were left blarentries that R22 we such as resting, who watching television 8/2015 identified R2 far for the month. It documented on R2 visited with in the homese, couldn't uncabout." On 8/19/15 R22's activity log the package from his fargoodies" he received to one visits noted.  The facility failed to needs for R22 as exprovide services as one to one and groencourage R22 to a identified as import himself. The facility R22 outside the activation or in his roowere occurring and offered to participat room he was left wistimulus occurring throughout the survor in bed with no te	lentified he attended formal 1 time a week. The logs were ify why R22 was not attending did not attend. The facility ted R22 refused but multiple nk. R22's activity log included ould do independent activities neeling/walking in halls and . The one to one activity log for 22 had (2) one to one visit so on 8/10/15 activity staff 2's activity log that R22 was allway,"wasn't making much derstand what he was talking 5 activity staff documented on neat they assisted him open a amily and talked about the red. There were no further one	F 24	48		
F 279 SS=D	interaction. 483.20(d), 483.20(k COMPREHENSIVE		F 2	79		10/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245362	B. WING		08/27/2015	
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME			3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 TROENDLE STREET MAPLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTION	
F 279	Continued From pa		F 279			
		the results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable stables to meet a resident's nd mental and psychosocial tified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise \$483.25 but are not provided as exercise of rights under the right to refuse treatment.).				
	by: Based on observareview the facility farelated to interventions for the sample who we skin tears.  Findings include: R22's admission Massessment, dated diagnoses which in kidney disease and	tion, interview and document ailed to develop a care plan ons for non-pressure related 2 of 3 residents (R8, R22) in the reviewed for bruising and inimum Data Set (MDS) 7/31/15, identified R22 had cluded dementia, chronic behavioral disturbance. The thad severe impaired		Immediate re-education was comp with nursing staff for writing of short care plans and following Policy and Procedures for Skin Tears and Brui Care plan and ongoing monitoring a healing of skin tear completed for F Skin tear is healed to date. Care plate ongoing monitoring until healing of completed for R8. Bruising has reso Will revise care plan to add risks, g and interventions in regards to R8; of bruising and/or bleeding due to F use.	sing. until	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245362	B. WING	<del></del>	08/	27/2015	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				301 TROENDLE STREET			
MAPLET	ON COMMUNITY HOI	ME		MAPLETON, MN 56065			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 279	staff for bed mobilit MDS identified R22 staff with mobility in During observations a.m. R22 was obse in the hallway in fro his feet dangling frowas noted to have storearms with the bentire aspect of bot of varying colors an also noted to have sthe medial aspect of covering a skin tear drainage under the During review of R2 noted R22 had a his aggressive towards have self injurious to on walls, wheelchair record contained madmission related to objects.  R22 had an admission conducted on 7/24/admitted with excess forearms. There was identified on the assume During further reviet the medical record risk factors, goals a risk of bruising or si	red extensive assist of two y and to transfer. Further, the required extensive assist of 1 in the wheelchair.  Is of cares on 8/25/15 at 10:09 rived seated in his wheelchair int of the nurses station with omichair unsupported. R14 severely bruised bilateral ruising encompassing the high forearms. The bruising was an Opsite (wound dressing) on of his left arm that was rewhich was presenting with dressing.  22's medical record it was story of being physically a staff and would sometimes behaviors such as pounding r, or tables. R22's medical ultiple notes since his of striking out at staff and would sometimes behaviors of the since his of striking out at staff and would sometimes of strikin	F 2	Licensed nursing and bath assist complete weekly skin audits of a residents and RN will assess as NARs will completed daily visual audits and report any concerns to charge nurse as soon as able. Linursing staff will follow Policy and Procedures for Skin Tears and Example and Exampl	I needed. skin of the censed of ruising.  a skin sion. Any d, care ing is boath in audits as as illy visual rns to the teration of in care the teration in nd in care the teration in the center of th		
		bruising or non pressure		Completion date October 5, 201	5		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245362	B. WING			08/2	27/2015
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP O 301 TROENDLE STREET MAPLETON, MN 56065	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE	(X5) COMPLETION DATE
F 279	on 8/26/15, at 11:02 current care plan di interventions for bro further verified there of the skin tear or brecord lacked any to R8's annual MDS, of moderate cognitive required extensive activities of daily living observations was observed to ha approximately 5 incher left arm and a cof her left arm and a cof her left hand. Du time, she stated that when she went to vago. R8 further indinarrow and she countering the home. bruises easily becan Review of an incide indicated the reside of the left arm that and a bruise to the cm by 4.0 cm. The bruised easily and to she had been out of what happened.  Review of R8'S cur included an order for aspirin.	th the registered nurse (RN)-C 2 a.m. it was verified R22's d not address risks, goals or uising or skin tears. It was e was no ongoing monitoring ruising as the treatment reatments for the skin tear. dated 6/3/15, identified R8 had impairment, no behaviors and assistance from staff for all ing (ADL).	F 2	79			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	X3) DATE SURVEY COMPLETED	
		245362	B. WING		08/27/2015
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME			3	TREET ADDRESS, CITY, STATE, ZIP CODE 01 TROENDLE STREET MAPLETON, MN 56065	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	Bruising and blood Review of the most include R8 as being or the use of a bloowere listed.  Interview with the d8/27/15 at 8:33 a.m should have been researched because she was a use of a blood thing 483.20(k)(3)(ii) SEF PERSONS/PER CATThe services provided by the service	e R8 as bruising easily, heavy clots (with nosebleeds)  current plan of care did not g at risk for bleeding/bruising d thinner. No interventions  irector of nursing (DON) on ., confirmed R8's bruising nonitored and care planned trisk for bruising due to the ner.  RVICES BY QUALIFIED	F 279		10/5/15
	by: Based on observat review the facility fa needs as directed b residents (R14 and reviewed for activiti nutritional needs as plan for 1 of 3 resid was reviewed for w  Findings include: R14's care plan for	ion, interview and document alled to provide the activity by the care plan for 2 of 3 R22) in the sample who were es and failed to provide the active care ents (R14) in the sample who eight loss.  activities, dated 7/6/15, quiet, private lady who like to		Immediate re-education was complete with all Therapeutic Recreation Staff in regards to activity needs, socialization a documentation. Care Plans of R22 and R18 were reviewed and updated to include in room activities, radio and/or television. A ¿Textile ¿ activity was introduced to both residents. R22 has increased 1:1 visits scheduled. Remind and invitations will be given to both R22 and R18 for group activity events. Re-education of dietary staff completed immediately for concern with R14 NIP program.	ers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245362	B. WING		08/2	7/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO	ME	3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 TROENDLE STREET MAPLETON, MN 56065	,	
(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 CORRECTIO  (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	read romance noved doing. The care plawatching TV and substituted further identified R. 1. Going through his she finds in them. 2. Going to and enprogram, where shweek. 3. Going to exercise 4. Going to music p. 5. Wheeling around afternoons. 6. Reading out loud working well for he reading but due to She declined book.  During observation 8/26/14 R14 was of her days in her reading but the reading but the television wother stimulus in her off and R14 was siremained in her root time she was wheeled and placed at the comeal time R14 speseated in her reclir staff attended to fe at the dining room eyes when staff placed.	els, which she has been not an identified R14 had been leeping more. The care plan 14's interest in activities as: er drawers and looking at what goying Music and Motion e is participating 3-5 days a e program on occasion. Orograms as well. It is the halls in the late deprogram, which has been recorded as always enjoyed sight she hasn't been able to.	F 282	If TR staff note any decline in active attendance, they will immediately in Therapeutic Recreation Director. Recreation care plans and program be reviewed for all residents. Weign NIP program and nutritional concent therapeutic diet and/or supplement reviewed for all residents and address needed.  TRD will review and revise care planonthly and with significant changon Dementia specific activities will be introduced for appropriate resident including but not limited to ¿Textile Awareness of activity in room will be educated to all staff, to include but limited to television, reading materizadio, CD players, and books on ta program list will be reviewed and utwice a month and as needed, by CADM. Weights will be reviewed as to identify need for therapeutic diet supplement. In service for all dieta will be held September 30th, 2015 include the NIP program. Nurse's Meeting to be held September 28, and NAR meeting to be held Octobe 2015 to address all deficient nursin practices.  TRD will complete weekly audits of activity participation logs for compledocumentation and activity level. Re-education for TR staff socializatinterests met and proper completic documentation. The audit findings	otify  ns will hts, rns for were essed  ans e. s, s, ie not als, pe. NIP pdated DM or needed and/or ry staff to  2015 per 1, g  the ete tion, n of	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245362	B. WING		<del> </del>	08/:	27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO			30	TREET ADDRESS, CITY, STATE, ZIP CODE 01 TROENDLE STREET 1APLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		BE	(X5) COMPLETION DATE
F 282	seated in front of hight off and televis in her wheelchair to when she remainer recliner with no stimular to be wheelchair in front and television off. R14 was wand wheeled to he wheelchair in front and television off. R14 observed untime wheeled out of her for the noon meal at the dining room unwhen she was wheeled out of her for the noon meal at the dining room unwhen she was wheeled out of her for the noon meal at the dining room unwhen she was wheeled in her recliner in her room other than he which is out of her observed through are mained in her reactivity occurring.  During observation a.m. R14 was observed through are activity occurring.  During observation a.m. R14 was observed through are activity occurring.	d wheeled to her room and left er recliner in her room with the ion off. R22 remained seated intil last observed at 7:45 p.m. d seated in her room in her	F 2	282	reported at the QA meeting and wil monitored until such time consister substantial compliance has been in The CDM, or designee, will conduct monthly audits during meals with 1 assigned specific to R14 for 3 mon The audit findings will be reported a QA meeting and will be monitored such time consistent substantial compliance has been met.  Completion date October 5, 2015	nt net. et 3 ths. at the	

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		245362	B. WING		08.	/27/2015
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
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F 282	On 8/26/15 at 8:24 seated in her whee left with eyes close at 8:40 a.m. R14 w of her room to the rat the dining room of placed at the table level met the edge small portions of he assistance. At 9:38 the dining room and transferred into her recliner with no stim remained in her recapproximately 12:1 of her recliner and wheeled to the dining be served her noon eating by staff places spoon. R14 was not the table. At 1:20 p wheeled out of the was transferred into Again R14 was left no stimulus occurriors. R14's activity attended the table at the was left no stimulus occurriors. The sactivity attended the served her noon the did not a indicated R14 refusion. R14's activity would do independ wheeling/walking in The one to one act R14 had (1) one to	activity occurring in the room. a.m. R14 was observed lchair in her room leaning to d. No stimulus noted in room. as observed to be wheeled out main dining room and placed table. R14 was observed to be in a position where her eye of the table. R14 only ate er meal with full staff a.m. R14 was wheeled out of d into her room then recliner. R14 was left in nulus in the room. R14 cliner until the noon meal. At 0 pm. R14 was transferred out into her wheelchair then ng room. R14 was observed to a meal and be assisted with ing food in her mouth with a at social and did not interact at .m. R14 was observed to be dining room to her room and other recliner in her room. in the room with light off and	F 28	2		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ( (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282		she would do with the kids.	F 2	82		
	(AD) was interviewed be in one to one accomprovement and the discontinued. The Ademonstrated a destroy of the AD states again. The AD states her to attend moves refused. The AD verified R14 needs to the AD verified R14	0:25 a.m. the activity director ed. The AD stated R14 used to tivities but had demonstrated he one to ones were AD stated R14 had recently cline in activity attendance and sed for need for one to ones ed staff ask R14 frequently for s and motion and R22 often wrified R14 was not involved in the facility environment and of her time in her room. The eded to be asked and icipate in activities she typically				
	R22 as dependent stimulation and sood disease process and further identified R2 focused for long peridentified as a militar singing and watching television. The care to attend/participate weekly. Intervention 1. assist/escort to a 2. Invite to activities 3. R22 is to have 1 and activities if unand events.  4. R22 prefers activity overly demanding of					

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F 282	Motion 5. When R22 choose organized activities provide sensory stire. During observation p.m. to 7:30 p.m. Reclining wheelchair except for brief perinto his room for a 8:40 a.m. R14 wheelchair. At 9:43 the dining room and nurses station reclinated his lift provided his held in the hallway in front a.m. R22 remained wheelchair until 11: wheeled into the dinated approximately 12 out of the dining room left beside his bed in 1:40 p.m. NA-E and attached his lift sling transferred him into remained in bed. Reencouraged to partinto a significant provided his were occurred buring observation.	ses not to participate in turn on TV, music in room to mulation  of R22 on 8/24/15, from 1:30 22 was observed seated in his in front of the nurses station ods when he was wheeled rsonal cares and meal times.  of morning cares on 8/25/15, as observed to be served g assisted out of bed;. After breakfast R22 was observed he dining room and hallways in by wheeling himself in his a.m. staff wheeled R22 out of d placed him in front of the hed in his wheelchair. At 0 a.m. R22 was wheeled to his riod then wheeled back to the of the nurses station at 10:09 d seated in his reclining 35 a.m. at which time he was hing room. After the noon meal 2:50 p.m. R22 was wheeled om and into his room. R22 was in the room with no activity. At d D entered R22's room and g to the mechanical lift and bed. At 2:35 p.m. R22 22 was not observed to be cipate or attend any activities.	F 28	32		

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F 282	his back with eyes a.m. R22 was trans of a mechanical lift R22 was wheeled in served his breakfast dining room until 9: wheeled out of the in front of the nurse was wheeled to his shirt as it was heav and liquids. At 9:55 seated in his wheel bed. There was no R22's activity attensince admission, id activities less than incomplete to ident activities when he coccasionally indicated dates were left blar entries that R22 we such as resting, who watching television 8/2015 identified R2 far for the month. In documented on R2 visited with in the his sense, couldn't und about." On 8/19/15 R22's activity log the package from his far goodies" he receiv to one visits noted.	ge 26 closed. At approximately 8:05 ferred out of bed with the use and two staff. At 8:20 a.m. Into the dining room and at meal. R22 remained in the 43 a.m. at which time he was dining room and to the hallway as station. At 9:49 a.m. R22 room by staff to change his ily soiled with breakfast foods a.m. R22 was observed to be chair in his room beside his activity occurring in the room.  I time a week. The logs were ify why R22 was not attending did not attend. The facility and R22 refused but multiple ack. R22's activity log included and do independent activities activity allow in halls and and the one to one activity log for activity log that R22 was allway, "wasn't making much berstand what he was talking activity staff documented on at they assisted him open a amily and talked about the activity director  0:25 a.m. the activity director	F 29	32		
	(AD) was interviewe	ed. The AD stated R22 was yed in activities. The AD stated				

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F 282	R22 was on 1 to 1 locate his one to o R22 was asked if hut often declined agreed R22 was nenvironment and shis room or position. The activity schedus a.m., Techniques; 2:00 p.m., happy how the activity schedus of the study; a.m. music and map.m., Rosary. The activity schedus of the study; a.m. music and map.m., Rosary. The activity schedus of the study; a.m., Exercisan, Bible study; a.m. music and map.m., Rosary. The activity schedus of the study; a.m., Exercisan, Discard it did the study of th	activities but was unable to me logs. The AD also stated he wanted to attend activities. The AD further stated she of involved in the facility pent the majority of his time in ned outside the nurses station.  The AD further stated she of involved in the facility pent the majority of his time in ned outside the nurses station.  The AD further stated she of involved in the facility pent the majority of his time in ned outside the nurses station.  The AD further stated she of involved in the facility pent the majority of his time in ned outside the nurses station.  The AD further stated she of involved in the facility pent the majority of his time in ned outside the nurses station.  The AD further stated she outside the facility pent the stations as follows:  The AD further stated she outside in the facility pent	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 282	beverages. R14 wa assistance with eat (NAR)-C was obserfood into R14's more during most of the repositioned in her whose where her the edge of the table fed approximately and consumed appoint of the edge of the table fed approximately and consumed appoint of the edge of the table fed approximately and consumed appoint of the edge of the table fed approximately and consumed appoint of the edge of the table fed approximately and consumed appoint of the edge of	ing and nursing assistant reved to feed R14 by spooning ath. R14 had her eyes closed meal time. R14 was also noted heelchair at the table in a nose was in line at level with le. R14 was observed to be 50% of her breakfast foods reximately 10% of her liquids.  a.m. an interview was arry aide (DA)-A related to any s for R14. DA-A stated she my special interventions and ants were on the Nutritional ram (NIP) and named off ing room on the program but an DA-A stated residents with a would have received Karo to add calories to the meal.	F 28	2		
	be seated at the dir with eating by NA-C slices of bread cover mashed potatoes a observed to attemp spoon food into R1-with her eyes close R14 was served ch for liquids. R14 was approximately 50% approximately 25%	7 p.m. R14 was observed to ning room table being assisted c. R14 was served (2) 1/2 ered with brown gravy, and cooked carrots. NA-C was at to encourage R14 to eat and 4's mouth. R14 was seated d during most of the meal. ocolate milk, juice and water is observed to consume of the bread and gravy and of her mashed potatoes.				

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F 282	about R14 receiving DA-B stated R14 hroods or supplement there was a list of r diet, DA-B retrieved food service area with RIP. DA-B look didn't know she was responding to R14' DA-B stated R14 shouter with her mass During interview with manager (CDM) or stated the staff wer for residents identified R14 had be not know exactly with risk for malnutrition 483.25 PROVIDE CHIGHEST WELL BEach resident must provide the necess or maintain the high mental, and psychological provides and plan of care.  This REQUIREMED by:  Based on observative review the facility for a comprehensive interventions to red	g any supplemental nutrition. ad not received any extra nts. When DA-B was asked if esidents who received the NIP d a list in a plastic sleeve at the which identified residents on ed at the list and stated,"Oh, I is supposed to get the NIP", is name which was on the list. Include have received extra hed potatoes for the NIP.  Ith the certified dietary a 8/26/15 12:30 p.m. the CDM is supposed to follow the NIP is ed on the program. The CDM is en placed on program but did then and verified R14 was at related to her poor intake.	F 282	Immediate re-education was complete with nursing staff for writing of short tercare plans and following Policy and Procedures for Skin Tears and Bruising Care plan and ongoing monitoring unti	rm g.

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F 309	Continued From page 30		F 309			
	for bruising and skin tears and failed to provide the necessary care and services to maintain good positioning based on a comprehensive assessment for 1 of 3 residents (R14) reviewed for positioning.  Findings include:  R22's admission Minimum Data Set (MDS) assessment, dated 7/31/15, identified R22 had diagnoses which included dementia, chronic kidney disease and behavioral disturbance. The MDS identified R22 had severe impaired cognition and required extensive assist of two staff for bed mobility and to transfer. Further, the MDS identified R22 required extensive assist of 1			healing of skin tear completed for R Skin tear is healed to date. Care plongoing monitoring until healing of completed for R8. Bruising has res Will revise care plan to add risks, gand interventions in regards to R8 of bruising and/or bleeding due to Ruse. Order was immediately reques and obtained by R14 Physician for evaluate and treat for W/C position. Therapy has evaluated and new wheelchair has been ordered. Reswas and continues to be care plansit in a dining room chair during metimes. Will continue to monitor for sin DR chair and will reassess where wheelchair arrives.	an and bruise olved. goals is risk Plavix sted PT to sident ned to eal seating	
	a.m. R22 was obsein the hallway in frohis feet dangling from was noted to have forearms with the bentire aspect of boof varying colors and also noted to have the medial aspect covering a skin teadrainage under the During observation p.m. NAR's E and R22's room and traof a mechanical lift skin tear on R22's sometimes would sthought that was here	as of cares on 8/25/15 at 10:09 erved seated in his wheelchair ont of the nurses station with om chair unsupported. R14 severely bruised bilateral oruising encompassing the th forearms. The bruising was an Opsite (wound dressing) on of his left arm that was in which was presenting with		Licensed nursing and bath assistant complete weekly skin audits of all residents and RN will assess as not NARs will completed daily visual skaudits and report any concerns to the charge nurse as soon as able. Visus monitoring of all residents for table appropriateness and W/C positioning be ongoing. Staff will report concerticensed nursing or therapy as need. Licensed nursing and bath assistant complete weekly skin audits of all residents and RN will assess as not NARs will completed daily visual skaudits and report any concerns to the charge nurse as soon as able. Licentary concerns to the charge staff will follow Policy and Procedures for Skin Tears and Bruth Residents were visually assessed that the height appropriateness and concerns and concerns to the charge staff will appropriateness and concerns to the charge staff will be appropriateness and concerns to the charge staff will be appropriateness and the charge staff will be appropriateness.	eeded. kin he ual height ng will rns to ded. ht will eeded. kin he ensed ising. for	

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F 309	just strike out at the around him.  During review of R2 noted R22 had a hi aggressive towards have self injurious on walls, wheelcharecord contained madmission related tobjects.  R22 had an admission related tobjects.  R22 had an injuries waited and the self record risk factors, goals arisk of bruising or splan did not identify related skin risk factors, goals arisk of bruising or splan did not identify related skin risk factors, goals or skin tears. It was ongoing monitoring the treatment record the skin tear.	e walls or whatever was  22's medical record it was story of being physically staff and would sometimes behaviors such as pounding ir, or tables. R22's medical rultiple notes since his o striking out at staff and  sion skin assessment 15 that identified he was esive bruising on bilateral as no indication of skin tears sessment.  The word R22's record it was noted lacked a care plan to address and interventions to reduce the kin tears. The admission care or bruising or non pressure	F 309	made accordingly. Nursing staff, and therapy will monitor residents positioning and make appropriate changes as needed. Nurse Meetineld September 28, 2015 and NA meeting to be held October 1, 20 address all deficient nursing prace. The Director of Nursing, or design conduct 8 monthly audits with 2 a specific to R22 and R8 for 3 mon skin concerns, R14 for wheelchait positioning and table height appropriateness. The audit finding reported at the QA meeting and with monitored until such time consists substantial compliance has been	a for W/C ng to be .R 15 to tices. nee, will ssigned ths for r gs will be ent	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 309	8/26/14 R14 was of of her days in her reseated in her whee multiple occasions her left side with he armrest of her wheobservations at the observed to be posmanner where her edge of the table.  During observation p.m. R14 was observom leaning to the facing the television was not on and the her room. R14's rossitting with eyes clossitting with eyes clossitting with eyes clossitting with eyes clossitting was as a seated in the dining room at the din	of R14 from 8/24/15 through observed to spend the majority oom seated in her recliner or lichair in front of her recliner on R14 was observed leaning to er head resting on either the elichair or recliner. During meal times R14 was itioned at the table in a eyes were at the level of the of cares on 8/24/15, at 4:26 erved in her recliner in her eleft while seated. R14 was in her room but the television re was non other stimulus in om light was off and R14 was seed.  of the evening meal on in. R14 was observed seated table in her wheelchair leaning eye level was at table edge. The with oted on bilateral sides when	F 30	9		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		E SURVEY IPLETED
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F 309	wheelchair armrest  During phone intervon 8/25/15, at 9:56 voiced a concern al family member stat communication with new wheelchair for been done. The fan frequently in her roo much being offered  On 8/26/15, at 6:40 her wheelchair in ho observed sleeping i left, resting her elbo face in her hand. R chair which is too la support R14 in goor remained seated in until 8:43 a.m. at wh into the dining room  On 8/26/15, at 8:44 seated at dining room  On 8/26/15, at 8:44 seated at dining room  on 8/26/15 a.m. R14 did attend activ leaning to the left in staff would have to to reposition her.  During interview with	riew with R14's family member a.m. the family member bout R14's positioning. The ed there had been in the staff about looking at a R14 but nothing had ever nily member stated R14 was om in her wheelchair with not it to her for activities or care.  am R14 was observed up in the room sleeping. R14 was in her wheelchair leaning to ow on left armrest with her 14's wheelchair is a high back arge for her, and too wide to did upright positioning. R14 her wheelchair in her room in hich time she was wheeled in for breakfast.  4 a.m. R!4 was observed om table and positioned at of table left the edge at R14's int does not feed self but tenable resident to be in a	F3	09			

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		245362	B. WING _		08	/27/2015
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 301 TROENDLE STREET MAPLETON, MN 56065		,,
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	had been some evalued and she would talk what they had done positioning. RN-C R14's leaning at time R14's annual MDS identified R14 requited 2 staff with all achad severe cognitic staff support with bewalking.  During interview with 10:30 a.m. the DNS obtain any docume had been assessed medical record lack	ated she was sure that there aluation of R14's positioning to physical therapy to see in relation to evaluation R14's verified she was aware of	F 30	09		
	dated 5/5/10, identi wheelchairs for sea to maintain optimur The procedure ider 1. The therapy depo for wheelchair posit receiving Medicare 2. The resident card a resident who is no Part B benefits is in positioning assess obtained for residen positioning evaluati 3. Proper wheelcha	or Wheelchair Positioning, fied residents who utilized uting will be properly positioned in comfort and well-being.  Intified on the policy indicate: artment will routinely assess tioning if the resident is Part A or Part B benefits. The coordinator will determine if the treceiving Medicare Part A or a need of a wheelchair ment. A physician order will be not in need of a wheelchair on.  It positioning will be evaluated the quarterly care conference.				

	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION  NG		TE SURVEY MPLETED
		245362	B. WING		08	/27/2015
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CO 301 TROENDLE STREET MAPLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	Observations of R8 observed to have a inches in diameter a quarter size bruis During interview with stated that she obtained that she obtained that she could have home. R8 further reside of the left arm that and a bruise to the cm by 4.0 cm. The bruises easily and the she was at her sisten happened.  Review of R8'S curincluded an order for a physicistic 5/5/15, identified the bruising and blood.  Review of R8's curincluded an order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded an order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded an order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising and blood.  Review of R8's curincluded in order for a physicis 5/5/15, identified the bruising of the physicis for a physicis fo	a on 8/25/15 at 3:19 p.m., was large bruise approximately 5 on the top of her left arm and e on the top of her left hand. In the resident at this time, she ained the bruise when she are about 2 weeks ago. R8 or sisters entry way is narrow bumped it when entering the evealed she bruises easily a blood thinner.  The report for R8 dated 8/16/15 and obtained a bruise to the top measured 7.5 cm by 6.0 cm right arm that measured 6.0 report indicated the resident the bruise was identified after ers, but was unsure what the properties or plavix (blood thinner) and an visit dictation note dated the R8 as bruising easily, heavy clots (with nosebleeds).  The rent plan of care, revised lude R8 as being at risk for the use of a blood thinner. Ere listed.  The confirmed R8's bruising monitored and care planned at risk for bruising due to the	F 3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		E SURVEY PLETED
		245362	B. WING _		08/2	27/2015
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 325 SS=D	7/12/15, included; identified, cause de monitored; enter tro on treatment sheet 483.25(i) MAINTAI UNLESS UNAVOID Based on a resider assessment, the faresident - (1) Maintains accestatus, such as bounless the resident demonstrates that	ty policy for bruises dated the residents bruises will be etermined, documented and eatment/observation schedule, notify physician and family. N NUTRITION STATUS DABLE of the comprehensive scility must ensure that a cotable parameters of nutritional dy weight and protein levels, the clinical condition this is not possible; and capeutic diet when there is a	F 30			10/5/15
	by: Based on observa review the facility for nutritional needs be assessment for 1 of for weight loss.  Findings include: R14's annual Minimassessment dated diagnoses that includementia, anemia	NT is not met as evidenced tion, interview and document ailed to provide the necessary ased on comprehensive of 3 residents (R14) reviewed num Data Set (MDS) 6/25/15 identified R14 had uded major depression, and atrial fibrillation. The MDS ired extensive assistance of ty.		Re-education of dietary staff was completed immediately for concern R14 NIP program and to assure compliance for all meals. Weights, NIP program and nutrition concerns for therapeutic diet and/o supplement were reviewed for all residents and addressed as needed NIP program list will be reviewed a updated twice a month and as need CDM or ADM. Weights will be reviewed to identify need for theraped diet and/or supplement. In service	nal or ed. and ided, by ewed as eutic	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION  NG		E SURVEY PLETED
		245362	B. WING _		08/:	27/2015
	NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME  (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 325  Continued From page 37  R14's nutritional Care Area Assessment, dated 6/26/15, identified R14 had no problems with chewing/swallowing, had no functional problem that affected R14's ability to eat, received Prosource for skin issues, and received a liberalized diabetic diet with small portions Further, the CAA identified R14 had a 10% weigloss in the last 6 months, house supplement was not given and would get that correct to start given the house supplement three times a day.  A dietary note, dated 7/7/2015 identified recommendation for R14's diet be changed to a regular diet with small portions as to not	ME		STREET ADDRESS, CITY, STATE, ZIF 301 TROENDLE STREET MAPLETON, MN 56065		
PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO THE CORRECTION OF CORE	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 325	R14's nutritional Ca 6/26/15, identified F chewing/swallowing that affected R14's Prosource for skin liberalized diabetic Further, the CAA id loss in the last 6 monot given and would her the house support A dietary note, date recommendation for regular diet with smoverwhelm R14 wit would include fortifithe goal was identified between 103-113 pouring review of R1 noted R14 had susweight loss in the phonotomy loss. R14's weight of 121 pounds and he dated 8/23/15 was R14's care plan, rerequired extensive The care plan ident of regular small por Other interventions 1. Serve meals in the 2. Offer extra fluids 3. Honor noted likes During observation	are Area Assessment, dated R14 had no problems with g, had no functional problems ability to eat, received a diet with small portions entified R14 had a 10% weight onths, house supplement was d get that correct to start giving element three times a day.  d 7/7/2015 identified or R14's diet be changed to a hall portions as to not h food portions. The diet ed foods (NIP) as accepted. If	F 32	dietary staff will be held Scanton to include the NIP properties of the NIP properties of the 2015 to address all deficies practices.  The CDM, or designee, wo monthly audits during means assigned specific to R14 for The audit findings will be not such time consistent substantiance has been metally and the Completion date October.	rogram. Nurse's mber 28, 2015 eld October 1, ent nursing ill conduct 3 als with 1 for 3 months. reported at the onitored until stantial t.	

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVE COMPLETED		
		245362	B. WING _		08	/27/2015	
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065	, 30		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 325	cinnamon raison to beverages. R14 was assistance with eat (NAR)-C was obserfood into R14's more during most of the positioned in her will manner where her the edge of the table fed approximately and consumed appoon 8/26/15 at 8:57 conducted with diet special intervention was not aware of a stated some reside improvement progresidents in the din did not include R14 the NIP intervention syrup in their juice to DA-B confirmed R1 in juice for the breauth of the breauth of the seated at the direction with eating by NA-C slices of bread cover mashed potatoes and observed to attemps spoon food into R1 with her eyes close R14 was served ch for liquids. R14 was approximately 50%	ed egg, two (2) 1/2 slices of ast with milk juice and water as observed to need ing and nursing assistant reved to feed R14 by spooning with. R14 had her eyes closed meal time. R14 was also noted heelchair at the table in a mose was in line at level with le. R14 was observed to be 50% of her breakfast foods roximately 10% of her liquids.  a.m. an interview was early aide (DA)-A related to any as for R14. DA-A stated she my special interventions and ints were on the nutritional am (NIP) and named off ing room on the program but an WIP, and calories to the meal.  4 had not received Karo syrup	F 32	25			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		245362	B. WING		08	/27/2015
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
(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)	OULD BE	(X5) COMPLETION DATE
F 325	On 8/26/15, at 12:2 about R14 receivin DA-B stated R14 h foods or suppleme residents in a plast area which identified looked at the list at she was supposed R14's name which R14 should have remashed potatoes of During interview we manager (CDM) or stated she expected residents identified verified R14 had be not know exactly we risk for malnutrition. The facility failed to directed by the care directed.  The facility failed to directed by the care directed.  The facility policy Normal Program, dated 8/2 policy of the facility minimal increase in nutritional status we The policy identified would include following and protein with his Foods identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring area which identified in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring in the policy identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk 2. 1 tablespoon of 3. 1 extra margaring identified in 1. Whole milk	22 p.m. DA-B was questioned g any supplemental nutrition. ad not received any extra nts. DA-B provided a list of ic sleeve at the food service ed residents on the NIP. DA-B nd stated,"Oh, I didn't know to get the NIP", responding to was on the list. DA-B stated eceived extra butter with her or the NIP.  Ith the certified dietary not be staff to follow the NIP for an on the program. The CDM een placed on program but did then and verified R14 was at a related to her poor intake.  In provide dietary services as no nutritional needs for R14. The plan on a routine basis as a plan on a routine basis as a plan on a routine basis as a difference of the plan on a routine basis as a difference of the poor intake with a food volume to improve the never feasible for residents. In the plan on a routine basis as a difference of the plan on a routine basis as a plan on a routine to improve the never feasible for residents. In the plan on a routine basis as a plan on a routine to improve the never feasible for residents. In the plan of the plan on a routine plan on a routine basis as a plan on a routine to improve the never feasible for residents. In the plan on a routine plan on	F 32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	TIPLE CONSTRUCTION NG	` '	TE SURVEY MPLETED
		245362	B. WING		08	/27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO	ME		STREET ADDRESS, CITY, STATE, ZIP COD 301 TROENDLE STREET MAPLETON, MN 56065	)E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 325	determination of ov discretion. 5. commercial supp	n meals per residents self wn or at dietary managers olements will also be dered by the physician if	F 3	25		
F 431 SS=C	483.60(b), (d), (e) I LABEL/STORE DF  The facility must er a licensed pharmac of records of receip controlled drugs in accurate reconcilia records are in orde controlled drugs is reconciled.  Drugs and biologic labeled in accordar professional princip appropriate access instructions, and the applicable.  In accordance with facility must store a locked compartment controls, and perment have access to the The facility must propermanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe	DRUG RECORDS, RUGS & BIOLOGICALS  Imploy or obtain the services of cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug er and that an account of all maintained and periodically  als used in the facility must be nee with currently accepted oles, and include the cory and cautionary the expiration date when  State and Federal laws, the all drugs and biologicals in ints under proper temperature it only authorized personnel to	F 4	31		10/5/15

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245362	B. WING		08/27/2015	
	PROVIDER OR SUPPLIER	ME	3	STREET ADDRESS, CITY, STATE, ZIP CODE 801 TROENDLE STREET MAPLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  YMUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTIO	N
F 431	This REQUIREMENT by: Based on observative the facility far pharmacological's in the potential to affer independent mobility from the potential to affer independent mobility.  Findings include:  During observation pass with trained mon 8/14/15 at 6:10 pobserved to be storn the was a drawer several vials of insufficient to the proceeded to word the treatment proceeded to word the treatment proceeded to word the passing medication unattended cart responsible to the cart is walked/wheeled by confirmed the cart in the proceeded to word the cart is walked/wheeled by confirmed the cart in the passing medication walked/wheeled by confirmed the cart in the passing medication walked/wheeled by confirmed the cart in the passing medication walked/wheeled by confirmed the cart in the passing medication was a passing medica	NT is not met as evidenced tion, interview and document ailed to maintain security of n the treatment cart. This had ct all residents with ty who reside in the facility.  of a medication administration redication assistant (TMA)-A o.m., a treatment cart was red in a tub room unsecured. In that was pulled open with all in and syringes in view from allocked cart also contained and treatment creams. TMA-A ment cart should be locked, ralk away from the red storage cart to continue is in the dining room. The mained unsecured until 6:35 staff and residents had the cart. At 6:35 p.m., TMA-A remained unsecured, and do notify the nurse who was in	F 431	Immediate corrective counseling a re-education completed with LPN-ATMA-A covering storage of medication/treatment cart to be in medication room and locking medication/treatment cart when not use. Following Policy and Procedur medication storage at all times.  The Director of Nursing, or designe conduct 6 monthly audits of the medication storage and medication/treatment cart locking. audit findings will be reported at the meeting and will be monitored until time consistent substantial complia has been met. Nurse Meeting to be September 28, 2015.	in e for e, will The QA such	
	8/14/15 at 6:40 p.m of the unlocked trea she usually stored t	sed practical nurse (LPN)-A on i. confirmed she was in charge atment cart. LPN-A indicated the cart in the locked out placed it in the tub room so				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE COMP	SURVEY LETED
		245362	B. WING			08/2	7/2015
	PROVIDER OR SUPPLIER	ME		STREET ADDRESS, CITY, 301 TROENDLE STREE MAPLETON, MN 560	ΞT		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD E NCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	Interview with the Dindicated the treatrall times when unat Review of the Polic 10/1/07 for storage needles included; the all medications and stored in a locked of the policity of the polici	sidents to the dining room for o lock the cart.  OON on 8/14/15 at 7:30 p.m. ment cart should be locked at	F4	31			

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(X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 01 B. WING 08/25/2015 245362 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **301 TROENDLE STREET** MAPLETON COMMUNITY HOME MAPLETON, MN 56065 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 25, 2015. At the time of this survey, Building 01 of Mapleton Community Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a). Life Safety from Fire, and the 2000 edition of National Fire Protection Association **EPOC** (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

**Electronically Signed** 

09/21/2015

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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(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION		E SURVEY APLETED
		245362	B. WING			08/	/25/2015
	PROVIDER OR SUPPLIER	ME		301	REET ADDRESS, CITY, STATE, ZIP CODE TROENDLE STREET APLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	By email to: Marian.Whitney@s Angela.Kappenmail THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO  1. A description of to correct the deficit 2. The actual, or pr  3. The name and/oresponsible for comprevent a reoccurre Building 01 of Mapiconstructed as folid The original buildin one-story, has a pasprinkler protected construction; The 1st Addition was one-story, has no be protected and is of The 2nd Addition was one-story, has no be protected and is of The 3rd Addition was one-story, has no be protected and is of The 4th Addition was one-story, has no be protected and is of The 4th Addition was one-story, has no be protected and is of The facility has a fidetection in the correction in the correction.	state.mn.us and n@state.mn.us  RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:  what has been, or will be, done iency.  roposed, completion date.  or title of the person rection and monitoring to ence of the deficiency.	K	000			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG <b>01</b>	(X3) DATE COMP	
	PROVIDER OR SUPPLIER	245362 ME	B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065	08/2	5/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT 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 APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
K 000	department notifica capacity of 60 beds time of the survey.	age 2 Ition. The facility has a s and had a census of 57 at 42 CFR, Subpart 483.70(a) is	K 00	00		
K 029 SS=D	NOT MET as evide NFPA 101 LIFE SA One hour fire rated fire-rated doors) or extinguishing syste and/or 19.3.5.4 pro the approved auton option is used, the a other spaces by sm doors. Doors are s field-applied protect	rnced by: FETY CODE STANDARD  construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1 tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and elf-closing and non-rated or tive plates that do not exceed bottom of the door are	K 02	29		3/25/15
	Based on observat facility failed to main partitions and doors following requirement	s not met as evidenced by: cion and staff interview, the ntain smoke-resisting in accordance with the ents of 2000 NFPA 101, the deficient practice could residents.		The latch on the oxygen storag door was adjusted so that it latc properly.		
	08/25/2015, observ	veen 1:00 PM and 3:00 PM on ation revealed that the orage Room - door will not				

CENTE	RS FOR MEDICARE	- & MEDICAID SERVICES			INID INC. USSC	<u>)-039 i</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION 3 <b>01</b>	(X3) DATE SURVEY COMPLETED 08/25/2015	
	245362		B. WING			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME		301 TROENDLE STREET MAPLETON, MN 56065		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COM	(X5) PLETION DATE
K 029	Continued From pa	age 3	K 02	9	10 mm	
K 144	Director of Mainter discovery.	tice was confirmed by the nance (DS) at the time of NFETY CODE STANDARD	K 14	4	8/25	5/15
SS=D	Generators are ins	pected weekly and exercised ninutes per month in FPA 99. 3.4.4.1.				
	Based on docume the facility has faile monthly inspection in accordance with deficient practice c	s not met as evidenced by: ntation review and interview, d to properly document s of the emergency generator NFPA 99 and NFPA 110. This ould affect all 57 residents, the event of a loss of power re.		A monthly test run log will be kept addition to the weekly test run log already being kept. This will be started immediately.		
I	Findings include:					
	08/25/2015, observ	veen 1:00 PM and 3:00 PM on vation revealed that a separate or the Emergency Generator or review.				
		ice was confirmed by the ance (DS) at the time of				

PRINTED: 09/22/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - 2011 ADDITION B. WING 245362 08/25/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **301 TROENDLE STREET** MAPLETON COMMUNITY HOME MAPLETON, MN 56065 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 K 000 INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE, YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC. AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on August 25, 2015. At the time of this survey, Building 02 of Mapleton Community Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC). Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY **DEFICIENCIES (K-TAGS) TO:** Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul. MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

09/21/2015

Electronically Signed

(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.

Facility ID: 00037

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - 2011 ADDITION		COMPLETED	
		245362	B. WING_		08/	25/2015
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME				STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET MAPLETON, MN 56065		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	Continued From pa	ge 1	K 00	00		
	By email to: Marian.Whitney@s Angela.Kappenmar					
	THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:					
	1. A description of what has been, or will be, done to correct the deficiency.					
	2. The actual, or proposed, completion date.					
	3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.					
	consists of the 2011 included a link to ar link incorporates a larooms and staff offi one-story in height,	eton Community Home I nursing home addition, which a assisted living facility. The barber/beauty shop, storage ce space. Building 02 is has no basement, is fully fire and was determined to be of uction.				
	detection in the corr corridors, which is r department notifical	e alarm system with smoke ridors and spaces open to the monitored for automatic fire tion. The facility has a and had a census of 57 at				
K 011	NOT MET as evide	42 CFR, Subpart 483.70(a) is nced by: FETY CODE STANDARD	K 0	11		8/25/15

PRINTED: 09/22/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - 2011 ADDITION B. WING 245362 08/25/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **301 TROENDLE STREET** MAPLETON COMMUNITY HOME MAPLETON, MN 56065 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 011 K 011 Continued From page 2 SS=D If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two-hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and are protected by approved self-closing fire doors. 18.1.1.4.1, 18.1.1.4.2 This STANDARD is not met as evidenced by: Based on observations and staff interviews, the The penetration was sealed with fire caulk. facility failed to provide 2-hour rated construction at building separation walls between the hospital building and the non-conforming building construction as required by NFPA 101" Life Safety Code "2000 edition, sections 18.1.1.4.1. The deficient practice could negatively impact the residents of the facility by allowing a fire to spread from one building to another. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/25/2015, observation revealed that the 1st floor - 2 hour fire rated building separation from the Nursing Home to the Assisted Living has open cable penetrations above the lay in ceiling This deficient practice was confirmed by the Director of Facility Maintenance (DS) at the time of discovery. 8/25/15 K 144 NFPA 101 LIFE SAFETY CODE STANDARD K 144 SS=D Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING 02 - 2011 ADDITION		(X3) DATE SURVEY COMPLETED		
2		245362	B. WING		08/25/2015		
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOME			STREET ADDRESS, CITY, STATE, ZIP CODE  301 TROENDLE STREET  MAPLETON, MN 56065				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	SHOULD BE COMPLETION		
K 144	Continued From pa	ge 3	K 144				
	Based on documenthe facility has failed monthly inspections in accordance with deficient practice or	s not met as evidenced by: ntation review and interview, d to properly document s of the emergency generator NFPA 99 and NFPA 110. This build affect all 57 residents, the event of a loss of power re.		A monthly test run log will be kept addition to the weekly test run log talready being kept. This will be started immediately.			
	08/25/2015, observ Monthly Test Log fo was not available fo This deficient practi	veen 1:00 PM and 3:00 PM on ation revealed that a separate or the Emergency Generator or review.  ce was confirmed by the ance (DS) at the time of					
	discovery.	·					



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered September 11, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5362023

Dear Ms. Gosson:

The above facility was surveyed on August 24, 2015 through August 27, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <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>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

Mapleton Community Home September 11, 2015 Page 2

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gail Anderson at (218) 332-5140 or email: gail.anderson@state.mn.us.

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

Please 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 related to this eNotice.

Sincerely,

Mark Weath

Mark Meath, Enforcement Specialist Program Assurance Unit Licensing and Certification Program Health Regulation Division Minnesota Department of Health Email: mark.meath@state.mn.us

Telephone: (651) 201-4118

Fax: (651) 215-9697

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  301 TROENDLE STREET	
301 TROENDLE STREET	
MAPLETON COMMUNITY HOME MAPLETON, MN 56065	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	AN OF CORRECTION (X5) VE ACTION SHOULD BE ED TO THE APPROPRIATE CICIENCY)  (X5) COMPLETE DATE
Initial Comments  *****ATTENTION******  NH LICENSING CORRECTION ORDER  In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.  Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.  You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.  INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

**Electronically Signed** 09/21/15

STATE FORM 6899 If continuation sheet 1 of 47 QPBP11

TITLE

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIEF	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLETON COMMUNITY HO	)N/I I—	ENDLE STRE DN, MN 5606			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
you electronically, is necessary for Senter the word "context. You must the State licensure procompletion date, the corrected prior to Minnesota Depart."  On 8/24/15 - 8/27/Department's staff the following corresplease indicate in correction that you and identify the data Minnesota Depart the State Licensing federal software. The assigned to Minnesota Depart the State Licensing federal software. The assigned to Minnesota Depart the State Licensing federal software. The assigned to Minnesota Depart the State Licensing federal software. The assigned tag column entitled "I statute/rule out of "Summary Statem and replaces the "correction order. The statement of the statement evidence by." Follower the Suggested Time period for Country Please DISREG FOURTH COLUM "PROVIDER'S PLAPPLIES TO FED	alth orders being submitted to Although no plan of correction tate Statutes/Rules, please rrected" in the box available for in indicate in the electronic docess, under the heading the date your orders will be electronically submitting to the ment of Health.  15 surveyors of this is, visited the above provider and ction orders are issued. your electronic plan of in have reviewed these orders, the when they will be completed.  The ment of Health is documenting go Correction Orders using ag numbers have been sota state statutes/rules for  The prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the this column also includes the in violation of the state statute t, "This Rule is not met as owing the surveyors findings Method of Correction and	2 000			

Minnesota Department of Health

STATE FORM 6899 QPBP11 If continuation sheet 2 of 47

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				) DATE SURVEY COMPLETED	
		A. BOILDING.					
		00037	B. WING		08/2	7/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
MAPLET	ON COMMUNITY HO	MF	NDLE STRE				
	01114144514054		ON, MN 5606		<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints		2 505			10/5/15	
	Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given.						
	method or physical material, or equipm the resident's body remove easily which movement or norm Physical restraints leg restraints, arm or vests, and whee restraints also include definition of a restration so tightly that a resimove; bed rails; chiplacing a resident in wall that the wall prising. Bed rails are restrict freedom of used solely to assist help the resident gois not used as a reson clothing that trig staff that a resident not, in and of thems movement and shorestraints.  B. "Chemical repsychopharmacological properties are restricted freedom of used solely to assist help the resident gois not used as a reson clothing that trig staff that a resident not, in and of thems movement and shorestraints.	straints" means any manual or mechanical device, sent attached or adjacent to that the individual cannot he restricts freedom of al access to one's body. include, but are not limited to, restraints, hand mitts, soft ties lichair safety bars. Physical ide practices which meet the aint, such as tucking in a sheet ident confined to bed cannot airs that prevent rising; or a wheelchair so close to a revents the resident from the considered a restraint if they movement. If the bed rail is set the resident in turning or to be tout of bed, then the bed rail straint. Wrist bands or devices ger electronic alarms to warn is leaving a room or area do selves, restrict freedom of build not be considered estraints" means any gic drug that is used for nience and is not required to					

Minnesota Department of Health

STATE FORM 6899 QPBP11 If continuation sheet 3 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00007	B. WING		00/0	7/0045
		00037	b. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	MI-	NDLE STRE N, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 505	treat medical symp C. "Discipline" nursing home for the penalizing a resident D. "Convenient solely to control resident with a less in the resident's be E. "Emergency immediate action in unexpected situations and urgent.  This MN Requirem by: Based on observative the facility for device for least am assessment for 1 controls as a sessment for 1 controls and bed.  Findings include:  R22's admission Massessment, dated diagnoses which in kidney disease and MDS identified R22 cognition and requistaff for bed mobility MDS identified R22 staff with mobility in R22's admission Controls and the service of t	toms. means any action taken by the ne purpose of punishing or nt. ce" means any action taken sident behavior or maintain a er amount of effort that is not st interest. measures" means the necessary to alleviate an on or sudden occurrence of a nature.  ent is not met as evidenced ion, interview and document alled to use the least restrictive ount of time based on an of 1 resident (R22) in the oserved to have restraints that m of movement in wheelchair  dinimum Data Set (MDS) 7/31/15, identified R22 had cluded dementia, chronic behavioral disturbance. The had severe impaired red extensive assist of two y and to transfer. Further, the required extensive assist of 1	2 505	Corrected		

Minnesota Department of Health

STATE FORM 6899 QPBP11 If continuation sheet 4 of 47

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 00/2	.,
MAPLET	ON COMMUNITY HO	MF	NDLE STRE			
	OLIMANA DV. OTA		N, MN 5606		ON!	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 505	Continued From pa	ge 4	2 505			
	transfer and utilized CAA identified R22 and go recliner about therapy goal of R22 wheelchair approximate identified R22 was stand independent transfers, alarms, leat bedside, and roc R22's admission calidentified R22 requigrooming, use of a use of a motion ser and directed staff to However, R22's califications.	ing, was not able to stand and d a mechanical lift. Further, the was able to move the rock ut 10 feet on his own, with a being able to move his mately 50 feet. The CAA at risk for falls, not able to y, used a mechanical lift for ow bed, sided mattress, matt k and go wheelchair for safety.  The plan, dated 7/25/15, ired assistance with dressing, mechanical lift for transfers, is not the floor at bedside of anticipate his needs. The plan did not include any ventions for the use of the ined wheelchair.				
	p.m. to 7:30 p.m. R reclining wheelchai except for brief perinto his room for perinto his recommendate. R22 was obpositioned in his recommendate where the chair was to attempt to sit forwheelchair when reso.  During observation a.m. R22 was observoom and placed in nurses station. Nurses station. Nurses station and that he was in a new	of R22 on 8/24/15, from 1:30 22 was observed seated in his r in front of the nurses station iods when he was wheeled ersonal cares or attended served multiple times clining wheelchair in a manner is reclined. R22 was observed ward in his reclining reclined but was unable to do of cares on 8/25/15, at 10:09 rived to be wheeled from his the hallway in front of the sing assistant (NA)-E was R22 back in his recliner so ar back lying position. R22 a safety alarm, attached with a				

Minnesota Department of Health

STATE FORM 6899 QPBP11 If continuation sheet 5 of 47

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00037	B. WING		08/	27/2015
	PROVIDER OR SUPPLIER	MF 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 505	cord, between the bashirt.  During interview on NA-E stated R22's keep R22 from bein the chair. NA-E state chair but he was no stated,"When the chair but he was no stated,"When the chair but of the whole to get out of the whole to get out of the whole to get out of the whole the side in bed. During on 8/25/15, at 1:50 not try to get out of because they put a in bed. The opposit against the bedroor stated R22 did not a wheelchair when it impeded his ability R22 lying in his bed pillow holding him in During observation p.m. R22 was obseside with a body pill his right side. A sen the floor beside the other side of the be	pack of his wheelchair and his 8/25/2015, at 10:14 a.m. wheelchair was leaned back to no able to self-transfer from ted R22 could try to get out of the steady or safe. NA-E further hair is reclined [R22] is unable elchair without assistance.  of cares on 8/25/15, at 1:40 Dentered R22's room and nechanical lift. NA-E and 22 into bed with the use of the rived to place a pillow behind eft him supported on his right interview with NA-E and NA-D p.m. the staff stated R22 did bed as much as he used to body pillow beside him when e side of R22's bed was m wall. NA-E and NA-D further attempt to get out of his was leaned back as it to do so. NA-E and NA-D left I on his right side with a body in that position.  of cares on 8/25/15, at 2:34 rived lying in bed on his right low behind him holding him on asor monitor was observed on egress side of his bed and d was against the wall.  p.m. R22 remained lying in	2 505			
	him in a right sided	pillow beside him supporting position. R22 was noted to n on the floor beside his bed.				

Minnesota Department of Health

STATE FORM 6899 QPBP11 If continuation sheet 6 of 47

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			B. WING			
		00037	b. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 505	back while lying in a remove the pillow frunable to remove it he was unable to make the was identified R22 times and did atternand bed at times. The was identified in the control of 7/27/2015, at 1 wheeled self to the room where he had was noted to be sless that were alerted by the control of 3 staff back to his room where range on the ground. He was changed to completed and vital he was changed to complete was	attempting to turn onto his ped and reaching to attempt to rom behind him but was. R22 was visibly agitated that have the pillows and change are record the nurses a was able to wheel himself at a pet to get out of his wheelchair the following documentation	2 505	DEFICIENC!)		
		:33 p.m. resident wheeled g. Staff brought him back.				

6899

Minnesota Department of Health STATE FORM

QPBP11 If continuation sheet 7 of 47

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI		STATE, ZIP CODE	1 00/-	
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	`	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 505	Continued From pa	ge 7	2 505			
	(pounding on wall, out for help). Call lig position, floor alarm					
	capable of wheeling	s demonstrated R22 was g himself, capable of sitting up of attempting to transfer self ir.				
	a.m. NA-A stated s R22 in his wheelch transfer out of it and utilized when he wa from attempting to stated she knew R2	th NA-A on 8/26/15 at 10:17 staff were directed to recline air to keep him from trying to d stated the body pillow as in bed was to keep R22 self transfer from bed. NA-A 22 at times attempted to get not observed him attempting to air.				
	a.m. NA-C stated F his bed and the bod out. NA-C stated sh his chair but stated	th NA-C on 8/26/15, at 10:53 822 did attempt to get out of dy pillow kept him from getting he had not seen him get out of she had been told to keep his so he did not attempt to self				
	(DNS) and registered 11:02 a.m. they conducted not been developed pillow or reclining with their had not been reclining wheelchait their restrictive nature be utilized as restrated.	th the director of nursing ed nurse (RN)-C on 8/26/15, at a firmed R22's care plan had do to identify the use of the body wheelchair. The DNS stated an assessment of the ror the body pillow to assess ure as neither were intended to a to the staff were locking R22 in a				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	ENDLE STRE ON, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 505	Continued From pareclined position in aware of the use of there had been not assess how they makes how they make how they makes how they had they had they makes how they had they had they had they had	ge 8 his wheelchair and was not body pillows. RN-C verified assessment of the devices to ight restrict R22 with access to his body and cted by the use of the body chair. R22 was observed to wheel himself around in his e wheelchair was not reclined ty of getting out of the chair, when it was not reclined. Estricted from free movement body pillow was placed so visibly agitated when able to remove the pillow from osition himself to a more	2 505		JFNIAI E	
	The policy indicated 1. Staff will identify unsafe. (frequent faor injury to self). Att chart on the effect of the interdisciplinary attempt by making Make sure all falls a	d the following procedures- resident's behavior that is alls, improper body alignment, tempt different alternatives, of the alternative. Make sure team (IDT) is aware of an note on 24-hour report sheet. are reported to the IDT. e coordinator (RCC) will				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER			ETATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	MF	NDLE STRE N, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 505	evaluate use of alte appropriate charting 3. The RCC will con assessment, which have been tried and 4. Obtain a physicia restraint, the reason the restraint will be 5. A safety assessnat care conferences	ernatives and make sure g is in residents chart. Inplete a physical restraint will include alternatives that d failed. In order which include, type of the for the restraint, and when	2 505			
	Director of Nursing provide education to constitutes a restrate could randomly audievices that potentiabeen assessed to expect the constitution of	THOD OF CORRECTION: The (DON) or designee, could onursing staff about what int. The DON or designee, dit resident records to ensure ally restrain a resident have ensure safe and least use.  R CORRECTION: Twenty-one				
2 560	Plan of Care; Contents comprehensive pla objectives and time long- and short-terr and mental and psy identified in the con assessment. The comust include the inc	of plan of care. The nof care must list measurable tables to meet the resident's nogals for medical, nursing, rchosocial needs that are aprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557,	2 560			10/5/15

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(VA) ID	STIMMA DV STA	TEMENT OF DEFICIENCIES	ON, MN 5600	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 10	2 560			
	subdivision 14, para	agraph (b).				
	by: Based on observati review the facility fa related to interventi skin conditions for 2 the sample who we skin tears.	on, interview and document alled to develop a care plan ons for non-pressure related 2 of 3 residents (R8, R22) in re reviewed for bruising and		Corrected		
	Findings include:					
	assessment, dated diagnoses which in kidney disease and MDS identified R22 cognition and requi staff for bed mobilit	inimum Data Set (MDS) 7/31/15, identified R22 had cluded dementia, chronic behavioral disturbance. The had severe impaired red extensive assist of two y and to transfer. Further, the required extensive assist of 1 the wheelchair.				
	a.m. R22 was obse in the hallway in fro his feet dangling fro was noted to have sometime aspect of bot of varying colors an also noted to have the medial aspect of covering a skin team drainage under the	· ·				
	noted R22 had a hi aggressive towards	22's medical record it was story of being physically staff and would sometimes behaviors such as pounding				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	00037	B. WING		08/2	27/2015	
NAME OF PROVIDER OR SUPP	HOME 301 TRO	DDRESS, CITY, S ENDLE STREION, MN 5606	ET			
PREFIX (EACH DEFIC	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
record contains admission relationship objects.  R22 had an addiconducted on 7 admitted with eforearms. There identified on the During further in the medical recrisk factors, goinsk of bruising plan did not idearelated skin risl.  During interview on 8/26/15, at current care plainterventions for further verified of the skin tear record lacked at R8's annual MI moderate cognized extensions activities of dai.  During observed that approximately sher left arm and of her left hand time, she state when she went.	chair, or tables. R22's medical d multiple notes since his ed to striking out at staff and mission skin assessment /24/15 that identified he was accessive bruising on bilateral e was no indication of skin tears assessment.  Eview of R22's record it was noted ord lacked a care plan to address als and interventions to reduce the or skin tears. The admission care notify bruising or non pressure factors.  Which was verified R22's noting or skin tears. It was there was no ongoing monitoring or bruising as the treatment my treatments for the skin tear.  PS, dated 6/3/15, identified R8 had tive impairment, no behaviors and ive assistance from staff for all					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	ME 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	entering the home. bruises easily becan Review of an incide indicated the reside of the left arm that and a bruise to the cm by 4.0 cm. The bruised easily and the sheat been out of what happened.  Review of R8'S cur included an order for aspirin.  Review of a physici 5/5/15, identified the bruising and blood Review of the most include R8 as being or the use of a blood were listed.  Interview with the d8/27/15 at 8:33 a.m. should have been resided.	R8 further revealed she use she is on a blood thinner.  ent report for R8 dated 8/16/15 ent obtained a bruise to the top measured 7.5 cm by 6.0 cm right arm that measured 6.0 report indicated the resident the bruise was identified after f the facility, but was unsure erent physicians orders or plavix (blood thinner) and an visit dictation note dated e R8 as bruising easily, heavy clots (with nosebleeds)  current plan of care did not g at risk for bleeding/bruising d thinner. No interventions  irector of nursing (DON) on an confirmed R8's bruising monitored and care planned trisk for bruising due to the	2 560			
	The director of nurs the policy and proce as needed, staff tra monitored and eval comprehensive pla	THOD OF CORRECTION: sing or designee could assure edures are reviewed, revised ined and systems assessed, uated to assure the n of care is developed and bjectives and timetables to				

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			(X3) DATE COMF	SURVEY		
		00037	B. WING		08/2	27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE N, MN 5600			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	Continued From pa	ge 13	2 560			
	meet each resident	s individual needs.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			10/5/15
		omprehensive plan of care I personnel involved in the 				
	by: Based on observati review the facility fa needs as directed b residents (R14 and reviewed for activiti nutritional needs as	ent is not met as evidenced on, interview and document alled to provide the activity by the care plan for 2 of 3 R22) in the sample who were es and failed to provide the directed by the active care lents (R14) in the sample who eight loss.		Corrected.		
	identified R14 as a read romance nove doing. The care pla watching TV and slutther identified R11. Going through he she finds in them.  2. Going to and enjute and enjute read romance novel to the she finds in them.	activities, dated 7/6/15, quiet, private lady who like to els, which she has been not in identified R14 had been eeping more. The care plan l4's interest in activities as: er drawers and looking at what oying Music and Motion e is participating 3-5 days a				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING:	TED
00037 B. WING 08/27/2	/2015
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
MAPLETON COMMUNITY HOME 301 TROENDLE STREET	
MAPLETON, MN 56065	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
week. 3. Going to exercise program on occasion. 4. Going to music programs as well. 5. Wheeling around the halls in the late afternoons. 6. Reading out loud program, which has been working well for her. R14 has always enjoyed reading but due to sight she hasn't been able to. She declined book on tapes.  During observation of R14 from 8/24/15 through 8/26/14 R14 was observed to spend the majority of her days in her room seated in her recliner or seated in her wheelchair in front of her recliner.  On 8/24/15 at 4:26 p.m. R14 was observed in her recliner in her room leaning to the left while seated. R14 was facing the television in her room but the television was not on and there was non other stimulus in her room. R14's room light was off and R14 was sitting with eyes closed. R14 remained in her room until 5:20 p.m. at which time she was wheeled into the main dining room and placed at the dining room table. During the meal time R14 spent much of her meal time seated in her recliner with her eyes closed while staff attended to feed her. R14 was not engaged at the dining room table and only opened her eyes when staff placed food in her mouth. At approximately 6:25 p.m. R14 was wheeled out of the dining room and wheeled to her room and left seated in front of her recliner in her room with the light off and television off. R22 remained seated in her wheelchair until last observed at 7:45 p.m. when she remained seated in her room in her recliner with no stimulus in her room in her recliner with no stimulus in her room in her recliner with no stimulus in her room in her recliner with no stomes atted at the dining room seated at the dining room on seated at the dining room seated at the d	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
712 . 271	0. 0020		A. BUILDING:		00	
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPI FT	ON COMMUNITY HO	MF	NDLE STRE			
WAI LET	ON COMMONT I TO	MAPLETO	N, MN 5606	65		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	placed at the table the table was at the observed sleeping a 8/25/14 R14 was w and wheeled to her wheelchair in front and television off. TR14 observed until wheeled out of her for the noon meal at the dining room unt when she was wheetransferred from he her room. R14 was out and no stimulus 8/25/15 R14 remain her recliner in her room other than he which is out of her vobserved through 3	le in her wheelchair. R14 was in a manner where the edge of elevel of her nose. R14 was at the table. At 8:40 a.m., on heeled out of the dining room room and left seated in her of her recliner with the light out there was no interaction with 11:30 a.m. when R14 was room and into the dining room at 11:30 a.m. R14 remained in il approximately 12:30 p.m. eled back to her room and r wheelchair to the recliner in left in her recliner with light in room. At 1:49 p.m. on ned seated with eyes closed in froom with no stimulus in the r roommates television on visual range. R14 was 1:40 p.m., on 8/25/20 and the stimulus in her room with no				
	a.m. R14 was obse wheelchair with eye television was on b 8/26/15, at 7:30 a.n her w/c in her room wheelchair with no On 8/26/15 at 8:24 seated in her wheel	of cares on 8/26/15, at 6:40 rved in her room in her es closed. Roommates ut out of the view of R14. On n. R14 was observed seated in leaning to her left in her activity occurring in the room. a.m. R14 was observed lchair in her room leaning to				
	at 8:40 a.m. R14 war of her room to the rat the dining room to placed at the table level met the edge.	d. No stimulus noted in room. as observed to be wheeled out main dining room and placed able. R14 was observed to be in a position where her eye of the table. R14 only ate er meal with full staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	ME 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	assistance. At 9:38 the dining room and transferred into her recliner with no stim remained in her reclapproximately 12:10 of her recliner and i wheeled to the dining be served her noon eating by staff placi spoon. R14 was not the table. At 1:20 p. wheeled out of the was transferred into Again R14 was left no stimulus occurring R14's activity attend months identified sl 2 times a week. The identify why R14 was when she did not at indicated R14 refus blank. R14's activity would do independe wheeling/walking in The one to one acti R14 had (1) one to on 8/18/15 where skids and activities significant in the one to one action R14 had (1) one to on 8/18/15 where skids and activities significant in the one to one action R14 had (1) one to on 8/18/15 where skids and activities significant in the one to one action R14 had (1) one to on 8/18/15 where skids and activities significant in the one to one action R14 had (1) one to on 8/18/15 where skids and activities significant recommendation r	a.m. R14 was wheeled out of d into her room then recliner. R14 was left in nulus in the room. R14 diner until the noon meal. At 0 pm. R14 was transferred out nto her wheelchair then no room. R14 was observed to meal and be assisted with no food in her mouth with a t social and did not interact at m. R14 was observed to be dining room to her room and other recliner in her room.	2 565			
	improvement and the discontinued. The Ademonstrated a decishould be reassess	tivities but had demonstrated ne one to ones were ND stated R14 had recently cline in activity attendance and ed for need for one to ones and staff ask R14 frequently for				

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STATEMEN	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	MF - T	NDLE STRE			
		MAPLETO	ON, MN 5606		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 17	2 565			
	refused. The AD ve many activities or the spent the majority of AD verified R14 near	s and motion and R22 often rified R14 was not involved in the facility environment and of her time in her room. The eded to be asked and cipate in activities she typically				
	R22 as dependent stimulation and sood disease process and further identified R2 focused for long peridentified as a militar singing and watching television. The care to attend/participate weekly. Intervention 1. assist/escort to a 2. Invite to activities 3. R22 is to have 1 and activities if unangular events.  4. R22 prefers activity overly demanding of simple, structured a Motion 5. When R22 choos organized activities provide sensory stimplements of the provide sensory stimplements of the provide sensory stimplements of the provide sensory for perion of the provide sensory for perion of the provide sensory for perion of the perion of the provide sensory for perion of the perion	to 1 bedside/in-room visits ble to attend out of room  vities which do not involve cognitive tasks. Engage in activities such as Music &  ses not to participate in turn on TV, music in room to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE : COMPI	
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE, ZIP CODE	1 00/2	172010
MAPLETON COMMUNITY HOME	301 TROE	NDLE STRE	ET		
		N, MN 5606			
PREFIX (EACH DEFICIENCY MUS			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTY)	D BE	(X5) COMPLETE DATE
R22 consumed his breat to wander around the dinear the dining room by wheelchair. At 9:43 a.m the dining room and planurses station reclined approximately 10:00 a.m room for a short period the hallway in front of the a.m. R22 remained sewheelchair until 11:35 a wheeled into the dining at approximately 12:50 out of the dining room a left beside his bed in the 1:40 p.m. NA-E and Deattached his lift sling to transferred him into bed remained in bed. R22 wencouraged to participa At 3:37 p.m. R22 remained in bed. R22 wencouraged to participa At 3:37 p.m. R22 remained in bed. R22 wencouraged to participa At 3:37 p.m. R22 remained in bed. R22 wencouraged to participa At 3:37 p.m. R22 remained in bed. R22 was obshis back with eyes close a.m. R22 was transferred for a mechanical lift and R22 was wheeled into the served his breakfast medining room until 9:43 and wheeled out of the dining in front of the nurses st was wheeled to his room shirt as it was heavily shand liquids. At 9:55 a.m seated in his wheelchai	observed to be served ssisted out of bed;. After takfast R22 was observed dining room and hallways by wheeling himself in his in. staff wheeled R22 out of aced him in front of the lin his wheelchair. At im. R22 was wheeled to his dithen wheeled back to the he nurses station at 10:09 tated in his reclining a.m. at which time he was groom. After the noon meal p.m. R22 was wheeled and into his room. R22 was ne room with no activity. At entered R22's room and of the mechanical lift and and at 2:35 p.m. R22 was not observed to be ate or attend any activities. Sined in his bed while grouping.  Cares on 08/26/2015 at served lying in his bed on sed. At approximately 8:05 red out of bed with the used two staff. At 8:20 a.m.	2 565			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	COMPLETE DATE
2 565	Continued From pa	ge 19	2 565			
	since admission, id activities less than incomplete to ident activities when he coccasionally indicat dates were left blar entries that R22 we such as resting, who watching television 8/2015 identified R2 far for the month. It documented on R2 visited with in the home sense, couldn't und about." On 8/19/15 R22's activity log the package from his far	dance logs for the past month, entified he attended formal 1 time a week. The logs were ify why R22 was not attending did not attend. The facility ted R22 refused but multiple ak. R22's activity log included ould do independent activities reeling/walking in halls and and the one to one activity log for 22 had (2) one to one visit so on 8/10/15 activity staff 2's activity log that R22 was allway,"wasn't making much lerstand what he was talking activity staff documented on at they assisted him open a amily and talked about the red. There were no further one				
	(AD) was interviewed difficult to get involved R22 was on 1 to 1 locate his one to or R22 was asked if hour often declined. agreed R22 was not environment and sphis room or position. The activity schedules a.m., Techniques; 12:00 p.m., happy have the activity schedules.	0:25 a.m. the activity director ed. The AD stated R22 was yed in activities. The AD stated activities but was unable to be logs. The AD also stated e wanted to attend activities. The AD further stated she of involved in the facility bent the majority of his time in the doutside the nurses station.  The B/24/15 was as follows: es; 10:00 a.m. Trivia; 11:00 also a.m., music and motion; bur; 4:00 p.m., men's group. The for 8/25/15 was as follows: es; 10:00 a.m. Trivia; 10:30				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING.			
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 565	a.m. music and mo p.m., Rosary. The activity schedu 9:30 a.m., Exercise 11:00 a.m., Technic motion; 2:00 p.m., sp.m., Discard it dice. The facility staff fail nutritional care plan required extensive. The care plan ident of regular small por Other interventions 1. Serve meals in the 2. Offer extra fluids 3. Honor noted like. During observation on 8/26/15, at 8:44 served a whole boil cinnamon raison to beverages. R14 was assistance with eat (NAR)-C was obserted into R14's moduring most of the positioned in her whose manner where her the edge of the table fed approximately 5 and consumed app. On 8/26/15 at 8:57 conducted with diet.	1:00 a.m., Techniques; 11:30 tion; 2:00 p.m., craft; 3:30  le for 8/25/15 was as follows: s; 10:00 a.m. Brain games; ques; 11:30 a.m., music and social; 2:15 p.m. Bingo; 4:00 e.  ed to implement R14's nuted 7/6/15, identified R14 assist with eating at times. ified R14's diet as consisting tions diet with the NIP. included: ne dining room. between meals and in room.	2 565			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00037	B. WING		08/2	7/2015
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLETO	ON COMMUNITY HO	ME	NDLE STRE N, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
	Improvement Progresidents in the dinidid not include R14 the NIP intervention syrup in their juice to When asked if R14 calories DA-A state.  On 8/26/15, at 12:1 be seated at the dirwith eating by NA-C slices of bread cover mashed potatoes a observed to attemp spoon food into R14 with her eyes close R14 was served chror liquids. R14 was approximately 50% approximately 25%.  On 8/26/15, at 12:2 about R14 receiving DA-B stated R14 has foods or supplement there was a list of rediet, DA-B retrieved food service area with NIP. DA-B looked didn't know she was responding to R14's DA-B stated R14 shoutter with her mas During interview with manager (CDM) on	nts were on the Nutritional am (NIP) and named off ng room on the program but. DA-A stated residents with a would have received Karo o add calories to the meal. I had received the added	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	7/2015
	PROVIDER OR SUPPLIER	ME 301 TROE	DRESS, CITY, S NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	verified R14 had be not know exactly what risk for malnutrition  SUGGESTED MET The director of nurs develop, review, an procedures to ensure plans according to a needs. The director could educate all agand procedures. The designee could devensure ongoing core	een placed on program but did nen and verified R14 was at related to her poor intake.  THOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re the facility develops care the residents individualized of nursing (DON) or designee opropriate staff on the policies ne director of nursing (DON) or relop monitoring systems to	2 565			
2 830	Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must rema prefers to remain in	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident	2 830			10/5/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	7/2015
	OF PROVIDER OR SUPPLIER ETON COMMUNITY HO	ME 301 TROE	DRESS, CITY, S NDLE STRE DN, MN 5600			
(X4) II PREFI TAG	X (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 8	Based on observation review the facility factor on a comprehensivinterventions to red skin tears for 2 of 3 for bruising and skin the necessary care positioning based of assessment for 1 of for positioning.  Findings include:  R22's admission Massessment, dated diagnoses which in kidney disease and MDS identified R22 cognition and requistaff for bed mobilit MDS identified R22 staff with mobility in During observations a.m. R22 was obsein the hallway in frohis feet dangling frowas noted to have storearms with the bentire aspect of bot of varying colors an also noted to have	on, interview and document ailed to provide services based assessment to develop uce the risk of bruising and residents (R8, R22) reviewed and services to maintain good and a comprehensive are comprehensive for 3 residents (R14) reviewed and services to maintain good and a comprehensive for 3 residents (R14) reviewed and services to maintain good and a comprehensive for a residents (R14) reviewed and severe impaired are developed assist of two and to transfer. Further, the arequired extensive assist of 1 and the wheelchair.  So of cares on 8/25/15 at 10:09 are developed as a formation with the modern and the severely bruised bilateral ruising encompassing the horearms. The bruising was an Opsite (wound dressing) on	2 830	Corrected		
	the medial aspect of covering a skin team drainage under the During observation	of his left arm that was which was presenting with				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00037	B. WING		08/2	7/2015
MAPI FTON COMMUNITY HOME 301 TROI			DRESS, CITY, S NDLE STRE DN, MN 5606			
(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 SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE	
2 830	of a mechanical lift. skin tear on R22's a sometimes would sthought that was he NAR-E verified R22 just strike out at the around him.  During review of R2 noted R22 had a hiaggressive towards have self injurious ton walls, wheelchair record contained madmission related to objects.  R22 had an admission related to objects.  R22 had an admission related to objects.  R22 had an admission related to objects.  During further reviet the medical record risk factors, goals a risk of bruising or splan did not identify related skin risk factors and it on 8/26/15, at 11:02 care plan had not be skin concerns and planned risks, goals or skin tears. It was ongoing monitoring	When interviewed about the arm NAR-D stated R22 trike out at staff and she ow the skin tear occurred. It would strike out at staff or example was a walls or whatever was a walls or whatever was a walls or whatever was a story of being physically a staff and would sometimes behaviors such as pounding ar, or tables. R22's medical aultiple notes since his or striking out at staff and would sometimes or striking out at staff and would sometimes or striking out at staff and would sometimes or striking out at staff and would sometimes are staff and would sometimes and would staff and would sometimes are staff and would sometimes a	2 830			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 25	2 830			
	depression, demen fibrillation.  During observation	that included major tia, anemia and atrial of R14 from 8/24/15 through oserved to spend the majority				
	of her days in her re seated in her whee multiple occasions her left side with he armrest of her whee observations at the observed to be pos	coom seated in her recliner or lchair in front of her recliner on R14 was observed leaning to be reclined resting on either the elchair or recliner. During meal times R14 was itioned at the table in a eyes were at the level of the				
	p.m. R14 was obse room leaning to the facing the televisior was not on and the	of cares on 8/24/15, at 4:26 erved in her recliner in her left while seated. R14 was in her room but the television re was non other stimulus in bm light was off and R14 was seed.				
	8/24/15, at 5:45 p.n at the dining room t to the left and her e R14's wheelchair w	of the evening meal on n. R14 was observed seated table in her wheelchair leaning eye level was at table edge. has too large for her with oted on bilateral sides when the wheelchair.				
	8/25/15, at 8:00 a.n the dining room at t wheelchair with the During observations	of the breakfast meal on n. R14 was observed seated in the dining room table in her edge of the table at her eyes. s on 8/25/15, at 9:44 a.m. R14 ed in her wheelchair in her				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIER  MAPLETON COMMUNITY HOP	ME 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
remained seated in leaning to the left wheelchair armrest.  During phone intervon 8/25/15, at 9:56 voiced a concern at family member state communication with new wheelchair for been done. The fan frequently in her roomuch being offered  On 8/26/15, at 6:40 her wheelchair in he observed sleeping i left, resting her elbot face in her hand. Richair which is too la support R14 in good remained seated in until 8:43 a.m. at whinto the dining room  On 8/26/15, at 8:44 seated at dining room table where height on nose level. Residen positioning does no social posture at table before the left in R14 did attend active leaning to the left in	sed. At 10:41 a.m. R14 her wheelchair in her room ith head resting on her left  view with R14's family member a.m. the family member bout R14's positioning. The ed there had been in the staff about looking at a R14 but nothing had ever nily member stated R14 was om in her wheelchair with not to her for activities or care.  am R14 was observed up in the room sleeping. R14 was on her wheelchair leaning to one on left armrest with her 14's wheelchair is a high back arge for her, and too wide to d upright positioning. R14 her wheelchair in her room which time she was wheeled on for breakfast.  4 a.m. R!4 was observed om table and positioned at of table left the edge at R14's at does not feed self but t enable resident to be in a	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	MF 301 TROE	ORESS, CITY, S NDLE STRE N, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 830	During interview wit (DNS) and registered 11:02 a.m. RN-C sthad been some evalued and she would talk what they had done positioning. RN-C R14's leaning at time R14's annual MDS identified R14 requited 2 staff with all achad severe cognitions staff support with bewalking.  During interview with 10:30 a.m. the DNS obtain any document had been assessed medical record lack comprehensive assent needs.  The facility policy for dated 5/5/10, identified wheelchairs for seat to maintain optimum. The procedure iden 1. The therapy depart of the resident care a resident who is not part B benefits is in positioning assessing assessing the same positioning assessing and services with the same position and services with the same positioning assessing and services with the same position and services with the	th the director of nursing and nurse (RN)-C on 8/26/15, at ated she was sure that there aluation of R14's positioning to physical therapy to see in relation to evaluation R14's verified she was aware of ites.  assessment, dated 6/25/15 ared extensive assistance of 1 tivities of daily living (ADL), on impairment, and needed alance when transferring or the DNS on 8/27/15 at 8 verified she was unable to intation that R14's positioning 1. The DNS verified R14's are any evidence of a ressment for her positioning or Wheelchair Positioning, fied residents who utilized atting will be properly positioned in comfort and well-being.  The DNS on 8/27/15 at a ressment for her positioning are seen that R14's positioning are seen that R14'	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMP	SURVEY LETED
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE	-	
MAPLETON COMMUNITY HOM	<b>-</b>	ENDLE STRE			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
Observations of R8 of observed to have a latinches in diameter or a quarter size bruise. During interview with stated that she obtain went to visit her sister further indicated her and she could have because she is on a Review of an incident indicated the resident of the left arm that me and a bruise to the right of the left arm that me and the	on 8/25/15 at 3:19 p.m., was arge bruise approximately 5 in the top of her left arm and on the top of her left hand. In the resident at this time, she ned the bruise when she are about 2 weeks ago. R8 sisters entry way is narrow bumped it when entering the realed she bruises easily blood thinner.  It report for R8 dated 8/16/15 in obtained a bruise to the top reasured 7.5 cm by 6.0 cm ght arm that measured 6.0 report indicated the resident rest, but was unsure what the bruise was identified after rest, but was unsure what the physicians orders replavix (blood thinner) and the resident rest of the use of a blood thinner.	2 830			

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00037	B. WING		08/2	7/2015
	PROVIDER OR SUPPLIER	ME 301 TROE	DRESS, CITY, S NDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	use of a blood thinn Review of the facilit 7/12/15, included; tl identified, cause de monitored; enter tre		2 830			
	The director of nurse establish procedure ensure that residen being met. The director of the could review and rerelated to non press and positioning, corprovide staff educates resident. The direct could develop an accare is provided.	HOD FOR CORRECTION: sing and/or designee could es, educate staff and audit to ts individualized needs are ector of nursing or designee, evise policies and procedures sure related skin conditions induct assessments and could tion related to the care of or of nursing or designee audit tool to ensure appropriate				
2 965	MN Rule 4658.0600 -Nutritional Status Subpart. 2. Nutritio must ensure that a which supplies the o determined by the o assessment. Subs	nal status. The nursing home resident is offered a diet caloric and nutrient needs as comprehensive resident titutes of similar nutritive value residents who refuse food	2 965			10/5/15

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00037	B. WING		08/2	7/2015
MAPI ETON COMMUNITY HOME 301 TRO			DRESS, CITY, ENDLE STRI DN, MN 560			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 965	This MN Requirements: Based on observation review the facility far nutritional needs be assessment for 1 or for weight loss.  Findings include:  R14's annual Minimassessment dated diagnoses that includementia, anemia a identified R22 requione staff for mobility.  R14's nutritional Ca 6/26/15, identified Find the chewing/swallowing that affected R14's Prosource for skin liberalized diabetic Further, the CAA id loss in the last 6 monot given and would her the house suppose A dietary note, date recommendation for regular diet with smoverwhelm R14 with would include fortifit The goal was identified between 103-113 per section of the control of the	ent is not met as evidenced ion, interview and document ailed to provide the necessary ased on comprehensive if 3 residents (R14) reviewed in a residents (R14) reviewed in a resident (R14) reviewed in a received in a re	2 965	Corrected		
1	noted R14 had sus	14's medical record it was tained a fifteen (15) pound ast 6 months which was 14.2				

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AND DI AN OF CODDECTION IDENTIFICATION NI IMPED:		(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00037	B. WING		08/	27/2015
	PROVIDER OR SUPPLIER	MF 301 TROI	DDRESS, CITY, S'ENDLE STREION, MN 5606	<b>ET</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
	loss. R14's weight of 121 pounds and he dated 8/23/15 was R14's care plan, reverequired extensive. The care plan ident of regular small por Other interventions 1. Serve meals in the 2. Offer extra fluids 3. Honor noted likes During observation on 8/26/15, at 8:44 served a whole boil cinnamon raison to beverages. R14 was assistance with eat (NAR)-C was obserfood into R14's more during most of the repositioned in her whost manner where her the edge of the table fed approximately 5 and consumed app On 8/26/15 at 8:57 conducted with diet special intervention was not aware of all stated some reside	weight, a significant weight on 2/22/15 was identified at r current recorded weight, 106 pounds.  vised 7/14/15, identified R14 assist with eating at times. ified R14's diet as consisting tions diet with NIP. included: ne dining room. between meals and in room. It is and dislikes.  of R14 at the breakfast meal a.m. R14 was observed to be ed egg, two (2) 1/2 slices of ast with milk juice and water is observed to need ing and nursing assistant and the reyes closed meal time. R14 was also noted neelchair at the table in a mose was in line at level with e. R14 was observed to be 50% of her breakfast foods roximately 10% of her liquids.  a.m. an interview was ary aide (DA)-A related to any is for R14. DA-A stated she my special interventions and ints were on the nutritional	2 965	DEFIGIENCY)		
	residents in the dini did not include R14 the NIP intervention syrup in their juice t	am (NIP) and named off ng room on the program but . DA-A stated residents with a would have received Karo o add calories to the meal. 4 had not received Karo syrup				

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AND DUAN OF CODDECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED	
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HOI	ME 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 965	be seated at the dir with eating by NA-C slices of bread cover mashed potatoes a observed to attemp spoon food into R14 with her eyes closed R14 was served chror liquids. R14 was approximately 50% approximately 25% On 8/26/15, at 12:2 about R14 receiving DA-B stated R14 has foods or supplement residents in a plasticate a which identified looked at the list and she was supposed R14's name which R14 should have remashed potatoes for During interview with manager (CDM) on stated she expected residents identified verified R14 had be not know exactly which is for malnutrition. The facility failed to assessed to met the The facility failed to	kfast meal.  7 p.m. R14 was observed to hing room table being assisted by R14 was served (2) 1/2 ered with brown gravy, and cooked carrots. NA-C was to to encourage R14 to eat and the first mouth. R14 was seated douring most of the meal. Cocolate milk, juice and water of the bread and gravy and of her mashed potatoes.  2 p.m. DA-B was questioned grany supplemental nutrition. and not received any extra that DA-B provided a list of cosleeve at the food service do residents on the NIP. DA-B do stated, "Oh, I didn't know to get the NIP", responding to was on the list. DA-B stated ceived extra butter with her	2 965			

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PRINTED: 10/12/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_\_ B. WING 00037 08/27/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 301 TROENDLE STREET **MAPLETON COMMUNITY HOME** MAPLETON, MN 56065 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 9 6 5 Continued From page 33 2 9 6 5 The facility policy Nutritional Intervention Program, dated 8/26/15, identified it was the policy of the facility to increase caloric intake with minimal increase in food volume to improve nutritional status whenever feasible for residents. The policy identified that changes in daily menus would include following increases in total calories and protein with higher fat containing foods. Foods identified included: 1. Whole milk 2. 1 tablespoon of syrup in breakfast juice. 3. 1 extra margarine pat or teaspoon of margarine with dinner and supper meals. 4. Snacks between meals per residents self determination of own or at dietary managers discretion. 5. commercial supplements will also be considered and ordered by the physician if deemed necessary. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise current policies and procedures related to weight loss and residents nutritionally at risk. The administrator or designee could educate responsible staff on the policy changes as well as audit to ensure all current recommendations are being carried out within the dietary department.

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(21) days.

The administrator or designee could conduct audits for compliance and review with the quality

TIME PERIOD FOR CORRECTION: Twenty-one

assurance committee.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00037	B. WING		00/0	7/201 F
NAME OF I	PROVIDER OR SUPPLIER			27ATE 7ID CODE	1 00/2	7/2015
		301 TROP	ENDLE STRE	STATE, ZIP CODE E <b>ET</b>		
MAPLET	ON COMMUNITY HO	MI I	ON, MN 5600			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 34	21435			
21435	MN Rule 4658.0900 Recreation Program	0 Subp. 1 Activity and n; General	21435			10/5/15
	home must provide recreation program based on each indistrengths, and need meet the physical, i well-being of each i comprehensive rescomprehensive pla 4658.0400 and 465 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and .				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary activity needs based on comprehensive assessment for 2 of 3 residents (R14 and R22) in the sample who were reviewed for activities.			Corrected		
	Findings include:					
	assessment dated diagnoses that includementia, anemia a identified R22 requione staff for mobilit was somewhat impactivities with other favorite activities armusic she likes and	num Data Set (MDS) 6/25/15 identified R14 had uded major depression, and atrial fibrillation. The MDS ired extensive assistance of y. The MDS further indicated it ortant for R14 to do group s, keep up with news, do her nd very important to listen to d going outside. ivity Assessment, dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING.			
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21435	3-5 times a week. In needed reminders a activities and identification appropriate behavior.  R14's Care Plan for identified R14 had I which she has beer identified R14 had I sleeping more. The R14's interest in act. Going through he she finds in them.  2. Going to and enj program, where she week.  3. Going to exercise 4. Going to music pto 5. Wheeling around afternoons.  6. Reading out loud working well for her reading but due to she declined book.  R14's care plan goal activities at least 3-for activity were ideactivity schedule, In attend activities of i programs), assist to socialization, and comaterials for independences.	R14 participated in activities The assessment identified R14 and assistance to attend fied she demonstrated ors while in activities.  If activities, dated 7/6/15, liked to read romance novels, in not doing. The care plan open watching TV and is care plan further identified tivities as: for drawers and looking at what oying Music and Motion for is participating 3-5 days a for program on occasion. For orgrams as well. If the halls in the late If program, which has been for R14 has always enjoyed sight she hasn't been able to. If the halls in the late It program, which has been for R14 has always enjoyed sight she hasn't been able to. If the halls in the late If program, which has been for R14 has always enjoyed sight she hasn't been able to. If the halls in the late If the halls in the l	21435			
	recliner in her room	p.m. R14 was observed in her leaning to the left while ucing the television in her room				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			B. WING			
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	MF	NDLE STRE			
		MAPLETO	N, MN 5606	55		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ge 36	21435			
	but the television wother stimulus in he off and R14 was sit remained in her root time she was whee and placed at the domeal time R14 spenseated in her reclinistaff attempted to feat the dining room to eyes when staff plate approximately 6:25 the dining room to front of her recliner and television off. Further wheelchair until last	as not on and there was noner room. R14's room light was ting with eyes closed. R14 om until 5:20 p.m. at which led into the main dining room ining room table. During the nt much of her meal time er with her eyes closed while eed her. R14 was not engaged able and only opened her ced food in her mouth. At p.m. R14 was wheeled out of her room and left seated in in her room with the light off R22 remained seated in her tobserved at 7:45 p.m. when ed in her room in her recliner				
	was observed in the dining room table in placed at the table the table was at the observed sleeping 8/25/14 R14 was w to her room and left front of her recliner television off. There observed until 11:30 out of her room and noon meal at 11:30 dining room until apshe was wheeled b transferred from he her room. R14 was out and no stimulus 8/25/15 R14 remain her recliner in her room.	s on 8/25/15, at 8:05 a.m. R14 e dining room seated at the her wheelchair. R14 was in a manner where the edge of elevel of her nose. R14 was at the table. At 8:40 a.m., on heeled out of the dining room to seated in her wheelchair in with the light out and e was no interaction with R14 0 a.m. when R14 was wheeled into the dining room for the a.m. R14 remained in the proximately 12:30 p.m. when ack to her room and r wheelchair to the recliner in left in her recliner with light in room. At 1:49 p.m. on hed seated with eyes closed in froom with no stimulus in the roommates television on				

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AND DIAN OF CODDECTION INDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	ME 301 TROI	DDRESS, CITY, S ENDLE STRE ON, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
21435	which is out of her observed through 3 remained in her recactivity occurring.  During phone intervon 8/25/15, at 9:56 voiced a concern alfacility environment R14 was frequently with not much being care.  During observation a.m. R14 was obse wheelchair with eye television was on bowelchair with eye television was on bowelchair with no On 8/26/15, at 7:30 a.m. her w/c in her room wheelchair with no On 8/26/15 at 8:24 seated in her wheeleft with eyes closed at 8:40 a.m. R14 woof her room to the reat the dining room to wheeled out of the other transferred intervention with the dining of her recliner and in wheeled to the dining be served her noon eating by staff placis spoon. R14 was nother table. At 1:20 p. wheeled out of the was transferred into was transferred into the was transferred i	ge 37  visual range. R14 was :40 p.m., on 8/25/15 and diner in her room with no  view with R14's family member a.m. the family member stated in her room in her wheelchair g offered to her for activities or  of cares on 8/26/15, at 6:40 rved in her room in her es closed. Roommates at out of the view of R14. On a. R14 was observed seated in leaning to her left in her activity occurring in the room. a.m. R14 was observed chair in her room leaning to d. No stimulus noted in room. as observed to be wheeled out main dining room and placed able. At 9:38 a.m. R14 was dining room and into her room of her recliner. R14 was left in mulus in the room. R14 diner until the noon meal. At 0 pm. R14 was transferred out not her wheelchair then mg room. R14 was observed to meal and be assisted with mg food in her mouth with a t social and did not interact at m. R14 was observed to be dining room to her room and her recliner in her room. in the room with light off and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	МЕ	ENDLE STRE DN, MN 5606			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	no stimulus occurri  The activity schedu 9:30 a.m., Exercise a.m., Techniques; 1 2:00 p.m., happy he The activity schedu 9:30 a.m., Exercise a.m., Bible study; 1 a.m. music and mo p.m., Rosary. The activity schedu 9:30 a.m., Exercise 11:00 a.m., Technic motion; 2:00 p.m., s p.m., Discard it dice  Review of R14's ac months of May, Jur revealed R22 had of in activities consiste R14's activity log id activities such as re halls and watching revealed at times F the logs did not incl attending activities any other activities  Review of R14's Or revealed a note on one to one visit whe her kids and activiti	ng.  alle for 8/24/15 was as follows: as; 10:00 a.m. Trivia; 11:00 all:30 a.m., music and motion; aur; 4:00 p.m., men's group. alle for 8/25/15 was as follows: as; 10:00 a.m. Trivia; 10:30 alle for 8/25/15 was as follows: as; 10:00 a.m., Techniques; 11:30 alle for 8/25/15 was as follows: as; 10:00 a.m. Brain games; aues; 11:30 a.m., music and asocial; 2:15 p.m. Bingo; 4:00 alle for 8/25/15 was as follows: as; 10:00 a.m. Brain games; aues; 11:30 a.m., music and asocial; 2:15 p.m. Bingo; 4:00 alle for 8/25/15 was as follows: as; 10:00 a.m. Brain games; aues; 11:30 a.m., music and asocial; 2:15 p.m. Bingo; 4:00 alle for 8/25/15 was as follows: as; 10:00 a.m. Brain games; aues; 11:30 a.m., music and asocial; 2:15 p.m. Bingo; 4:00 asocial;	21435			
		0:25 a.m. the activity director ed. The AD stated R14 used to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
MAPLETON COMMUNITY HOM	ME	ENDLE STRE DN, MN 5606			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	.D BE	(X5) COMPLETE DATE
improvement and the discontinued. The Ademonstrated a dec should be reassess again. The AD confillongs and stated state to attend moves and refused. The AD vermany activities or the spent the majority of AD verified R14 need encouraged to partienjoyed.  The facility failed to needs for R14 as exprovide services as one to one and grouencourage R14 to a identified as importate. The facility did needs when they ideand attendance has the three days of ob 8/26/14, during time being conducted at observed to be encactively involved in a observed to spend to time in her room with stimulus (I.e., televis interaction).  R22's admission Massessment, dated diagnoses which incomplete in the service of the service o	tivities but had demonstrated ne one to ones were AD stated R14 had recently cline in activity attendance and red for need for one to ones irmed the monthly attendance aff ask R14 frequently for her d motion and R22 often rified R14 was not involved in ne facility environment and of her time in her room. The reded to be asked and recipate in activities she typically by the provide the necessary activity activities and failed to directed by their failure to directed by the care plan for up activities and failed to attend activities which she ant or somewhat important to not reassess R14's activities entified her activity preference as significantly changed. During observation 8/24/15 through the facility, R14 was not ouraged to attend or be any formal activities. R14 was the majority of the observation the lights out and no	21435			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00037	B. WING		08/2	7/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	ENDLE STRE DN, MN 5606			
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	MDS identified R22 cognition and requistaff for bed mobilit MDS identified R22 staff with mobility in R22's Activity assertidentified R22 with interests that include exercises, reading, shopping, outdoors gardening and keep Further, the assess attending activities loved bingo and en TV.  R22's activity care R22 as dependent stimulation and sood disease process are further identified R2 focused for long peridentified as a militate singing and watching The care plan identities as indentified as a militate singing and watching the care plan id	2 had severe impaired red extensive assist of two by and to transfer. Further, the 2 required extensive assist of 1 in the wheelchair.  Sesment dated 8/10/15 past and current activity ded: cards, games, crafts, music, sports, religion, so, watching television, ping current with news. Sement identified R22 enjoyed both morning and afternoon, joyed watching ball games on plan, dated 8/4/15, identified on staff for activities, cognitive stal interaction due to his and dementia. The care plan 22 could be hard to keep eriods of time. He was arry veteran who enjoyed and ball games on television. It if it is a goal for R22 to a 3-5 activities of choice as were identified as follows: activity functions.	21435			
	overly demanding of simple, structured a Motion 5. When R22 chool	vities which do not involve cognitive tasks. Engage in activities such as Music & ses not to participate in turn on TV, music in room to				

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AND DIAN OF CORRECTION IN IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	ME 301 TROE	DRESS, CITY, S INDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21435	provide sensory stir  During observation p.m. to 7:30 p.m. R reclining wheelchair except for brief peri into his room for pe  During observation at 8:40 a.m. R14 w breakfast after bein R22 consumed his to wander around th near the dining room wheelchair. At 9:43 the dining room and nurses station reclin approximately 10:00 room for a short pe the hallway in front a.m. R22 remained wheelchair until 11: wheeled into the dir at approximately 12 out of the dining roo left beside his bed i 1:40 p.m. NA-E and and with the use of him into bed. At 2:3 R22 was not observ participate or attend R22 remained in his were occurring.  During observation 6:47 a.m. R22 was his back with eyes of a.m. R22 was trans of a mechanical lift		21435			

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		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE COMP	
	00037	B. WING		08/2	7/2015
NAME OF PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		.,
MAPLETON COMMUNITY HOM	ИF	NDLE STRE			
OUR MAR DV OTA:		N, MN 5606		ON	0.5
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dining room until 9:4 wheeled out of the cin front of the nurses was wheeled to his shirt as it was heavi and liquids. At 9:55 seated in his wheeled bed. There was no a lidentified a care con interdisciplinary tear. The note identified I activities, cognitive sinteraction.  The activity schedul 9:30 a.m., Exercises a.m., Techniques; 1 2:00 p.m., happy ho The activity schedul 9:30 a.m., Exercises a.m., Bible study; 11 a.m. music and mot p.m., Rosary. The activity schedul 9:30 a.m., Exercises 11:00 a.m., Techniq motion; 2:00 p.m., sp.m., Discard it dice.  On 08/26/2015 at 10 (AD) was interviewed difficult to get involv R22 was on one to to locate his one to	st meal. R22 remained in the 43 a.m. at which time he was dining room and to the hallway is station. At 9:49 a.m. R22 room by staff to change his ily soiled with breakfast foods a.m. R22 was observed to be chair in his room beside his activity occurring in the room.  ed 8/12/2015, at 11:53 a.m. inference was held with the m and R22's family member. R22 as dependent on staff for stimulation and social  le for 8/24/15 was as follows: s; 10:00 a.m. Trivia; 11:00 1:30 a.m., music and motion; our; 4:00 p.m., men's group. le for 8/25/15 was as follows: s; 10:00 a.m. Trivia; 10:30 1:00 a.m., Techniques; 11:30 tion; 2:00 p.m., craft; 3:30  le for 8/25/15 was as follows: s; 10:00 a.m. Brain games; jues; 11:30 a.m., music and social; 2:15 p.m. Bingo; 4:00	21435			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00037	B. WING		08/2	27/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	_D BE	(X5) COMPLETE DATE
IAG	nedoznom om z	oo is Electric Filter and or allow the leave	IAG	DEFICIENCY)		
21435	environment and sphis room or position R22's activity attending since admission, id activities less than incomplete to ident activities when he coccasionally indicated dates were left blar entries that R22 we such as resting, who watching television 8/2015 identified R2 far for the month. It documented on R2 visited with in the his sense, couldn't und about." On 8/19/15 R22's activity log the package from his fargoodies" he receive to one visits noted.  The facility failed to needs for R22 as e provide services as	a not involved in the facility bent the majority of his time in ned outside the nurses station.  I dance logs for the past month, entified he attended formal 1 time a week. The logs were ify why R22 was not attending did not attend. The facility ted R22 refused but multiple lik. R22's activity log included build do independent activities leeling/walking in halls and and the one to one activity log for 22 had (2) one to one visit so on 8/10/15 activity staff 2's activity log that R22 was allway,"wasn't making much lerstand what he was talking is activity staff documented on at they assisted him open a family and talked about the red. There were no further one of provide the necessary activity videnced by their failure to a directed by the care plan for	21435			
	encourage R22 to a identified as import himself. The facility R22 outside the act station or in his roo were occurring and offered to participat room he was left wistimulus occurring throughout the surv	up activities and failed to attend activities which he ant or somewhat important to a staff frequently positioned tivity room by the nurses m when organized activities R22 was not observed to be the When R22 was left in his with no activity or environmental in his room. He was observed they in his room beside his bed levision, radio or staff				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:	<del></del>	COMP	LEIED
		00037	B. WING		08/2	7/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
MAPLET	ON COMMUNITY HO	ME	NDLE STRE			
		MAPLETO	N, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	ige 44	21435			
	interaction.					
21610	The activities direct and revise policies the cognitively impadesignee could eduactivities programmensure activities be interests and abilitie referred to the qual ensure ongoing cor TIME PERIOD FOR (21) days.	THOD OF CORRECTION: tor or designee could review and programming related to aired. The activities director or acate staff on individualized ning, and conduct audits to sing provided reflect resident es. The audits could be ity assurance committee to ity assurance committee to mpliance.  R CORRECTION: Twenty-one	21610			10/5/15
	and Preparation Are Subpart 1. Storage must store all drugs under proper tempe only authorized nur access to the keys.  This MN Requirement by: Based on observati review the facility far pharmacological's i the potential to affe independent mobili  Findings include:  During observation	ea;Storage e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have  ent is not met as evidenced ion, interview and document ailed to maintain security of in the treatment cart. This had ict all residents with ty who reside in the facility.		Corrected		10/0/10
		nedication assistant (TMA)-A				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER	ME 301 TRO	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21610	observed to be stored there was a drawer several vials of insumante the hallway. The unseveral eye drops a indicated the treation the hallway. The unseveral eye drops a indicated the treation that the proceeded to what the proceeding medication unattended cart responder while several shall wheeled by confirmed the cart indicated she would charge of the treation of the unlocked treation and the proceeding that the proceeding with the proceeding that the proceeding the proceeding that the proceeding the proceeding that the proceeding that the proceeding the proceeding that the proceeding that the proceeding that the proceeding the proceeding that the proceeding that the proceeding that the proceeding that the proceeding the proceeding that the proceeding the proceeding the proceeding that the proceeding the	red in a tub room unsecured. It that was pulled open with ulin and syringes in view from allocked cart also contained and treatment creams. TMA-A ment cart should be locked, alk away from the ed storage cart to continue is in the dining room. The mained unsecured until 6:35 staff and residents had the cart. At 6:35 p.m., TMA-A remained unsecured, and do notify the nurse who was in ment cart.  Seed practical nurse (LPN)-A on a confirmed she was in charge atment cart. LPN-A indicated the cart in the locked out placed it in the tub room so asidents to the dining room for to lock the cart.  OON on 8/14/15 at 7:30 p.m. ment cart should be locked at tended.  It y and Procedure dated of medications, syringes and the facility should ensure that a treatment items are securely eabinet/cart or locked at is inaccessible by residents				
		THOD OF CORRECTION: The tor of nursing (DON) and				

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-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		00037	B. WING		08/2	27/2015
	PROVIDER OR SUPPLIER ON COMMUNITY HO	ME 301 TROE	DRESS, CITY, S ENDLE STRE DN, MN 5606			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21610	consulting pharmac policies and proced medications. Nursin necessary to the im medications. The D the pharmacist, cou basis to ensure con	cist could review and revise lures for proper storage of ng staff could be educated as aportance of properly securing OON or designee, along with ald conduct audits on a regular	21610			

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# Confirmation page! Thank you for using the data entry system. If you have comments please send to:

monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: 08/24/15 To F2: 08/27/15	Extended Survey Date Format: mm/dd/yy From F3: To F4:							
Name of Facility: MAPLETON COMMUNITY HOME	Provider Number: 245362	Fiscal Year ending:						
Address: 301 TROENDLE STREET, MAPLETON, B	BLUE EARTH, MN 56	065						
Telephone Number: F6 507-524-3315	State/County Code: MN / BLUE EARTH	State/Region Code: MN / 05						
B. Is this facility hospital based? F10 No	A. F9 01 - Skilled Nursing Facility (SNF) - Medicare Participation  B. Is this facility hospital based? F10 No  If yes, indicate Hopsital Provider Number: F11							
Ownership: F12 05 - Non Profit - Nonprofit C	Corporation							
Owned or leased by Multi-Facility Organizatio Name of Multi-Facility Organization: F14	n: <b>F13 No</b>							
Dedicated Special Care Units (show number of	beds for all that apply)							
AIDS F15 0 Alzh	neimer's Disease F16 0							
Dialysis F17 0 Disa	bled Child Young Adul	t F18 <b>0</b>						

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Head Trama F19 0 Hospice F20 0 Ventilator/Respiratory Care F22 0 Huntington's Disease F21 0 Other Spec Rehab. F23 0 Does the facility currently have an organized resident group? F24 Yes Does the facility currently have an organized group of family Yes members of residents? F25 Does the facility conduct experimental research? F26 No Is the facility part of a continuing care retirement community No (CCRC)? F27 If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks. Hours waived per Date: mm/dd/yy Waiver of seven day RN requirement. week: F28 F29 Hours waived per Date: mm/dd/yy Waiver of 24 hr licensed nursing requirement. week: F31 Does the facility currently have an approved nurse aide training and No competency program? F32 The following three questions are to be completed by the survey team. 1) Was this a staggered Survey? No - Not Staggered 2) If staggered, day of the week starting? **Surveyor to Complete** 3) If staggered, starting time? Surveyor to complete AM

FACILITY STAFFING							
	1 · I	ACILITI STA	FINO		1		
		A	В	С	D		
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)		
Administration	F33		0	0	0		
Physician Services	F34	Yes No No					
Medical Director	F35		0	0	0		
Other Physician	F36		0	0	0		
Physician Extender	F37	Yes No No	0	0	0		

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F38	Yes No No			
F39		0	0	0
F40		0	0	0
F41		473	0	0
F42		73	62	0
F43		1199	752	0
F44		0	0	0
F45		175	26	0
F46	Yes No No	0	0	8
F47	Yes No No			
F48		0	0	0
F49		160	581	0
F50				
F51	Yes No No	0	0	10
F52		0	0	75
F53		0	0	0
F54	Yes No No	0	0	20
F55		0	0	88
F56		0	0	0
F57	Yes No No	0	0	17
F58	No No No	0	0	0
F59	No No No	0	0	0
F60	Yes No No	83	118	0
F61	No No No	0	0	0
	F39   F40   F42   F45   F46   F47   F50   F51   F55   F56   F57   F58   F60   F60	F39	F39	F39

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Other Social Services Staff	F62	Yes No No	0	0	0
Dentists	F63	No No No	0	0	0
Podiatrists	F64	No No No	0	0	0
Mental Health Services	F65	Yes No No	0	0	4
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	78	262	0
Other	F71		0	148	0
Name of Person Completing Form:  RoxAnne Gosson					Date: <b>08/28/15</b>

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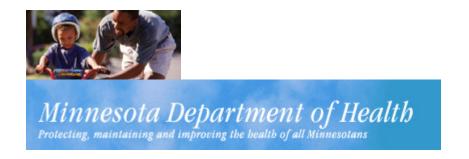
See also > Compliance Monitoring Home

For questions about this page, please contact our Compliance Monitoring Division: <a href="health.fpc-web@state.mn.us">health.fpc-web@state.mn.us</a>

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# Confirmation page! Thank you for using the data entry system. If you have comments please send to:

monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

MAPLETON COMMUNITY HOME							
Provider No. <b>245362</b>	Medicare F75	Medicaid F76 28	Other <b>F</b> '/'	Total Residents F78 57			

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 <b>1</b>	F80 <b>50</b>	F81 6
Dressing	F82 3	F83 53	F84 <b>1</b>
Transferring	F85 10	F86 41	F87 6
Toilet Use	F88 <b>5</b>	F89 <b>49</b>	F90 3
Eating	F91 32	F92 22	F93 <b>3</b>

## A. Bowel/Bladder Status

F94 6 With indwelling or external catheter.

F95 Of total number of residents with catheters, 5 were present on admission.

## **B.** Mobility

F100 0 Bedfast all or most of time..

F101 48 In chair all or most of time.

F102 9 Independently ambulatory.

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F96 38 Occasionally or frequently incontinent of bladder.

F97 24 Occasionally or frequently incontinent of bowel.

F98 38 On individually written bladder training program.

F99 24 On individually written bowel training program.

F103 27 Ambulation with assistance or assistive device.

F104 1 Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 23 With contractures.

F107 Of total number of residents with contractures, **20** had contractures on admission.

#### C. Mental Status

F108 **0** With mental retardation.

F109 42 With documentation signs and symptoms of depression.

F110 14 With documentation psychiatric diagnosis (excluding dementias and depression).

F111 28 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 11 With behavioral symptoms.

F113 **0** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

## D. Skin Integrity

F115 2 With pressure sores (exclude stage I).

F116 2 Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **43** Receiving preventive skin care.

F118 0 With rashes.

### E. Special Care

F119 0 Receiving hospice care benefit.

F120 0 Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 15 Receiving injections (exclude vitamin B12 injections)

F129 0 Receiving tube feedings.

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F122 0 Receiving dialysis.

F123 0 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.

F124 8 Receiving respiratory treatment.

F125 0 Receiving tracheostomy care.

F126 0 Receiving ostomy care.

F126 0 Receiving dialysis.

F130 12 Receiving mechanically altered diets including pureed and all chopped food (not only meat).

F131 16 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).

F132 12 Assistive devices while eating.

#### F. Medication

F133 33 Receiving any psychoactive medication.

F134 3 Receiving antipsychotic medications.

F135 5 Receiving antianxiety medications.

F136 31 Receiving antidepressant medications.

F137 **0** Receiving hypnotic medication.

F138 10 Receiving antibiotics.

F139 40 On pain management program.

#### G. Other

F140 11 With unplanned significant weight loss/gain.

F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).

F142 **0** Who use non-oral communication devices.

F143 21 With advance directives.

F144 50 Received influenza immunization.

F145 52 Received pneumococcal vaccine.

I certify that this Information is accurate to the best of my knowledge.							
Name of Person Completing	Title	Date					
Lori Swehla	RN DON	08/28/2015					

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? Yes
F147 Was ombudsman present during any portion of the survey? No
F148 Medication error rate 0%

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See also > Compliance Monitoring Home

Y

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project(0838-0583), Washington, D.C. 20503.

Provider/Supplier 245362											
Type of Survey (select all that apply):  I  Extent of Survey (Select all that apply):  A			A Complaint Investigation E Initial Certification I Recertification B Dumping Investigation F Inspection of Care J Sanction/Hearing C Federal Monitoring G Validation K State License D Follow-up Visit H Life safety Code L Chow  A Routine/Standard (all providers/suppliers) B Extended Survey (HHA or long term care facility) C Partial Extended Survey (HHA)								
			D Other Surv	rey							
			SURVEY TEAM A								
Please enter the wor		tion for eac Last		Use the sur							
Surveyor Id Number (A)	First Date Arrived (B)	Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (H)	ff-Site Report Preparation Hours (I)			
1. 22113	08-24-2015	08-27-2015	0.00	1.00	23.50	2.00	5.50	6.00			
2. 28591	08-24-2015	08-27-2015	0.00	1.00	26.50	2.00	0.00	8.50			
3. Team Leader	08-24-2015	08-27-2015	2.00	1.00	23.25	2.00	0.50	4.50			
4. 34986	08-24-2015	08-27-2015	0.00	0.00	30.00	2.00	2.75	0.00			
5.											
6.											
7.											
8.											
9.											
10.											
			•								

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

#### SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Public reporting burden 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 Office of Financial Management, HCFA, P.O. Box 26684, Baltimore, MD 21207; or to the Office of Management and Budget, Paperwork Reduction Project (0838-0583), Washington, D.C. 20503.

Provider/Supplier	Number	Pro	vider/Supplie	er Name				
245362		MAE	PLETON COMMUNI	TY HOME				
e of Survey (sele			A Complaint B Dumping In C Federal Mo D Follow-up	vestigation nitoring	F Inspec G Valida	tion of Car	e J San	certification ction/Hearing te License
A			A Routine/St B Extended S C Partial Ex D Other Surv	urvey (HHA o	r long term		ity)	
		i	SURVEY TEAM A	ND WORKLOAD 1	DATA			
ease enter the wor				Use the sur	veyor's info			
rveyor Id Number	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel (H)	off-Site Report Preparation Hours (I)
. 34764	08-25-2015	08-25-2015	1.00	0.00	3.00	0.00	4.00	0.00
Team Leader 35482	08-25-2015	08-25-2015	1.00	0.00	3.00	0.00	1.50	1.50
).								
		1					1	1
al Supervisory Re	view Hours							0.75

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

## FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	SURVEY DATE		
K1 245362	MAPLETON COMMUNITY HOM	TE	*K4 <b>08/25/2015</b>
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS NUMBER OF THIS BUILDING	2A	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR    He	2000 EXISTING 2000 NEW	COMPLETE IF ICF/MR IS SURVEYED UND SMALL (16 BEDS OR  1 PROMPT 2 SLOW 3 IMPRACT	LESS)
14   2786 U 15   2786 U I 16   2786 V, W,	ASC Form	LARGE  4 PROMPT 5 SLOW 6 IMPRACT	ICAL
	OF FORM USED FROM ABOVE	APARTMENT HOUSE  7 PROMPT 8 SLOW 9 IMPRACT	ïCAL
2786 M, R, T, U, V, W, X	e marked as not applicable in the X, Y and Z.)  K56: 3	ENTER E-SCORE HERE  K5: e.g 2.5	
*K9 : FACILITY MEETS LSO  A1  (COMP. WITH ALL PROVISIONS)	C BASED ON: (Check all that apply)  A2 X A3 (ACCEPTABLE POC) (WA	AIVERS) (FSES)	A5 PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET	FULLY SPRINKLI (All required areas are s		C. NONE (No sprinkler system)
*MANDATORY			

2000	CODE
2000	CODE

Form Approved OMB Exempt

FIRE SAFETY SURVEY RE Medica	PORT 2000 CODE - HEA	ALTH CARE	1. (A)	) PROVIDER NU	IMBER 1. (	B) MEDICAID I.D. NO.	
		ife Safety Cod – Waiver Reco			·		
Identifying information as shown in appl	cable records. Enter changes	s, if any, alongs	side each it	em, giving da	te of change.		
			2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)  A Fully Sprinklered (All required areas are sp  B Partially Sprinklered (Not all required areas are C None (No sprinkler syst				
3. SURVEY FOR	4. DATE OF SURVEY	DAT	E OF PLAN A	PPROVAL	SURVEY UNDE		
MEDICARE MEDICAID	  K4	K6			5. 2000 EXIS	STING 6. 2000 NEW	
7. A THE FACILITY MEETS, BASED UPON	ROPRIATE ITEM(S) BELOW  ART OF (SPECIFY)  HOSPITAL BEDS C. NUMBER CERTIFIE  (CHECK ALL APPROPRIATE BOXE SIONS 2. ACCEPTANCE OF A P	OF SKILLED BED D FOR MEDICAR	DS d.	3. IF DIST a	YES b. SKILLED BEDS R MEDICAID	DSPITAL, IS HOSPITAL ACCREDITED?  NO  e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID  FSES 5. PERFORMANCE BASED DESIGN  DATE	
SURVEYOR ID K10	SIISOIIIILE					DATE	
FIRE AUTHORITY OFFICIAL (Signature)	TITLE		OFFICE			09/01/2015	

ID PREFIX				MET	NOT MET	N/A	REMARKS
	ı	PART I - LSC REQUIREMENTS -	Items in italics relate to the FSES				
		BUILDING CO	NSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2						
K12	Bu	2000 EXISTING Building construction type and height meets one of the following 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1					
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with complete automatic				
	6	IV (2HH)	sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
	☐ Building contains fire treated wood.  Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.						

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		2000 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	☐ Building contains fire treated wood.  Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.						
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3						
	(Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)						

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW  Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2  Indicate flame spread rating/s				
K15	2000 EXISTING  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2  Indicate flame spread rating/s				
	2000 NEW  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.  Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING  Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3  In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
<b>K17</b>	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)  19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5  If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW  Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		IVIL I		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW  Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings).  18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				
	40.0700P.(00/0040)				

ID PREFIX		МЕТ	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	<ul> <li>□ (a) The required manual fire alarm system and</li> <li>□ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</li> </ul>				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

			NGT	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW			
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	MO 0700D (00/0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING  Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW  Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING  Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW  Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
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the bottom of the door are permitted. 19.3.2.1  Area Automatic Sprinkler Separation N/A  a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
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a. Boiler and Fuel-Fired Heater Rooms c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms	Aroa	Automatic Sprinkler	Sonaration N/A				
c. Laundries (greater than 100 sq feet) d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms		Automatic Sprinkler	Separation IN/A				
d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
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g. Trash Collection Rooms i. Soiled Linen Rooms							
i. Soiled Linen Rooms	f. Combustible Storage Rooms/Spaces (over 50 sq feet)						
	i. Soiled Linen Rooms						
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ID			NOT		D=11121/2
PREFIX		MET	MET	N/A	REMARKS
	2000 NEW				
	Hazardous areas are protected in accordance with 8.4. The				
	areas shall be enclosed with a one hour fire-rated barrier, with a				
	·	·			
	3/4 hour fire-rated door, without windows (in accordance with				
	8.4). Doors shall be self-closing or automatic closing in				
	accordance with 7.2.1.8. Hazardous areas are protected by a				
	sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				
	Area Automatic Sprinkler Separation N/A	1			
	a. Boiler and Fuel-Fired Heater Rooms				
	c. Laundries (greater than 100 sq feet)				
	d. Repair, Maintenance and Paint Shops				
	e. Laboratories (if classified a Severe Hazard - see K31)				
	f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)				
	g. Trash Collection Rooms				
	i. Soiled Linen Rooms	1			
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)				
		'			
	Describe the floor and zone locations of hazardous areas that				
	are deficient in REMARKS.				
			-		-
K30	Gift shops shall be protected as hazardous areas when used for	•			
	storage or display of combustibles in quantities considered				
	hazardous. Non-rated walls may separate gift shops that are no	t			
	considered hazardous, have separate protected storage and that				
	are completely sprinkled. Gift shops may be open to the corrido				
	if they are not considered hazardous, have separate protected				
	storage, are completely sprinklered and do not exceed 500				
	square feet. 18.3.2.5, 19.3.2.5				
	Area Automatic Sprinkler Separation N/A  L. Gift Shop storing hazardous quantities				
	of combustibles				

			NOT		
ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed:  The corridor is at least 6 feet wide  The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)  The dispensers shall have a minimum spacing of 4 ft from each other  Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.  Dispensers are not installed over or adjacent to an ignition source.  If the floor is carpeted, the building is fully sprinklered.  18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	l				4

ID   MET   NOT   N/A	
PREFIX MET N/A	
2000 NEW	
Exit enclosures (such as stairways) in buildings four stories or	
more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous	
path of escape, and provide a protection against fire and smoke	
from other parts of the building. In all buildings less than four	
stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,	
8.2.5.4, 18.3.1.1, 18.2.2.3	
If enclosures are less than required, give a brief description and specific location in REMARKS.	
K34 Stairways and smokeproof enclosures used as exits are in	
accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	
K35 The capacity of required mean of egress is based on its width, in accordance with 7.3.	
K36 Travel distance (exit access) to exits are measured in	
accordance with 7.6.	
Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)	
<ul> <li>Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)</li> </ul>	
• Point in room to room door ≤ 50 ft	
• Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	
K37 2000 EXISTING	
Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that	
exists are accessible in not less than two different directions	
from all points in aisles, passageways, and corridors. 19.2.5.10	
2000 NEW	
Every exit and exit access shall be arranged so that no corridor,	
aisle or passageway has a pocket or dead-end exceeding 30 feet, 18.2.5.10	
K38 Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	
K39 2000 EXISTING	
Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	
Extractess shall be at least 4 leet. 19.2.3.3	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1  If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

		Т		
ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			

———ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
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ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)  An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in				
	accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1				
	Smoke Detection System  ☐ Corridors ☐ Rooms ☐ Bath				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3				
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING				
	Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8				
	2000 NEW	<del> </del>	·		
	Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

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ID PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

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ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, <i>Safety Code for Existing Elevators and Escalators.</i> 19.5.3, 9.4.2.2				

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ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
<b>K73</b>	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
<b>&lt;</b> 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	□ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
<b>K</b> 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
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ID PREFIX		MET	NOT MET	N/A	RE
THEID	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

ID		MET	NOT	N/A	REMARKS
PREFIX		IVIEI	MET	IN/A	NEWANNS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	<ul> <li>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</li> <li>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.</li> <li>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</li> </ul>				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	<ul> <li>Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.</li> <li>(b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3</li> </ul>				
K140	<ul> <li>Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Master alarm panels are in two separate locations and have audible and visible signals.</li> <li>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2</li> <li>(c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4.</li> <li>4-3.1.2.2 (NFPA 99)</li> </ul>				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:  CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and  (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.  8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

ID			NOT		
PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

#### PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)			JUSTIFICATION	
K84				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signa	ature)	Title	ffice	Date

# FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME			,	SURVEY DATE
K1					* K4
к6 DATE OF PLAN APPROVAL	TRUCTI BUILDIN JILDING	IGS		A BUILDING B WING C FLOOR D APARTMENT UNIT	
LSC FORM INDICATOR	<u>i</u>		COMPLETE IF	ICF/MR IS SURVEY	/ED UNDER CHAPTER 21
	are Form 000 EXISTING 000 NEW		K8:	1 PROMPT 2 SLOW 3 IMPRACTICAL	55)
15 2786U 20	000 EXISTING 000 NEW		LARGE	4 PROMPT 5 SLOW 6 IMPRACTICAL	
17 2786V, W, X 20	000 EXISTING 000 NEW DF FORM USED FROM	ABOVE	APARTMENT K8:	HOUSE 7 PROMPT 8 SLOW 9 IMPRACTICAL	
(Check if K29 or K56 are main the 2786 M, R, T, U, V, W			ENTER E – SO	e.g. 2.5	
*K9: FACILITY MEETS LSC E  A1. (COMP. WITH ALL PROVISIONS)	A2. (ACCEPTABLE POC)	A3.	y)  WAIVERS)	A4. [FSES]	A5. (PERFORMANCE BASED DESIGN)
FACILITY DOES NOT MEET B.			SPRINKLERED areas are sprinklered)	B. PARTIALLY SPRINI (Not all required areas are	

\* MANDATORY

### FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245362	MAPLETON COMMUNITY HOM	*K4 <b>08/25/2015</b>
K6 DATE OF PLAN APPROVAL	K3: MULTIPLE CONSTRUCTION TOTAL NUMBER OF BUILDINGS NUMBER OF THIS BUILDING	A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR    12   2786 R	ealth Care Form  2000 EXISTING  2000 NEW	COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21 SMALL (16 BEDS OR LESS)  1 PROMPT 2 SLOW 3 IMPRACTICAL
	ASC Form  2000 EXISTING 2000 NEW	LARGE 4 PROMPT 5 SLOW 6 IMPRACTICAL
16 2786 V, W. 17 2786 V, W.  *K7 13 SELECT NUMBER		APARTMENT HOUSE  7 PROMPT 8 SLOW 9 IMPRACTICAL
(Check if K29 or K56 ar 2786 M, R, T, U, V, W, X K29: 3	re marked as not applicable in the X, Y and Z.)  K56: 3	ENTER E-SCORE HERE  K5: e.g 2.5
*K9 : FACILITY MEETS LSO  A1  (COMP. WITH ALL PROVISIONS)	C BASED ON: (Check all that apply)  A2 X A3  (ACCEPTABLE POC) (WA	AIVERS)  A4
FACILITY DOES NOT MEE	FULLY SPRINKLI (All required areas are s	
*MANDATORY	•	

Form Approved OMB Exempt

	PORT 2000 CODE - HEALTH C are – Medicaid	1. (A)	PROVIDER NU	JMBER 1.	(B) MEDICAID I.I	D. NO.
	PART I — Life Safety PART IV — Waiver			,		
Identifying information as shown in appl	icable records. Enter changes, if any, a	longside each it	em, giving da	ate of change.		
2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)  A. BUILDING  B. WING	2. (B) ADDRESS C	OF FACILITY (S	TREET, CITY, ST	TATE, ZIP CODE)	(All required areas are sprinklered)  B. Partially Sprinklered
	C. FLOOR					(Not all required areas are sprinklere  C. None (No sprinkler system)  K0180
3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN A	PPROVAL	SURVEY UND		
MEDICARE MEDICAID	K4	K6		5. 2000 EX	(ISTING 6.	2000 NEW
5. SURVEY FOR CERTIFICATION OF						
1. HOSPITAL 2. SKILLED/NI	JRSING FACILITY 4. ICF/MR UN	NDER HEALTH CAF	RE 5.	HOSPICE		
IF "2" OR "5" ABOVE IS MARKED, CHECK APP	ROPRIATE ITEM(S) BELOW		3. IF DIS	TINCT PART OF H	HOSPITAL, IS HOSI	PITAL ACCREDITED?
1. ENTIRE FACILITY 2. DISTINCT PA	ART OF (SPECIFY)		a	YES b.	NO	
	C. NUMBER OF SKILLEI COR MEDICARE		NUMBER OF S			R OF NF or ICF/MR BEDS
7. A THE FACILITY MEETS, BASED UPON	(CHECK ALL APPROPRIATE BOXES)	'			'	
1. COMPLIANCE WITH ALL PROVIS	SIONS 2. ACCEPTANCE OF A PLAN OF CO	PRRECTION 3.	RECOMMENDE	D WAIVERS 4.	FSES 5.	PERFORMANCE BASED DESIGN
B. THE FACILITY DOES NOT MEET THE						
SURVEYOR (Signature) kimberly S	Wenson	OFFICE			DATE	
FIRE OUTHORITY OFFICIAL (Signature)	TITLE	OFFICE			DATE	
					09	/01/2015
/ / /	•				1	

ID PREFIX				MET	NOT MET	N/A	REMARKS
	ı	PART I - LSC REQUIREMENTS -	- LSC REQUIREMENTS - Items in italics relate to the FSES				
		BUILDING CONSTRUCTION					
K11	the res ad sh lea	the building has a common wa e common wall is a fire barrier sistance rating constructed of raddition. Communicating opening hall be protected by approved s ast 1½ hour fire resistance rations. 3.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 1	materials as required for the gs occur only in corridors and self-closing fire doors with at ang				
K12	Bu	000 EXISTING uilding construction type and he 0.1.6.2, 19.1.6.3, 19.1.6.4, 19.3	eight meets one of the following:				
	1	I (443), I (332), II (222)	Any Height				
	2	II (111)	One story only (non-sprinklered).				
	3	II (111)	Not over three stories with complete automatic sprinkler system.				
	4	III (211)					
	5	V (111)	Not over two stories with complete automatic				
	6	IV (2HH)	sprinkler system.				
	7	II (000)					
	8	III (200)	Not over one story with complete automatic				
	9	V (000)	sprinkler system.				
	Giv nui are	Building contains fire treated wave a brief description, in REMAR amber of stories, including basence located, location of smoke or approval. Complete sketch or attailding as appropriate.	KS, of the construction, the ments, floors on which patients fire barriers and dates of				

					NOT		
ID PREFIX				MET	NOT MET	N/A	REMARKS
K12		00 NEW					
		lding construction type and height 1.6.2, 18.1.6.3, 18.3.5.1.	t meets one of the following:				
	10.	1.0.2, 10.1.0.3, 10.3.3.1.					
	1	I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2	II (111)	Not over three stories with complete automatic sprinkler system	_			
	3	III (211)					
	4	V (111)	Not over one story with complete automatic				
	5	IV (2HH)	sprinkler system.				
	6	II (000)					
	7	III (200)	- Not Permitted				
	8	V (000)	TVOCT CHINICOL				
	Give nun are app	Building contains fire treated wood e a brief description, in REMARK onber of stories, including baseme located, location of smoke or fire proval. Complete sketch or attach lding as appropriate.	(S, of the construction, the ents, floors on which patients barriers and dates of				
K103	con	erior walls and partitions in building estruction shall be noncombustible terials. 18.1.6.3, 19.1.6.3	gs of Type I or Type II or limited-combustible				
	trea	dicate N/A for existing buildings us ated wood studs within non-load buttions.)	sing listed fire retardant earing one-hour rated				

ID		MET	NOT	N/A	REMARKS
PREFIX	INTERIOR FINIOU	IVILI	MET	IN/A	TILMATIKO
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than ½8 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 Indicate flame spread rating/s				
	2000 NEW  Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2  Indicate flame spread rating/s				
K15	2000 EXISTING  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2  Indicate flame spread rating/s				
	2000 NEW  Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2.  Indicate flame spread rating/s				

ID PREFIX		MET	NOT MET	N/A	REMARKS
(16	2000 EXISTING  Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3  In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
<b>K17</b>	Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.)  19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5  If the walls have a fire resistance rating, give rating if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.				
	2000 NEW  Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING  Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3		IVIE I		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW  Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.² and the opening is installed in bottom half of the wall (80 in.² in fully sprinklered buildings).  18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW				
	Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of:				
	<ul> <li>□ (a) The required manual fire alarm system and</li> <li>□ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and</li> </ul>				
	☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2				
	Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1				
	Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.				

		1	No.	_
ID PREFIX		MET	NOT MET	N/A
	Describe method used in REMARKS			
	SMOKE COMPARTMENTATION AND CONTROL			
K23	2000 EXISTING			
	Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2			
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2			
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1			
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.			
K25	2000 EXISTING			
	Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5			
	2000 NEW		<del> </del>	
	Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5			
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4			
	40 0700D (00 (0040)			

ID PREFIX				MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING  Doors in smoke barriers rating or are at least 1¾ Non-rated protective plathe bottom of the door a comply with 7.2.1.14. Do closing in accordance wirequired to swing with exprequired. 19.3.7.5, 19.3.	inch thick solid to tes that do not exercised. However, pors shall be self th 19.2.2.2.6. Swaress and positive	oonded core wood. xceed 48 inches from rizontal sliding doors -closing or automatic- vinging doors are not				
	2000 NEW  Doors in smoke barriers have rating or are at least 1¾ in rated protective plates that of the door are permitted. 7.2.1.14. Swinging doors in an opposite direction. Devels or astragals are relatching is not required.	nch thick solid bor at do not exceed 4 Horizontal sliding shall be arranged Doors shall be self quired at the mee	nded core wood. Non- 8 inches from the bottom doors comply with so that each door swings -closing and rabbets, ting edges. Positive				
K28	2000 EXISTING  Door openings in smoke width of 32 inches (81 cr 19.3.7.7						_
	2000 NEW  Door openings in smoke horizontal doors shall pro						
	Provider Type	Swinging Doors	Horizontal Sliding Doors				
	Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)				
	Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)				
	18.3.7.7						

Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5  Describe any mechanical smoke control system in REMARKS.  HAZARDOUS AREAS  2000 EXISTING  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1    Area							
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d. Repair Shops and Paint Shops e. Laboratories (if classified a Severe Hazard - see K31) f. Combustible Storage Rooms/Spaces (over 50 sq feet) g. Trash Collection Rooms i. Soiled Linen Rooms							
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g. Trash Collection Rooms i. Soiled Linen Rooms							
i. Soiled Linen Rooms	f. Combustible Storage Rooms/Spaces (over 50 sq feet)						
	i. Soiled Linen Rooms						
	are deficient in REMARKS.						
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	Hazardous areas are protected in accord	ance with 8.4. The				
	areas shall be enclosed with a one hour t	fire-rated barrier, with a				
	3/4 hour fire-rated door, without windows (	in accordance with				
	8.4). Doors shall be self-closing or autom					
	accordance with 7.2.1.8. Hazardous area					
	sprinkler system in accordance with 9.7,	18.3.2.1, 18.3.5.1.				
	Area Automa	atic Sprinkler   Separation   N/A				
	a. Boiler and Fuel-Fired Heater Rooms	and opinines deparation 1471				
	c. Laundries (greater than 100 sq feet)					
	d. Repair, Maintenance and Paint Shops					
	e. Laboratories (if classified a Severe Hazard - see K31)					
	f. Combustible Storage Rooms/Spaces					
	(over 50 and less than 100 sq feet) g. Trash Collection Rooms					
	i. Soiled Linen Rooms					
	m. Combustible Storage Rooms/Spaces (over 100 sq feet)					
	Describe the floor and zone locations of ha	zardous areas that				
	are deficient in REMARKS.					
	are denoient in right into.					
K30	Gift shops shall be protected as hazardou	us areas when used for				
	storage or display of combustibles in qua					
	hazardous. Non-rated walls may separate gift shops that are not					
	considered hazardous, have separate protected storage and that					
	are completely sprinkled. Gift shops may					
	if they are not considered hazardous, hav					
	storage, are completely sprinklered and do not exceed 500					
	square feet. 18.3.2.5, 19.3.2.5					
	- equal o 10011 10101210, 10101210					
	Area Automa	tic Sprinkler   Separation   N/A				
	L. Gift Shop storing hazardous quantities					
	of combustibles					

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ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed:  The corridor is at least 6 feet wide  The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)  The dispensers shall have a minimum spacing of 4 ft from each other  Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.  Dispensers are not installed over or adjacent to an ignition source.  If the floor is carpeted, the building is fully sprinklered.  18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623				
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating "No Exit". 7.10, 18.2.10.1, 19.2.10.1				
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2				
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1				
	If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box. □				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
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PREFIX		IVIE	MET	N/A	REMARKS
	2000 NEW				
	Exit enclosures (such as stairways) in buildings four stories or				
	more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous				
	path of escape, and provide a protection against fire and smoke				
	from other parts of the building. In all buildings less than four				
	stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2,				
	8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and				
	specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in				
	accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4				
K35	The capacity of required mean of egress is based on its width, in				
	accordance with 7.3.				
K36	Travel distance (exit access) to exits are measured in				
	accordance with 7.6.				
	• Room door to exit ≤ 100 ft (≤ 150 ft sprinklered)				
	<ul> <li>Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered)</li> <li>Point in room to room door ≤ 50 ft</li> </ul>				
	<ul> <li>Point in room to room door ≤ 50 ft</li> <li>Point in suite to suite door ≤ 100 ft</li> </ul>				
	18.2.6, 19.2.6				
K37	2000 EXISTING				
	Existing dead-end corridors shall be permitted to be continued to				
	be used if it is impractical and unfeasible to alter them so that				
	exists are accessible in not less than two different directions				
	from all points in aisles, passageways, and corridors. 19.2.5.10				
	2000 NEW				
	Every exit and exit access shall be arranged so that no corridor,				
	aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
1400					
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1				
K39	2000 EXISTING				
1108					
	Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3				
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ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW				
	Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW				
	Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1  If doors lead directly to grade from each room, check this box.				
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2				
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key.				
	Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5				
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2				
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5				
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1				
	(Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)				

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ID PREFIX		MET	NOT MET	N/A
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1			
	ILLUMINATION			
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8			
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.			
K105	2000 NEW (INDICATE N/A FOR EXISTING)			
	Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			
	EMERGENCY PLAN AND FIRE DRILLS	1	1	I
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1			
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2			

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PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6				
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,				
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8				
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				
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ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES)  An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1  Smoke Detection System  □ Corridors □ Rooms				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING  Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8  2000 NEW  Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID		MET	NOT	N/A	REMARKS
PREFIX	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8		MET		
(60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1				
	AUTOMATIC SPRINKLER SYSTEMS				
(56	2000 EXISTING				
	Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW				
	There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
(154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.				
	A. Date sprinkler system last checked and necessary maintenance provided				

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ID PREFIX		MET	NOT MET	N/A
	B. Show who provided the service			
	C. Note the source of water supply for the automatic sprinkler system.			
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)			
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72			
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5			
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13			
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6			
	SMOKING REGULATIONS			
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99)			
	(1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the internationa symbol for no smoking.			
	Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)			

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	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision.				
	(3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted.				
	(4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.				
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2				
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.				
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96				
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8				
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82				
	(1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5.				
	(2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7.				
	(3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.				

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PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.				
K160	2000 EXISTING				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	Existing elevators conform to ASME/ANSI A17.3, Safety Code for Existing Elevators & Escalators. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW				
	Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record.				
	New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3				
	(Includes firefighters service <b>phase I</b> key recall and smoke detector automatic recall, firefighters service <b>phase II</b> emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING				
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, Safety Code for Existing Elevators and Escalators. 19.5.3, 9.4.2.2				
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	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW	1			
	Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4.				
	All escalators and conveyors comply with ASME/ANSI A17.1, Safety Code for Elevators and Escalators. 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
<b>K73</b>	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4				
<b>&lt;</b> 74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13				
	□ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2.				
	□ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3				
	☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	3			
<b>K</b> 75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft² (20.4 L/m²). A	,			
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THEID	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft² (5.9-m²) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5		IVIL I		
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)				
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1				
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)				
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).				
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).				
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).				
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.				

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	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)				
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	<ul> <li>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.</li> <li>(b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside.</li> <li>4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4</li> </ul>				
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.				
K78	<ul> <li>Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others.</li> <li>(b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3</li> </ul>				
K140	<ul> <li>Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities.</li> <li>(a) Master alarm panels are in two separate locations and have audible and visible signals.</li> <li>(b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2</li> <li>(c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4.</li> <li>4-3.1.2.2 (NFPA 99)</li> </ul>				
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum:  CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)				

	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	MET	NOT MET	N/A	REMARKS
	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows::  (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and  (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and  (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association.  8-6.2.5.2 (NFPA 99)				
	ELECTRICAL AND EMERGENCY POWER				
	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)				
	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1				
K108	2000 NEW (INDICATE N/A FOR EXISTING)				
	Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2				
	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)				
	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)				

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PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)				
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1				
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.				

#### PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

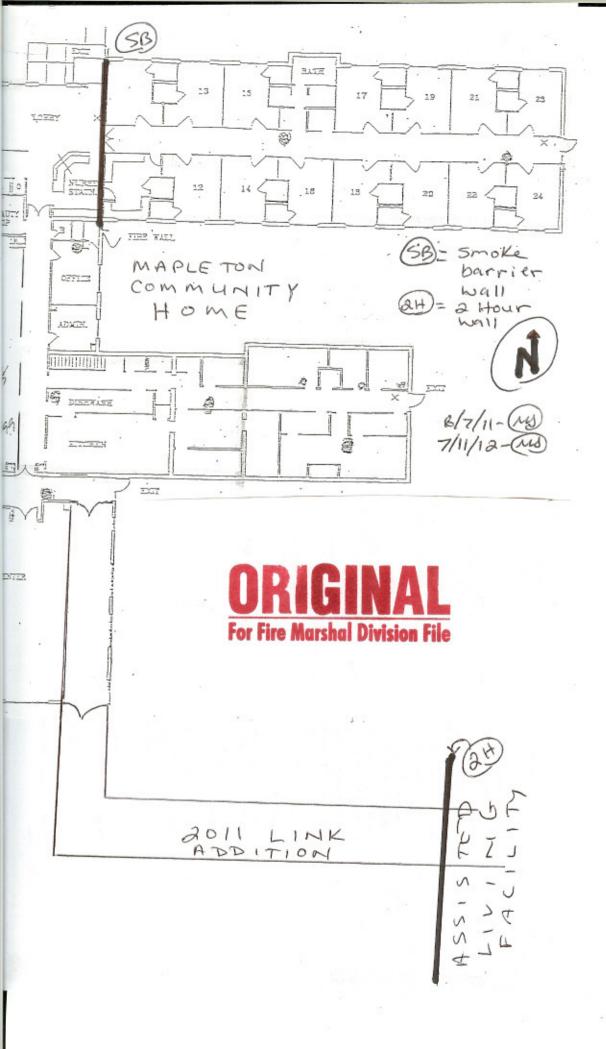
For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

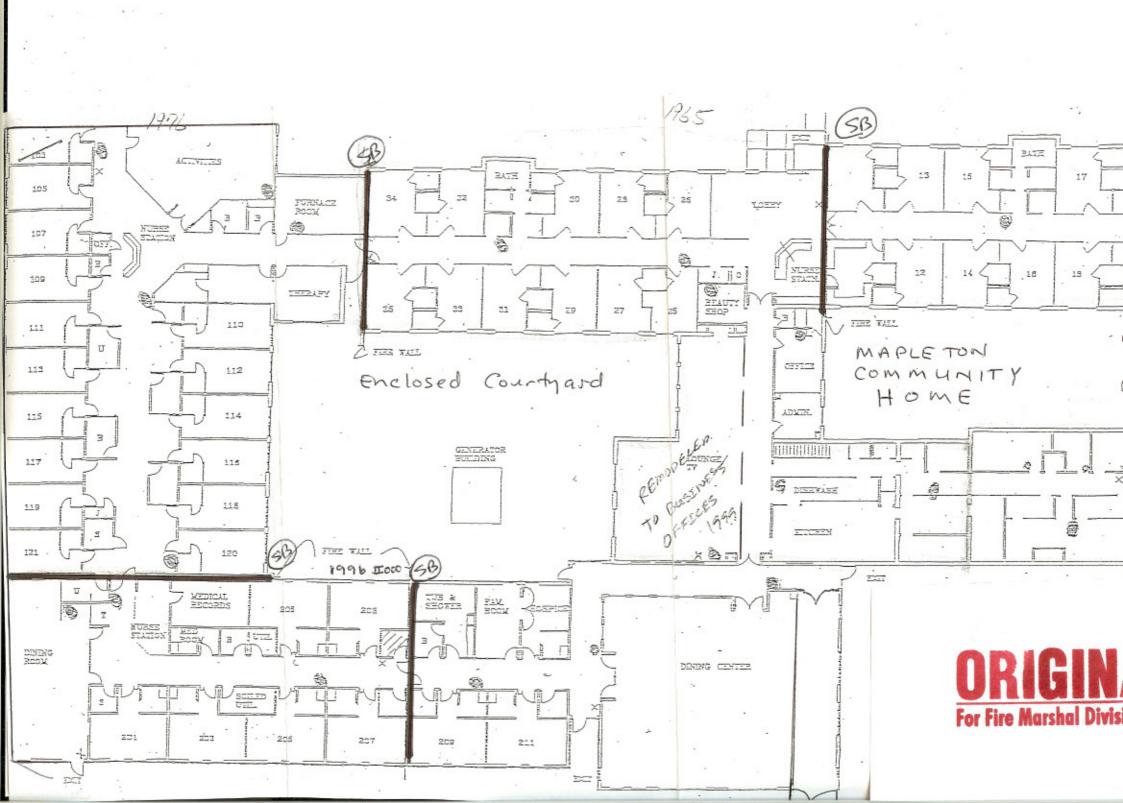
PROVISION NUMBER(S)			JUSTIFICATION	
K84				
Surveyor (Signature)		Title	ffice	Date
Fire Authority Official (Signa	ature)	Title	ffice	Date

# FIRE SAFETY SURVEY REPORT CRUCIAL DATA EXTRACT (TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME			,	SURVEY DATE
K1					* K4
K6 DATE OF PLAN APPROVAL  K3 MULTIPLE CO TOTAL NUMBER  NUMBER OF THIS		BUILDIN	IGS		A BUILDING B WING C FLOOR D APARTMENT UNIT
LSC FORM INDICATOR	<u>i</u>		COMPLETE IF	ICF/MR IS SURVEY	ED UNDER CHAPTER 21
	are Form 000 EXISTING 000 NEW		K8:	1 PROMPT 2 SLOW 3 IMPRACTICAL	55)
15 2786U 20	000 EXISTING 000 NEW		LARGE	4 PROMPT 5 SLOW 6 IMPRACTICAL	
17 2786V, W, X 20	000 EXISTING 000 NEW  DF FORM USED FROM A	ABOVE	APARTMENT K8:	HOUSE 7 PROMPT 8 SLOW 9 IMPRACTICAL	
(Check if K29 or K56 are main the 2786 M, R, T, U, V, W	• •		ENTER E – SO	e.g. 2.5	
*K9: FACILITY MEETS LSC BASED ON (Check all that apply)  A1. A2. A3. A4. A5. (COMP. WITH (ACCEPTABLE POC) (WAIVERS) (FSES) (PERFORMANCE ALL PROVISIONS)					
FACILITY DOES NOT MEET B.	F		SPRINKLERED areas are sprinklered)	B. PARTIALLY SPRINI (Not all required areas are	

\* MANDATORY





Ainnesota 4 6 1	State Fire Marsh	nal Division-CMS Survey Draft Statemen	t of Deficiencies		Page of
PROJEC	T NUMBER:	PROVIDER NAME			SURVEY DATE
Adminis	strator:		Phone Numl	per:	
Email a	ddress:				W
State Fir	re Inspector:	2			** *** *******************************
	re preliminary f	findings only. A complete and final S	tatement of Deficiencies	2567 report v	vill be provided
Sa	fety Code appl	s inspection. this facility was found to licable to: SNF/NF Hospital Medicaid programs.			
☐ Th	e following fir	re/life safety deficiencies were fou	nd during this inspect	ion:	
K TAG S& S	☐ Draft	Summary of Deficiency(ies)	☐ Revisit	☐ Clea	rance
			0.00.000		

# MINNESOTA DEPARTMENT OF HEALTH

Division of Health Policy, Information and Compliance Monitoring 85 East Seventh Place, Suite 300, P.O. Box 64900 St. Paul, Minnesota 55164-0900

Name of Facility: MAPLETON COMMUNITY HOME City: MAPLETON  Name of Legal Entity Operating Provider: MAPLETON COMMUNITY HOME  Name and Address of Governing Board President:  Name: JANISE BRINDLEY Address: 16762 - 563RD AVE  City/State/Zip: GOOD THUNDER, MN 56037  If legal entity or president of the governing board is different than what is noted above, please provide the information below.  Name of Facility: City: City: Name and Address of Governing Board President:  Name: Address: City/State/Zip: City/Stat	National Provid  One facility m  provider type the Nursing He	er Identifier (NPI) Number: 11947308: ay have multiple NPI Numbers. Please verify the for this survey, i.e. for a nursing home survey, the ome.	NPI number associated with the NPI Number will be associated with
Name of Legal Entity Operating Provider: MAPLETON COMMUNITY HOME  Name and Address of Governing Board President:  Name: JANISE BRINDLEY Address: 16762 - 563RD AVE  City/State/Zip: GOOD THUNDER, MN 56037  If legal entity or president of the governing board is different than what is noted above, please provide the information below.  Name of Facility: City:  Name of Legal Entity Operating Provider:  Name: Address:  City/State/Zip:  City/State/Zip:	OWNERSHIP II	NFORMATION AT THE TIME OF SURV	VEY
Name and Address of Governing Board President:  Name: JANISE BRINDLEY Address: 16762 - 563RD AVE  City/State/Zip: GOOD THUNDER, MN 56037  If legal entity or president of the governing board is different than what is noted above, please provide the information below.  Name of Facility: City:  Name of Legal Entity Operating Provider:  Name and Address of Governing Board President:  Name: Address:  City/State/Zip:	Name of Facility:	MAPLETON COMMUNITY HOME	City: <u>MAPLETON</u>
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Name of Facility: City: Name of Legal Entity Operating Provider: Name and Address of Governing Board President:  Name: Address: City/State/Zip:	City/State/Zip:	GOOD THUNDER, MN 56037	
Name of Legal Entity Operating Provider:  Name and Address of Governing Board President:  Name: Address:  City/State/Zip:			nan what is noted above, please
Name and Address of Governing Board President:  Name: Address:  City/State/Zip:	Name of Facilit	y:	City:
Name:	Name of Legal	Entity Operating Provider:	
Address:	Name and Addr	ress of Governing Board President:	
City/State/Zip:	Name:		
	Address:		·····
SIGNATURE	City/State/Zip:		
	SIGNATURE	Fr. A. S. Marson	
Completed by: XIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII		AUUMAL SISSION I	
Title: $\frac{Hdm/n/ST/Qt/OC}{Date: 8/24/15}$	_	110111115110TO	