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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPBP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**
2.STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

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

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/22/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Joseph Garvey, HFE NE II 10/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 Fiske-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 Fiske-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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245362	A. Building B. Wing	10/22/2015

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 **F0221** Reg. # **483.13(a)** LSC	Correction Completed **10/05/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **10/05/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **10/05/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **10/05/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **10/05/2015**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **10/05/2015**
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **10/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** KS/kfd	**Date:** 10/28/2015	**Signature of Surveyor:** 22113	**Date:** 11/22/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 8/27/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245362	A. Building B. Wing **01 - MAIN BUILDING 01**	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	08/25/2015	ID Prefix Reg. # NFPA 101 LSC K0144	08/25/2015	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GS/kfd	Date: 10/28/2015	Signature of Surveyor: 35482	Date: 10/07/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/25/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245362	A. Building B. Wing **02 - 2011 ADDITION**	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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0011	**08/25/2015**	ID Prefix Reg. # **NFPA 101** LSC K0144	**08/25/2015**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By GS/kfd	Date: 10/28/2015	Signature of Surveyor: 35482	Date: 10/07/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 8/25/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	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 Fiske-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	(Y2) Multiple Construction	(Y3) Date of Revisit
00037	A. Building B. Wing	10/22/2015

Name of Facility	Street Address, City, State, Zip Code
MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

This report is completed by a 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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20505** Reg. # **MN Rule 4658.0300 Subp.** LSC	Correction Completed **10/05/2015**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **10/05/2015**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp.** LSC	Correction Completed **10/05/2015**
ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp.** LSC	Correction Completed **10/05/2015**	ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp.** LSC	Correction Completed **10/05/2015**	ID Prefix **21435** Reg. # **MN Rule 4658.0900 Subp.** LSC	Correction Completed **10/05/2015**
ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp.** LSC	Correction Completed **10/05/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	10/28/2015	22113	10/22/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
8/27/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QPBP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245362**
2.STATE VENDOR OR MEDICAID NO.
(L2) **106540800**

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

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/27/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Wendy Buckholz, HFE NE II 10/12/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 10/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

Remedies - 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;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), 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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING _____ B. WING _____	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was completed on August 27, 2015. Deficiencies were found. Refer to the CMS 2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to use the least restrictive device for least amount of time based on an assessment for 1 of 1 resident (R22) in the sample who was observed to have restraints that inhibited his freedom of movement in wheelchair and bed. Findings include:	F 221	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.	10/5/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/21/2015

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F 221	Continued From page 1 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 staff with mobility in the wheelchair. R22's admission Care Area Assessment (CAA), dated 8/6/15, identified R22 had diagnoses of dementia, weakness, knee pain, had severe cognitive impairment, required assistance with all activities of daily living, was not able to stand and transfer and utilized a mechanical lift. Further, the CAA identified R22 was able to move the rock and go recliner about 10 feet on his own, with a therapy goal of R22 being able to move his wheelchair approximately 50 feet. The CAA identified R22 was at risk for falls, not able to stand independently, used a mechanical lift for transfers, alarms, low bed, sided mattress, matt at bedside, and rock and go wheelchair for safety. R22's admission care plan, dated 7/25/15, identified R22 required assistance with dressing, grooming, use of a mechanical lift for transfers, use of a motion sensor on the floor at bedside and directed staff to anticipate his needs. However, R22's care plan did not include any risks, goals or interventions for the use of the body pillows or reclined wheelchair. During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station	F 221	Immediate re-education was completed with nursing staff through verbal and written resources. R22 will no longer have body pillow in room and chair will not be tilted for ¿safety¿. Neither will be utilized as a restrictive device. A small pillow will be available in room for repositioning and tilt will only be used for comfort. Nursing staff were interviewed by the Director of Nursing, to determine other residents whom may have restrictive devices being utilized. No other concerns were found. NARs will communicate all concerns and new intervention ideas to the Director of Nursing or designee. Will educate QA team to do visual audits and to have heighten awareness of inappropriate use of restrictive devices and/or practice. If restrictive devise is necessary, it will be properly identified, evaluated, documented, Restraint Policy and Procedure will be followed and care plan will be written with appropriate risks, goals and interventions. Nurse's Meeting to be held September 28, 2015 and NAR meeting to be held October 1, 2015 to address all deficient nursing practices. The Director of Nursing, or designee, will conduct 6 monthly audits with 2 assigned specific to R22 for 3 months. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met.	

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F 221	Continued From page 2 except for brief periods when he was wheeled into his room for personal cares or attended meals. R22 was observed multiple times positioned in his reclining wheelchair in a manner where the chair was reclined. R22 was observed to attempt to sit forward in his reclining wheelchair when reclined but was unable to do so. During observation of cares on 8/25/15, at 10:09 a.m. R22 was observed to be wheeled from his room and placed in the hallway in front of the nurses station. Nursing assistant (NA)-E was observed to recline R22 back in his recliner so that he was in a near back lying position. R22 was noted to have a safety alarm, attached with a cord, between the back of his wheelchair and his shirt. During interview on 8/25/2015, at 10:14 a.m. NA-E stated R22's wheelchair was leaned back to keep R22 from being able to self-transfer from the chair. NA-E stated R22 could try to get out of chair but he was not steady or safe. NA-E further stated,"When the chair is reclined [R22] is unable to get out of the wheelchair without assistance. During observation of cares on 8/25/15, at 1:40 p.m. NA-E and NA-D entered R22's room and attached R22 to a mechanical lift. NA- E and NA-D transferred R22 into bed with the use of the lift. NA-E was observed to place a pillow behind R22's back which left him supported on his right side in bed. During interview with NA-E and NA-D on 8/25/15, at 1:50 p.m. the staff stated R22 did not try to get out of bed as much as he used to because they put a body pillow beside him when in bed. The opposite side of R22's bed was against the bedroom wall. NA-E and NA-D further	F 221	Completion date October 5, 2015	

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F 221	Continued From page 3	F 221		

stated R22 did not attempt to get out of his wheelchair when it was leaned back as it impeded his ability to do so. NA-E and NA-D left R22 lying in his bed on his right side with a body pillow holding him in that position.

During observation of cares on 8/25/15, at 2:34 p.m. R22 was observed lying in bed on his right side with a body pillow behind him holding him on his right side. A sensor monitor was observed on the floor beside the egress side of his bed and other side of the bed was against the wall.

On 8/25/15, at 3:34 p.m. R22 remained lying in his bed with a body pillow beside him supporting him in a right sided position. R22 was noted to have a sensor alarm on the floor beside his bed. R22 was observed attempting to turn onto his back while lying in bed and reaching to attempt to remove the pillow from behind him but was unable to remove it. R22 was visibly agitated that he was unable to move the pillows and change his positioning.

During review of R22's medical record the nurses notes identified R22 was able to wheel himself at times and did attempt to get out of his wheelchair and bed at times. The following documentation was identified in the progress notes:

-On 7/27/2015, at 11:01 a.m. resident had wheeled self to the front lobby from the dining room where he had refused to eat breakfast. He was noted to be sleeping in front of the television. Staff were alerted by his clip alarm sounding and resident yelling "help me". He was found sitting on his footrests and said he couldn't take it anymore. Staff lowered resident to his right side

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F 221	Continued From page 4	F 221		

on the ground. He was than hoyered with assist of 3 staff back to his wheelchair and taken to his room where range of motion (ROM) was completed and vital signs (VS) taken. At this time he was changed to a rock-n-go chair for safety.

-On 8/2/2015, at 9:29 p.m. resident sat up on side of bed at 9 p.m. setting off his motion sensor.

-On 8/6/2015, at 12:19 p.m. resident trying to climb out of recliner this morning. Resident kicking at writer when she was putting eucerin cream on his lower extremities and ace wrapping his lower legs.

-On 8/15/2015, at 4:33 p.m. resident wheeled himself to Old Wing. Staff brought him back.

-On 8/20/2015, at 3:43 a.m. resident restless (pounding on wall, crawling out of bed and yelling out for help). Call light in reach, bed in low position, floor alarm on.

The progress notes demonstrated R22 was capable of wheeling himself, capable of sitting up in bed and capable of attempting to transfer self out of his wheelchair.

During interview with NA-A on 8/26/15 at 10:17 a.m. NA-A stated staff were directed to recline R22 in his wheelchair to keep him from trying to transfer out of it and stated the body pillow utilized when he was in bed was to keep R22 from attempting to self transfer from bed. NA-A stated she knew R22 at times attempted to get out of bed but had not observed him attempting to stand out of his chair.

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F 221	Continued From page 5 During interview with NA-C on 8/26/15, at 10:53 a.m. NA-C stated R22 did attempt to get out of his bed and the body pillow kept him from getting out. NA-C stated she had not seen him get out of his chair but stated she had been told to keep his wheelchair reclined so he did not attempt to self transfer and fall. During interview with the director of nursing (DNS) and registered nurse (RN)-C on 8/26/15, at 11:02 a.m. they confirmed R22's care plan had not been developed to identify the use of the body pillow or reclining wheelchair. The DNS stated there had not been an assessment of the reclining wheelchair or the body pillow to assess their restrictive nature as neither were intended to be utilized as restraints. The DNS further stated she was not aware the staff were locking R22 in a reclined position in his wheelchair and was not aware of the use of body pillows. RN-C verified there had been no assessment of the devices to assess how they might restrict R22.. R22 independence with access to his body and mobility were restricted by the use of the body pillow and reclining chair. R22 was observed to have the ability to wheel himself around in his wheelchair when the wheelchair was not reclined and had the capacity of getting out of the chair, whether safe or not, when it was not reclined. Further, R22 was restricted from free movement in his bed when the body pillow was placed behind him. R2 was visibly agitated when observed to not be able to remove the pillow from behind him and reposition himself to a more comfortable lying position. The facility failed to assess R22's devices as	F 221		

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F 221	Continued From page 6 restraints, failed to develop a care plan to direct staff how to utilize devices and failed to ensure R22 was not restricted by the interventions used. The facility's policy Physical restraints, undated, identified residents have a right to be free of physical restraints imposed for the purpose of discipline or staff convenience. Staff would assess the restraint for the least restrictive devise possible for resident's comfort and safety. The policy indicated the following procedures- 1. Staff will identify resident's behavior that is unsafe. (frequent falls, improper body alignment, or injury to self). Attempt different alternatives , chart on the effect of the alternative. Make sure the interdisciplinary team (IDT) is aware of an attempt by making note on 24-hour report sheet. Make sure all falls are reported to the IDT. 2. The resident care coordinator (RCC) will evaluate use of alternatives and make sure appropriate charting is in residents chart. 3. The RCC will complete a physical restraint assessment, which will include alternatives that have been tried and failed. 4. Obtain a physician order which include, type of restraint, the reason for the restraint , and when the restraint will be used. 5. A safety assessment will be reviewed quarterly at care conferences. Family needs to sign the assessment. Information sheet will be mailed to representative.	F 221		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and	F 248		10/5/15

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F 248	Continued From page 7 the physical, mental, and psychosocial well-being of each resident. This 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. Findings include: R14's annual Minimum Data Set (MDS) assessment dated 6/25/15 identified R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation. The MDS identified R22 required extensive assistance of one staff for mobility. The MDS further indicated it was somewhat important for R14 to do group activities with others, keep up with news, do her favorite activities and very important to listen to music she likes and going outside. R14's quarterly Activity Assessment, dated 6/26/15, identified R14 participated in activities 3-5 times a week. The assessment identified R14 needed reminders and assistance to attend activities and identified she demonstrated appropriate behaviors while in activities. R14's Care Plan for activities, dated 7/6/15, identified R14 had liked to read romance novels, which she has been not doing. The care plan identified R14 had been watching TV and sleeping more. The care plan further identified R14's interest in activities as: 1. Going through her drawers and looking at what	F 248	Immediate re-education was completed with all Therapeutic Recreation Staff in regards to activity needs, socialization and 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 all residents, including R22 & R18. R22 has increased 1:1 visits scheduled. Reminders and invitations will be given to both R22 and R18 for group activity events. If TR staff note any decline in activity attendance, they will immediately notify Therapeutic Recreation Director. Recreation care plans and programs will be reviewed for all residents. TRD will review and revise care plans monthly and with significant change. Dementia specific activities will be introduced for appropriate residents, including but not limited to ¿Textiles¿. Awareness of activity in room will be educated to all staff, to include but not limited to television, reading materials, radio, CD players, and books on tape. TRD will complete weekly audits of the activity participation logs for complete documentation and activity level. Re-education for TR staff socialization,	

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F 248	Continued From page 8 she finds in them. 2. Going to and enjoying Music and Motion program, where she is participating 3-5 days a 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. R14's care plan goal was identified for her to join activities at least 3-5 times weekly. Interventions for activity were identified as: Keep informed of activity schedule, Invite and encourage her to attend activities of interest (music and special programs), assist to and from activity, visit for socialization, and check to see if resident has materials for independent activity (i.e.. romance novels). 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 attempted 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	F 248	interests met and proper completion of documentation. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. Completion date October 5, 2015	

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F 248	Continued From page 9	F 248		

the dining room 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.

During observations on 8/25/15, at 8:05 a.m. R14 was observed in the dining room seated at the dining room table in her wheelchair. R14 was placed at the table in a manner where the edge of the table was at the level of her nose. R14 was observed sleeping at the table. At 8:40 a.m., on 8/25/14 R14 was wheeled out of the dining room to her room and left seated in her wheelchair in front of her recliner with the light out and television off. There was no interaction with R14 observed until 11:30 a.m. when R14 was wheeled out of her room and into the dining room for the noon meal at 11:30 a.m. R14 remained in the dining room until approximately 12:30 p.m. when she was wheeled back to her room and transferred from her wheelchair to the recliner in her room. R14 was left in her recliner with light out and no stimulus in room. At 1:49 p.m. on 8/25/15 R14 remained seated with eyes closed in her recliner in her room with no stimulus in the room other than her roommates television on which is out of her visual range. R14 was observed through 3:40 p.m., on 8/25/15 and remained in her recliner in her room with no activity occurring.

During phone interview with R14's family member on 8/25/15, at 9:56 a.m. the family member voiced a concern about R14's involvement in the facility environment. The family member stated R14 was frequently in her room in her wheelchair with not much being offered to her for activities or

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care.

During observation of cares on 8/26/15, at 6:40 a.m. R14 was observed in her room in her wheelchair with eyes closed. Roommates television was on but out of the view of R14. On 8/26/15, at 7:30 a.m. R14 was observed seated in her w/c in her room leaning to her left in her wheelchair with no activity occurring in the room. On 8/26/15 at 8:24 a.m. R14 was observed seated in her wheelchair in her room leaning to left with eyes closed. No stimulus noted in room. at 8:40 a.m. R14 was observed to be wheeled out of her room to the main dining room and placed at the dining room table. At 9:38 a.m. R14 was wheeled out of the dining room and into her room then transferred into her recliner. R14 was left in recliner with no stimulus in the room. R14 remained in her recliner until the noon meal. At approximately 12:10 pm. R14 was transferred out of her recliner and into her wheelchair then wheeled to the dining room. R14 was observed to be served her noon meal and be assisted with eating by staff placing food in her mouth with a spoon. R14 was not social and did not interact at the table. At 1:20 p.m. R14 was observed to be wheeled out of the dining room to her room and was transferred into her recliner in her room. Again R14 was left in the room with light off and no stimulus occurring.

The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30 a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30

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p.m., Rosary.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice.

Review of R14's activity attendance logs for the months of May, June, July and August 2015 revealed R22 had documentation of attendance in activities consistently less than 2 times a week. R14's activity log identified R14 had independent activities such as resting, wheeling/walking in halls and watching television. The documentation revealed at times R14 refused a activity, however, the logs did not include why R14 was not attending activities when she did not attend nor any other activities that had been offered.

Review of R14's One to One Activity Log revealed a note on 8/2015 identified R14 had (1) one to one visit where staff visited with her about her kids and activities she would do with the kids. No other documentation of one to one visits was provided by the facility.

On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R14 used to be in one to one activities but had demonstrated improvement and the one to ones were discontinued. The AD stated R14 had recently demonstrated a decline in activity attendance and should be reassessed for need for one to ones again. The AD confirmed the monthly attendance longs and stated staff ask R14 frequently for her to attend moves and motion and R22 often refused. The AD verified R14 was not involved in

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many activities or the facility environment and spent the majority of her time in her room. The AD verified R14 needed to be asked and encouraged to participate in activities she typically enjoyed.

The facility failed to provide the necessary activity needs for R14 as evidenced by their failure to provide services as directed by the care plan for one to one and group activities and failed to encourage R14 to attend activities which she identified as important or somewhat important to her. The facility did not reassess R14's activities needs when they identified her activity preference and attendance has significantly changed. During the three days of observation 8/24/15 through 8/26/14, during times when formal activities were being conducted at the facility, R14 was not observed to be encouraged to attend or be actively involved in any formal activities. R14 was observed to spend the majority of the observation time in her room with the lights out and no stimulus (I.e.. television, radio, or staff interaction).

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 staff with mobility in the wheelchair.

R22's Activity assessment dated 8/10/15

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identified R22 with past and current activity interests that included: cards, games, crafts, exercises, reading, music, sports, religion, shopping, outdoors, watching television, gardening and keeping current with news. Further, the assessment identified R22 enjoyed attending activities both morning and afternoon, loved bingo and enjoyed watching ball games on TV.

R22's activity care plan, dated 8/4/15, identified R22 as dependent on staff for activities, cognitive stimulation and social interaction due to his disease process and dementia. The care plan further identified R22 could be hard to keep focused for long periods of time. He was identified as a military veteran who enjoyed singing and watching ball games on television. The care plan identified a goal for R22 to attend/participate in 3-5 activities of choice weekly. Interventions were identified as follows:
1. assist/escort to activity functions.
2. Invite to activities
3. R22 is to have 1 to 1 bedside/in-room visits and activities if unable to attend out of room events.
4. R22 prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as Music & Motion
5. When R22 chooses not to participate in organized activities, turn on TV, music in room to provide sensory stimulation

During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station except for brief periods when he was wheeled into his room for personal cares and meal times.

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F 248	Continued From page 14 During observation of morning cares on 8/25/15, at 8:40 a.m. R14 was observed to be served breakfast after being assisted out of bed;. After R22 consumed his breakfast R22 was observed to wander around the dining room and hallways near the dining room by wheeling himself in his wheelchair. At 9:43 a.m. staff wheeled R22 out of the dining room and placed him in front of the nurses station reclined in his wheelchair. At approximately 10:00 a.m. R22 was wheeled to his room for a short period then wheeled back to the the hallway in front of the nurses station at 10:09 a.m. R22 remained seated in his reclining wheelchair until 11:35 a.m. at which time he was wheeled into the dining room. After the noon meal at approximately 12:50 p.m. R22 was wheeled out of the dining room and into his room. R22 was left beside his bed in the room with no activity. At 1:40 p.m. NA-E and NA-D entered R22's room and with the use of a mechanical lift transferred him into bed. At 2:35 p.m. R22 remained in bed. R22 was not observed to be encouraged to participate or attend any activities. At 3:37 p.m. R22 remained in his bed while group activities were occurring. During observation of cares on 08/26/2015 at 6:47 a.m. R22 was observed lying in his bed on his back with eyes closed. At approximately 8:05 a.m. R22 was transferred out of bed with the use of a mechanical lift and two staff. At 8:20 a.m. R22 was wheeled into the dining room and served his breakfast meal. R22 remained in the dining room until 9:43 a.m. at which time he was wheeled out of the dining room and to the hallway in front of the nurses station. At 9:49 a.m. R22 was wheeled to his room by staff to change his shirt as it was heavily soiled with breakfast foods	F 248		

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and liquids. At 9:55 a.m. R22 was observed to be seated in his wheelchair in his room beside his bed. There was no activity occurring in the room.

An activity note dated 8/12/2015, at 11:53 a.m. identified a care conference was held with the interdisciplinary team and R22's family member. The note identified R22 as dependent on staff for activities, cognitive stimulation and social interaction.

The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30 a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30 p.m., Rosary.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice.

On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R22 was difficult to get involved in activities. The AD stated R22 was on one to one activities but was unable to locate his one to one logs. The AD also stated R22 was asked if he wanted to attend activities but often declined. The AD further stated she confirmed R22 was not involved in the facility environment and spent the majority of his time in his room or positioned outside the nurses station.

R22's activity attendance logs for the past month,

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F 248	Continued From page 16 since admission, identified he attended formal activities less than 1 time a week. The logs were incomplete to identify why R22 was not attending activities when he did not attend. The facility occasionally indicated R22 refused but multiple dates were left blank. R22's activity log included entries that R22 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R22 had (2) one to one visit so far for the month. on 8/10/15 activity staff documented on R22's activity log that R22 was visited with in the hallway,"wasn't making much sense, couldn't understand what he was talking about." On 8/19/15 activity staff documented on R22's activity log that they assisted him open a package from his family and talked about the "goodies" he received. There were no further one to one visits noted. The facility failed to provide the necessary activity needs for R22 as evidenced by their failure to provide services as directed by the care plan for one to one and group activities and failed to encourage R22 to attend activities which he identified as important or somewhat important to himself. The facility staff frequently positioned R22 outside the activity room by the nurses station or in his room when organized activities were occurring and R22 was not observed to be offered to participate. When R22 was left in his room he was left with no activity or environmental stimulus occurring in his room. He was observed throughout the survey in his room beside his bed or in bed with no television, radio or staff interaction.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		10/5/15

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F 279	Continued From page 17 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan related to interventions for non-pressure related skin conditions for 2 of 3 residents (R8, R22) in the sample who were reviewed for bruising and skin tears. 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	F 279	Immediate re-education was completed with nursing staff for writing of short term care plans and following Policy and Procedures for Skin Tears and Bruising. Care plan and ongoing monitoring until healing of skin tear completed for R22. Skin tear is healed to date. Care plan and ongoing monitoring until healing of bruise completed for R8. Bruising has resolved. Will revise care plan to add risks, goals and interventions in regards to R8¿s risk of bruising and/or bleeding due to Plavix use.	

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F 279	Continued From page 18 cognition and required extensive assist of two staff for bed mobility and to transfer. Further, the MDS identified R22 required extensive assist of 1 staff with mobility in the wheelchair. During observations of cares on 8/25/15 at 10:09 a.m. R22 was observed seated in his wheelchair in the hallway in front of the nurses station with his feet dangling from chair unsupported. R14 was noted to have severely bruised bilateral forearms with the bruising encompassing the entire aspect of both forearms. The bruising was of varying colors and healing stages. R22 was also noted to have an Opsite (wound dressing) on the medial aspect of his left arm that was covering a skin tear which was presenting with drainage under the dressing. During review of R22's medical record it was noted R22 had a history of being physically aggressive towards staff and would sometimes have self injurious behaviors such as pounding on walls, wheelchair, or tables. R22's medical record contained multiple notes since his admission related to striking out at staff and objects. R22 had an admission skin assessment conducted on 7/24/15 that identified he was admitted with excessive bruising on bilateral forearms. There was no indication of skin tears identified on the assessment. During further review of R22's record it was noted the medical record lacked a care plan to address risk factors, goals and interventions to reduce the risk of bruising or skin tears. The admission care plan did not identify bruising or non pressure related skin risk factors.	F 279	Licensed nursing and bath assistant will complete weekly skin audits of all residents and RN will assess as needed. NARs will completed daily visual skin audits and report any concerns to the charge nurse as soon as able. Licensed nursing staff will follow Policy and Procedures for Skin Tears and Bruising. All residents will continue to have a skin assessment completed on admission. Any skin concerns will be documented, care planned and monitored until healing is complete. Licensed nursing and bath assistant will complete weekly skin audits of all residents and RN will assess as needed. NARs will completed daily visual skin audits and report any concerns to the charge nurse as soon as able. Alteration in Skin Condition will be identified in care plans, reviewed quarterly and with significant change. Short term Alteration in Skin plan of care will be written and placed in TAR until healing is complete. Nurse's Meeting to be held September 28, 2015 and NAR meeting to be held October 1, 2015 to address all deficient nursing practices. The Director of Nursing, or designee, will conduct 8 monthly audits with 2 assigned specific to R22 and R8 for 3 months. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. Completion date October 5, 2015	

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During interview with the registered nurse (RN)-C on 8/26/15, at 11:02 a.m. it was verified R22's current care plan did not address risks, goals or interventions for bruising or skin tears. It was further verified there was no ongoing monitoring of the skin tear or bruising as the treatment record lacked any treatments for the skin tear. R8's annual MDS, dated 6/3/15, identified R8 had moderate cognitive impairment, no behaviors and required extensive assistance from staff for all activities of daily living (ADL).

During observations on 8/25/15 at 3:19 p.m., R8 was observed to have a large bruise approximately 5 inches in diameter on the top of her left arm and a quarter size bruise on the top of her left hand. During interview with R8 at this time, she stated that she obtained the bruise when she went to visit her sister about 2 weeks ago. R8 further indicated her sisters entry way is narrow and she could have bumped it when entering the home. R8 further revealed she bruises easily because she is on a blood thinner.

Review of an incident report for R8 dated 8/16/15 indicated the resident obtained a bruise to the top of the left arm that measured 7.5 cm by 6.0 cm and a bruise to the right arm that measured 6.0 cm by 4.0 cm. The report indicated the resident bruised easily and the bruise was identified after she had been out of the facility, but was unsure what happened.

Review of R8'S current physicians orders included an order for plavix (blood thinner) and aspirin.

Review of a physician visit dictation note dated

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F 279	Continued From page 20 5/5/15, identified the R8 as bruising easily, heavy bruising and blood clots (with nosebleeds) Review of the most current plan of care did not include R8 as being at risk for bleeding/bruising or the use of a blood thinner. No interventions were listed. Interview with the director of nursing (DON) on 8/27/15 at 8:33 a.m., confirmed R8's bruising should have been monitored and care planned because she was at risk for bruising due to the use of a blood thinner.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the activity needs as directed by the care plan for 2 of 3 residents (R14 and R22) in the sample who were reviewed for activities and failed to provide the nutritional needs as directed by the active care plan for 1 of 3 residents (R14) in the sample who was reviewed for weight loss. Findings include: R14's care plan for activities, dated 7/6/15, identified R14 as a quiet, private lady who like to	F 282	Immediate re-education was completed with all Therapeutic Recreation Staff in regards to activity needs, socialization and 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. Reminders 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.	10/5/15

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F 282	Continued From page 21 read romance novels, which she has been not doing. The care plan identified R14 had been watching TV and sleeping more. The care plan further identified R14's interest in activities as: 1. Going through her drawers and looking at what she finds in them. 2. Going to and enjoying Music and Motion program, where she is participating 3-5 days a 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	F 282	If TR staff note any decline in activity attendance, they will immediately notify Therapeutic Recreation Director. Recreation care plans and programs will be reviewed for all residents. Weights, NIP program and nutritional concerns for therapeutic diet and/or supplement were reviewed for all residents and addressed as needed. TRD will review and revise care plans monthly and with significant change. Dementia specific activities will be introduced for appropriate residents, including but not limited to ¿Textiles¿. Awareness of activity in room will be educated to all staff, to include but not limited to television, reading materials, radio, CD players, and books on tape. NIP program list will be reviewed and updated twice a month and as needed, by CDM or ADM. Weights will be reviewed as needed to identify need for therapeutic diet and/or supplement. In service for all dietary staff will be held September 30th, 2015 to include the NIP program. Nurse's Meeting to be held September 28, 2015 and NAR meeting to be held October 1, 2015 to address all deficient nursing practices. TRD will complete weekly audits of the activity participation logs for complete documentation and activity level. Re-education for TR staff socialization, interests met and proper completion of documentation. The audit findings will be	

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F 282	Continued From page 22 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. During observations on 8/25/15, at 6 8:05 a.m. R14 was observed in the dining room seated at the dining room table in her wheelchair. R14 was placed at the table in a manner where the edge of the table was at the level of her nose. R14 was observed sleeping at the table. At 8:40 a.m., on 8/25/14 R14 was wheeled out of the dining room and wheeled to her room and left seated in her wheelchair in front of her recliner with the light out and television off. There was no interaction with R14 observed until 11:30 a.m. when R14 was wheeled out of her room and into the dining room for the noon meal at 11:30 a.m. R14 remained in the dining room until approximately 12:30 p.m. when she was wheeled back to her room and transferred from her wheelchair to the recliner in her room. R14 was left in her recliner with light out and no stimulus in room. At 1:49 p.m. on 8/25/15 R14 remained seated with eyes closed in her recliner in her room with no stimulus in the room other than her roommates television on which is out of her visual range. R14 was observed through 3:40 p.m., on 8/25/20 and remained in her recliner in her room with no activity occurring. During observation of cares on 8/26/15, at 6:40 a.m. R14 was observed in her room in her wheelchair with eyes closed. Roommates television was on but out of the view of R14. On 8/26/15, at 7:30 a.m. R14 was observed seated in her w/c in her room leaning to her left in her	F 282	reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. The CDM, or designee, will conduct 3 monthly audits during meals with 1 assigned specific to R14 for 3 months. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. Completion date October 5, 2015	

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wheelchair with no activity occurring in the room. On 8/26/15 at 8:24 a.m. R14 was observed seated in her wheelchair in her room leaning to left with eyes closed. No stimulus noted in room. at 8:40 a.m. R14 was observed to be wheeled out of her room to the main dining room and placed at the dining room table. R14 was observed to be placed at the table in a position where her eye level met the edge of the table. R14 only ate small portions of her meal with full staff assistance. At 9:38 a.m. R14 was wheeled out of the dining room and into her room then transferred into her recliner. R14 was left in recliner with no stimulus in the room. R14 remained in her recliner until the noon meal. At approximately 12:10 pm. R14 was transferred out of her recliner and into her wheelchair then wheeled to the dining room. R14 was observed to be served her noon meal and be assisted with eating by staff placing food in her mouth with a spoon. R14 was not social and did not interact at the table. At 1:20 p.m. R14 was observed to be wheeled out of the dining room to her room and was transferred into her recliner in her room. Again R14 was left in the room with light off and no stimulus occurring.

R14's activity attendance logs for the past 4 months identified she attended activities less than 2 times a week. The logs were incomplete to identify why R14 was not attending activities when she did not attend. The facility occasionally indicated R14 refused but multiple dates were left blank. R14's activity log included entries that R14 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R14 had (1) one to one visit so far for the month on 8/18/15 where staff visited with her about her

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F 282	Continued From page 24 kids and activities she would do with the kids. On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R14 used to be in one to one activities but had demonstrated improvement and the one to ones were discontinued. The AD stated R14 had recently demonstrated a decline in activity attendance and should be reassessed for need for one to ones again. The AD stated staff ask R14 frequently for her to attend moves and motion and R22 often refused. The AD verified R14 was not involved in many activities or the facility environment and spent the majority of her time in her room. The AD verified R14 needed to be asked and encouraged to participate in activities she typically enjoyed. R22's activity care plan, dated 8/4/15, identified R22 as dependent on staff for activities, cognitive stimulation and social interaction due to his disease process and dementia. the care plan further identified R22 could be hard to keep focused for long periods of time. He was identified as a military veteran who enjoyed singing and watching watching ball games on television. The care plan identified a goal for R22 to attend/participate in 3-5 activities of choice weekly. Interventions were identified as follows: 1. assist/escort to activity functions. 2. Invite to activities 3. R22 is to have 1 to 1 bedside/in-room visits and activities if unable to attend out of room events. 4. R22 prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as Music &	F 282		

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F 282	Continued From page 25 Motion 5. When R22 chooses not to participate in organized activities, turn on TV, music in room to provide sensory stimulation During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station except for brief periods when he was wheeled into his room for personal cares and meal times. During observation of morning cares on 8/25/15, at 8:40 a.m. R14 was observed to be served breakfast after being assisted out of bed;. After R22 consumed his breakfast R22 was observed to wander around the dining room and hallways near the dining room by wheeling himself in his wheelchair. At 9:43 a.m. staff wheeled R22 out of the dining room and placed him in front of the nurses station reclined in his wheelchair. At approximately 10:00 a.m. R22 was wheeled to his room for a short period then wheeled back to the the hallway in front of the nurses station at 10:09 a.m. R22 remained seated in his reclining wheelchair until 11:35 a.m. at which time he was wheeled into the dining room. After the noon meal at approximately 12:50 p.m. R22 was wheeled out of the dining room and into his room. R22 was left beside his bed in the room with no activity. At 1:40 p.m. NA-E and D entered R22's room and attached his lift sling to the mechanical lift and transferred him into bed. At 2:35 p.m. R22 remained in bed. R22 was not observed to be encouraged to participate or attend any activities. At 3:37 p.m. R22 remained in his bed while group activities were occurring. During observation of cares on 08/26/2015 at 6:47 a.m. R22 was observed lying in his bed on	F 282		

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his back with eyes closed. At approximately 8:05 a.m. R22 was transferred out of bed with the use of a mechanical lift and two staff. At 8:20 a.m. R22 was wheeled into the dining room and served his breakfast meal. R22 remained in the dining room until 9:43 a.m. at which time he was wheeled out of the dining room and to the hallway in front of the nurses station. At 9:49 a.m. R22 was wheeled to his room by staff to change his shirt as it was heavily soiled with breakfast foods and liquids. At 9:55 a.m. R22 was observed to be seated in his wheelchair in his room beside his bed. There was no activity occurring in the room.

R22's activity attendance logs for the past month, since admission, identified he attended formal activities less than 1 time a week. The logs were incomplete to identify why R22 was not attending activities when he did not attend. The facility occasionally indicated R22 refused but multiple dates were left blank. R22's activity log included entries that R22 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R22 had (2) one to one visit so far for the month. on 8/10/15 activity staff documented on R22's activity log that R22 was visited with in the hallway,"wasn't making much sense, couldn't understand what he was talking about." On 8/19/15 activity staff documented on R22's activity log that they assisted him open a package from his family and talked about the "goodies" he received. There were no further one to one visits noted.

On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R22 was difficult to get involved in activities. The AD stated

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F 282	Continued From page 27 R22 was on 1 to 1 activities but was unable to locate his one to one logs. The AD also stated R22 was asked if he wanted to attend activities but often declined. The AD further stated she agreed R22 was not involved in the facility environment and spent the majority of his time in his room or positioned outside the nurses station. The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30 a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30 p.m., Rosary. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice. The facility staff failed to implement R14's nutritional care plan R14's care plan, dated 7/6/15, identified R14 required extensive assist with eating at times. The care plan identified R14's diet as consisting of regular small portions diet with the NIP. Other interventions included: 1. Serve meals in the dining room. 2. Offer extra fluids between meals and in room. 3. Honor noted likes and dislikes. During observation of R14 at the breakfast meal on 8/26/15, at 8:44 a.m. R14 was observed to be served a whole boiled egg, two (2) 1/2 slices of cinnamon raison toast with milk juice and water	F 282		

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beverages. R14 was observed to need assistance with eating and nursing assistant (NAR)-C was observed to feed R14 by spooning food into R14's mouth. R14 had her eyes closed during most of the meal time. R14 was also noted positioned in her wheelchair at the table in a manner where her nose was in line at level with the edge of the table. R14 was observed to be fed approximately 50% of her breakfast foods and consumed approximately 10% of her liquids.

On 8/26/15 at 8:57 a.m. an interview was conducted with dietary aide (DA)-A related to any special interventions for R14. DA-A stated she was not aware of any special interventions and stated some residents were on the Nutritional Improvement Program (NIP) and named off residents in the dining room on the program but did not include R14. DA-A stated residents with the NIP intervention would have received Karo syrup in their juice to add calories to the meal. When asked if R14 had received the added calories DA-A stated, "No."

On 8/26/15, at 12:17 p.m. R14 was observed to be seated at the dining room table being assisted with eating by NA-C. R14 was served (2) 1/2 slices of bread covered with brown gravy, mashed potatoes and cooked carrots. NA-C was observed to attempt to encourage R14 to eat and spoon food into R14's mouth. R14 was seated with her eyes closed during most of the meal. R14 was served chocolate milk, juice and water for liquids. R14 was observed to consume approximately 50% of the bread and gravy and approximately 25% of her mashed potatoes.

On 8/26/15, at 12:22 p.m. DA-B was questioned

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F 282	Continued From page 29 about R14 receiving any supplemental nutrition. DA-B stated R14 had not received any extra foods or supplements. When DA-B was asked if there was a list of residents who received the NIP diet, DA-B retrieved a list in a plastic sleeve at the food service area which identified residents on the NIP. DA-B looked at the list and stated,"Oh, I didn't know she was supposed to get the NIP", responding to R14's name which was on the list. DA-B stated R14 should have received extra butter with her mashed potatoes for the NIP. During interview with the certified dietary manager (CDM) on 8/26/15 12:30 p.m. the CDM stated the staff were supposed to follow the NIP for residents identified on the program. The CDM verified R14 had been placed on program but did not know exactly when and verified R14 was at risk for malnutrition related to her poor intake.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide services based on a comprehensive assessment to develop interventions to reduce the risk of bruising and skin tears for 2 of 3 residents (R8, R22) reviewed	F 309	Immediate re-education was completed with nursing staff for writing of short term care plans and following Policy and Procedures for Skin Tears and Bruising. Care plan and ongoing monitoring until	10/5/15

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F 309	Continued From page 30 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 staff with mobility in the wheelchair. During observations of cares on 8/25/15 at 10:09 a.m. R22 was observed seated in his wheelchair in the hallway in front of the nurses station with his feet dangling from chair unsupported. R14 was noted to have severely bruised bilateral forearms with the bruising encompassing the entire aspect of both forearms. The bruising was of varying colors and healing stages. R22 was also noted to have an Opsite (wound dressing) on the medial aspect of his left arm that was covering a skin tear which was presenting with drainage under the dressing. During observation of cares on 8/25/15 at 1:40 p.m. NAR's E and D PM were observed to enter R22's room and transfer him into bed with the use of a mechanical lift. When interviewed about the skin tear on R22's arm NAR-D stated R22 sometimes would strike out at staff and she thought that was how the skin tear occurred. NAR-E verified R22 would strike out at staff or	F 309	healing of skin tear completed for R22. Skin tear is healed to date. Care plan and ongoing monitoring until healing of bruise completed for R8. Bruising has resolved. Will revise care plan to add risks, goals and interventions in regards to R8¿s risk of bruising and/or bleeding due to Plavix use. Order was immediately requested and obtained by R14 Physician for PT to evaluate and treat for W/C positioning. Therapy has evaluated and new wheelchair has been ordered. Resident was and continues to be care planned to sit in a dining room chair during meal times. Will continue to monitor for seating in DR chair and will reassess when new wheelchair arrives. Licensed nursing and bath assistant will complete weekly skin audits of all residents and RN will assess as needed. NARs will completed daily visual skin audits and report any concerns to the charge nurse as soon as able. Visual monitoring of all residents for table height appropriateness and W/C positioning will be ongoing. Staff will report concerns to licensed nursing or therapy as needed. Licensed nursing and bath assistant will complete weekly skin audits of all residents and RN will assess as needed. NARs will completed daily visual skin audits and report any concerns to the charge nurse as soon as able. Licensed nursing staff will follow Policy and Procedures for Skin Tears and Bruising. Residents were visually assessed for table height appropriateness and changes	

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F 309	Continued From page 31 just strike out at the walls or whatever was around him. During review of R22's medical record it was noted R22 had a history of being physically aggressive towards staff and would sometimes have self injurious behaviors such as pounding on walls, wheelchair, or tables. R22's medical record contained multiple notes since his admission related to striking out at staff and objects. R22 had an admission skin assessment conducted on 7/24/15 that identified he was admitted with excessive bruising on bilateral forearms. There was no indication of skin tears identified on the assessment. During further review of R22's record it was noted the medical record lacked a care plan to address risk factors, goals and interventions to reduce the risk of bruising or skin tears. The admission care plan did not identify bruising or non pressure related skin risk factors. During interview with the registered nurse (RN)-C on 8/26/15, at 11:02 a.m. it was verified R22's care plan had not been developed to address skin concerns and there was no current care planned risks, goals or interventions for bruising or skin tears. It was further verified there was no ongoing monitoring of the skin tear or bruising as the treatment record lacked any treatments for the skin tear. R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation.	F 309	made accordingly. Nursing staff, QA team and therapy will monitor residents for W/C positioning and make appropriate changes as needed. Nurse Meeting to be held September 28, 2015 and NAR meeting to be held October 1, 2015 to address all deficient nursing practices. The Director of Nursing, or designee, will conduct 8 monthly audits with 2 assigned specific to R22 and R8 for 3 months for skin concerns, R14 for wheelchair positioning and table height appropriateness. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met.	

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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 multiple occasions R14 was observed leaning to her left side with her head resting on either the armrest of her wheelchair or recliner. During observations at the meal times R14 was observed to be positioned at the table in a manner where her eyes were at the level of the edge of the table. .

During observation of cares 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.

During observation of the evening meal on 8/24/15, at 5:45 p.m. R14 was observed seated at the dining room table in her wheelchair leaning to the left and her eye level was at table edge. R14's wheelchair was too large for her with excessive space noted on bilateral sides when she was seated in the wheelchair.

During observation of the breakfast meal on 8/25/15, at 8:00 a.m. R14 was observed seated in the dining room at the dining room table in her wheelchair with the edge of the table at her eyes.

During observations on 8/25/15, at 9:44 a.m. R14 was observed seated in her wheelchair in her room with eyes closed. At 10:41 a.m. R14 remained seated in her wheelchair in her room leaning to the left with head resting on her left

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

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wheelchair armrest.

During phone interview with R14's family member on 8/25/15, at 9:56 a.m. the family member voiced a concern about R14's positioning. The family member stated there had been communication with the staff about looking at a new wheelchair for R14 but nothing had ever been done. The family member stated R14 was frequently in her room in her wheelchair with not much being offered to her for activities or care.

On 8/26/15, at 6:40 am R14 was observed up in her wheelchair in her room sleeping. R14 was observed sleeping in her wheelchair leaning to left, resting her elbow on left armrest with her face in her hand. R14's wheelchair is a high back chair which is too large for her, and too wide to support R14 in good upright positioning. R14 remained seated in her wheelchair in her room until 8:43 a.m. at which time she was wheeled into the dining room for breakfast.

On 8/26/15, at 8:44 a.m. R!4 was observed seated at dining room table and positioned at table where height of table left the edge at R14's nose level. Resident does not feed self but positioning does not enable resident to be in a social posture at table.

During interview with the activity aide-A on 8/26/15 10:25 a.m. the activity aide stated when R14 did attend activities she would often be leaning to the left in her wheelchair and activity staff would have to ask nursing staff to come in to reposition her.

During interview with the director of nursing (DNS) and registered nurse (RN)-C on 8/26/15, at

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11:02 a.m. RN-C stated she was sure that there had been some evaluation of R14's positioning and she would talk to physical therapy to see what they had done in relation to evaluation R14's positioning. RN-C verified she was aware of R14's leaning at times.

R14's annual MDS assessment, dated 6/25/15 identified R14 required extensive assistance of 1 to 2 staff with all activities of daily living (ADL), had severe cognition impairment, and needed staff support with balance when transferring or walking.

During interview with the DNS on 8/27/15 at 10:30 a.m. the DNS verified she was unable to obtain any documentation that R14's positioning had been assessed. The DNS verified R14's medical record lacked any evidence of a comprehensive assessment for her positioning needs.

The facility policy for Wheelchair Positioning, dated 5/5/10, identified residents who utilized wheelchairs for seating will be properly positioned to maintain optimum comfort and well-being.

The procedure identified on the policy indicate:
1. The therapy department will routinely assess for wheelchair positioning if the resident is receiving Medicare Part A or Part B benefits.
2. The resident care coordinator will determine if a resident who is not receiving Medicare Part A or Part B benefits is in need of a wheelchair positioning assessment. A physician order will be obtained for residents in need of a wheelchair positioning evaluation.
3. Proper wheelchair positioning will be evaluated quarterly at time of the quarterly care conference.

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F 309	Continued From page 35 Observations of R8 on 8/25/15 at 3:19 p.m., was observed to have a large bruise approximately 5 inches in diameter on the top of her left arm and a quarter size bruise on the top of her left hand. During interview with the resident at this time, she stated that she obtained the bruise when she went to visit her sister about 2 weeks ago. R8 further indicated her sisters entry way is narrow and she could have bumped it when entering the home. R8 further revealed she bruises easily because she is on a blood thinner. Review of an incident report for R8 dated 8/16/15 indicated the resident obtained a bruise to the top of the left arm that measured 7.5 cm by 6.0 cm and a bruise to the right arm that measured 6.0 cm by 4.0 cm. The report indicated the resident bruises easily and the bruise was identified after she was at her sisters, but was unsure what happened. Review of R8'S current physicians orders included an order for plavix (blood thinner) and aspirin. Review of a physician visit dictation note dated 5/5/15, identified the R8 as bruising easily, heavy bruising and blood clots (with nosebleeds). Review of R8's current plan of care, revised 6/25/15, did not include R8 as being at risk for bleeding/bruising or the use of a blood thinner. No interventions were listed. Interview with the director of nursing (DON) on 8/27/15 at 8:33 a.m., confirmed R8's bruising should have been monitored and care planned because she was at risk for bruising due to the use of a blood thinner.	F 309		

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F 309	Continued From page 36 Review of the facility policy for bruises dated 7/12/15, included; the residents bruises will be identified, cause determined, documented and monitored; enter treatment/observation schedule on treatment sheet, notify physician and family.	F 309		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary nutritional needs based on comprehensive assessment for 1 of 3 residents (R14) reviewed for weight loss. Findings include: R14's annual Minimum Data Set (MDS) assessment dated 6/25/15 identified R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation. The MDS identified R22 required extensive assistance of one staff for mobility.	F 325	Re-education of dietary staff was completed immediately for concern with R14 NIP program and to assure compliance for all meals. Weights, NIP program and nutritional concerns for therapeutic diet and/or supplement were reviewed for all residents and addressed as needed. NIP program list will be reviewed and updated twice a month and as needed, by CDM or ADM. Weights will be reviewed as needed to identify need for therapeutic diet and/or supplement. In service for all	10/5/15

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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 problems 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% weight loss in the last 6 months, house supplement was not given and would get that correct to start giving her 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 overwhelm R14 with food portions. The diet would include fortified foods (NIP) as accepted. The goal was identified to keep R14's weight between 103-113 pounds. During review of R14's medical record it was noted R14 had sustained a fifteen (15) pound weight loss in the past 6 months which was 14.2 % loss of total body weight, a significant weight loss. R14's weight on 2/22/15 was identified at 121 pounds and her current recorded weight, dated 8/23/15 was 106 pounds. R14's care plan, revised 7/14/15, identified R14 required extensive assist with eating at times. The care plan identified R14's diet as consisting of regular small portions diet with NIP. Other interventions included: 1. Serve meals in the dining room. 2. Offer extra fluids between meals and in room. 3. Honor noted likes and dislikes. During observation of R14 at the breakfast meal on 8/26/15, at 8:44 a.m. R14 was observed to be	F 325	dietary staff will be held September 30th, 2015 to include the NIP program. Nurse's Meeting to be held September 28, 2015 and NAR meeting to be held October 1, 2015 to address all deficient nursing practices. The CDM, or designee, will conduct 3 monthly audits during meals with 1 assigned specific to R14 for 3 months. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. Completion date October 5, 2015	

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served a whole boiled egg, two (2) 1/2 slices of cinnamon raison toast with milk juice and water beverages. R14 was observed to need assistance with eating and nursing assistant (NAR)-C was observed to feed R14 by spooning food into R14's mouth. R14 had her eyes closed during most of the meal time. R14 was also noted positioned in her wheelchair at the table in a manner where her nose was in line at level with the edge of the table. R14 was observed to be fed approximately 50% of her breakfast foods and consumed approximately 10% of her liquids.

On 8/26/15 at 8:57 a.m. an interview was conducted with dietary aide (DA)-A related to any special interventions for R14. DA-A stated she was not aware of any special interventions and stated some residents were on the nutritional improvement program (NIP) and named off residents in the dining room on the program but did not include R14. DA-A stated residents with the NIP intervention would have received Karo syrup in their juice to add calories to the meal. DA-B confirmed R14 had not received Karo syrup in juice for the breakfast meal.

On 8/26/15, at 12:17 p.m. R14 was observed to be seated at the dining room table being assisted with eating by NA-C. R14 was served (2) 1/2 slices of bread covered with brown gravy, mashed potatoes and cooked carrots. NA-C was observed to attempt to encourage R14 to eat and spoon food into R14's mouth. R14 was seated with her eyes closed during most of the meal. R14 was served chocolate milk, juice and water for liquids. R14 was observed to consume approximately 50% of the bread and gravy and approximately 25% of her mashed potatoes.

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On 8/26/15, at 12:22 p.m. DA-B was questioned about R14 receiving any supplemental nutrition. DA-B stated R14 had not received any extra foods or supplements. DA-B provided a list of residents in a plastic sleeve at the food service area which identified residents on the NIP. DA-B looked at the list and stated,"Oh, I didn't know she was supposed to get the NIP", responding to R14's name which was on the list. DA-B stated R14 should have received extra butter with her mashed potatoes for the NIP.

During interview with the certified dietary manager (CDM) on 8/26/15 12:30 p.m. the CDM stated she expected staff to follow the NIP for residents identified on the program. The CDM verified R14 had been placed on program but did not know exactly when and verified R14 was at risk for malnutrition related to her poor intake.

The facility failed to provide dietary services as assessed to met the nutritional needs for R14. The facility failed to implement the NIP as directed by the care plan on a routine basis as directed.

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.

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F 325	Continued From page 40 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.	F 325		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the	F 431		10/5/15

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F 431	Continued From page 41 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain security of pharmacological's in the treatment cart. This had the potential to affect all residents with independent mobility who reside in the facility. Findings include: During observation of a medication administration pass with trained medication assistant (TMA)-A on 8/14/15 at 6:10 p.m., a treatment cart was observed to be stored in a tub room unsecured. There was a drawer that was pulled open with several vials of insulin and syringes in view from the hallway. The unlocked cart also contained several eye drops and treatment creams. TMA-A indicated the treatment cart should be locked, but proceeded to walk away from the unlocked/unattended storage cart to continue passing medications in the dining room. The unattended cart remained unsecured until 6:35 p.m. while several staff and residents had walked/wheeled by the cart. At 6:35 p.m., TMA-A confirmed the cart remained unsecured, and indicated she would notify the nurse who was in charge of the treatment cart. Interview with licensed practical nurse (LPN)-A on 8/14/15 at 6:40 p.m. confirmed she was in charge of the unlocked treatment cart. LPN-A indicated she usually stored the cart in the locked medication room, but placed it in the tub room so	F 431	Immediate corrective counseling and re-education completed with LPN-A and TMA-A covering storage of medication/treatment cart to be in medication room and locking medication/treatment cart when not in use. Following Policy and Procedure for medication storage at all times. The Director of Nursing, or designee, will conduct 6 monthly audits of the medication storage and medication/treatment cart locking. The audit findings will be reported at the QA meeting and will be monitored until such time consistent substantial compliance has been met. Nurse Meeting to be held September 28, 2015.	

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F 431	Continued From page 42 she could assist residents to the dining room for supper and forgot to lock the cart. Interview with the DON on 8/14/15 at 7:30 p.m. indicated the treatment cart should be locked at all times when unattended. Review of the Policy and Procedure dated 10/1/07 for storage of medications, syringes and needles included; the facility should ensure that all medications and treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors.	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, 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 (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	K 000	EPOC	

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

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K 000	Continued From page 2 department notification. The facility has a capacity of 60 beds and had a census of 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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 are separated from other spaces by smoke resisting partitions and doors. Doors are 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 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 25 out of 57 residents. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/25/2015, observation revealed that the Oxygen Cylinder Storage Room - door will not latch	K 029	The latch on the oxygen storage room door was adjusted so that it latches properly.	8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01** B. WING _____	**08/25/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 This deficient practice was confirmed by the Director of Maintenance (DS) at the time of discovery.	K 029		
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility has failed to properly document monthly inspections of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 57 residents, staff and visitors in the event of a loss of power and generator failure. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/25/2015, observation revealed that a separate Monthly Test Log for the Emergency Generator was not available for review. This deficient practice was confirmed by the Director of Maintenance (DS) at the time of discovery.	K 144	A monthly test run log will be kept in addition to the weekly test run log that is already being kept. This will be started immediately.	8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/25/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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	K 000	EPOC	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/25/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		
	By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Building 02 of Mapleton Community Home consists of the 2011 nursing home addition, which included a link to an assisted living facility. The link incorporates a barber/beauty shop, storage rooms and staff office space. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 57 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		8/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/25/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 011 SS=D	Continued From page 2 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 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.	K 011	The penetration was sealed with fire caulk.	
K 144 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.	K 144		8/25/15

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	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**08/25/2015**

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K 144	Continued From page 3 This STANDARD is not met as evidenced by: Based on documentation review and interview, the facility has failed to properly document monthly inspections of the emergency generator in accordance with NFPA 99 and NFPA 110. This deficient practice could affect all 57 residents, staff and visitors in the event of a loss of power and generator failure. Findings include: On facility tour between 1:00 PM and 3:00 PM on 08/25/2015, observation revealed that a separate Monthly Test Log for the Emergency Generator was not available for review. This deficient practice was confirmed by the Director of Maintenance (DS) at the time of discovery.	K 144	A monthly test run log will be kept in addition to the weekly test run log that is already being kept. This will be started immediately.	

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 only a suggestion 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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.

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 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 8/24/15 - 8/27/15 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 505	MN Rule 4658.0300 Subp. 1 A-E Use of Restraints Subpart 1. Definitions. For purposes of this part, the following terms have the meanings given. A. "Physical restraints" means any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, and wheelchair safety bars. Physical restraints also include practices which meet the definition of a restraint, such as tucking in a sheet so tightly that a resident confined to bed cannot move; bed rails; chairs that prevent rising; or placing a resident in a wheelchair so close to a wall that the wall prevents the resident from rising. Bed rails are considered a restraint if they restrict freedom of movement. If the bed rail is used solely to assist the resident in turning or to help the resident get out of bed, then the bed rail is not used as a restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room or area do not, in and of themselves, restrict freedom of movement and should not be considered restraints. B. "Chemical restraints" means any psychopharmacologic drug that is used for discipline or convenience and is not required to	2 505		10/5/15

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2 505	Continued From page 3 treat medical symptoms. C. "Discipline" means any action taken by the nursing home for the purpose of punishing or penalizing a resident. D. "Convenience" means any action taken solely to control resident behavior or maintain a resident with a lesser amount of effort that is not in the resident's best interest. E. "Emergency measures" means the immediate action necessary to alleviate an unexpected situation or sudden occurrence of a serious and urgent nature. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to use the least restrictive device for least amount of time based on an assessment for 1 of 1 resident (R22) in the sample who was observed to have restraints that inhibited his freedom of movement in wheelchair and bed. 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 staff with mobility in the wheelchair. R22's admission Care Area Assessment (CAA), dated 8/6/15, identified R22 had diagnoses of dementia, weakness, knee pain, had severe cognitive impairment, required assistance with all	2 505	Corrected	

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2 505	Continued From page 4 activities of daily living, was not able to stand and transfer and utilized a mechanical lift. Further, the CAA identified R22 was able to move the rock and go recliner about 10 feet on his own, with a therapy goal of R22 being able to move his wheelchair approximately 50 feet. The CAA identified R22 was at risk for falls, not able to stand independently, used a mechanical lift for transfers, alarms, low bed, sided mattress, matt at bedside, and rock and go wheelchair for safety. R22's admission care plan, dated 7/25/15, identified R22 required assistance with dressing, grooming, use of a mechanical lift for transfers, use of a motion sensor on the floor at bedside and directed staff to anticipate his needs. However, R22's care plan did not include any risks, goals or interventions for the use of the body pillows or reclined wheelchair. During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station except for brief periods when he was wheeled into his room for personal cares or attended meals. R22 was observed multiple times positioned in his reclining wheelchair in a manner where the chair was reclined. R22 was observed to attempt to sit forward in his reclining wheelchair when reclined but was unable to do so. During observation of cares on 8/25/15, at 10:09 a.m. R22 was observed to be wheeled from his room and placed in the hallway in front of the nurses station. Nursing assistant (NA)-E was observed to recline R22 back in his recliner so that he was in a near back lying position. R22 was noted to have a safety alarm, attached with a	2 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 505	Continued From page 5 cord, between the back of his wheelchair and his shirt. During interview on 8/25/2015, at 10:14 a.m. NA-E stated R22's wheelchair was leaned back to keep R22 from being able to self-transfer from the chair. NA-E stated R22 could try to get out of chair but he was not steady or safe. NA-E further stated,"When the chair is reclined [R22] is unable to get out of the wheelchair without assistance. During observation of cares on 8/25/15, at 1:40 p.m. NA-E and NA-D entered R22's room and attached R22 to a mechanical lift. NA- E and NA-D transferred R22 into bed with the use of the lift. NA-E was observed to place a pillow behind R22's back which left him supported on his right side in bed. During interview with NA-E and NA-D on 8/25/15, at 1:50 p.m. the staff stated R22 did not try to get out of bed as much as he used to because they put a body pillow beside him when in bed. The opposite side of R22's bed was against the bedroom wall. NA-E and NA-D further stated R22 did not attempt to get out of his wheelchair when it was leaned back as it impeded his ability to do so. NA-E and NA-D left R22 lying in his bed on his right side with a body pillow holding him in that position. During observation of cares on 8/25/15, at 2:34 p.m. R22 was observed lying in bed on his right side with a body pillow behind him holding him on his right side. A sensor monitor was observed on the floor beside the egress side of his bed and other side of the bed was against the wall. On 8/25/15, at 3:34 p.m. R22 remained lying in his bed with a body pillow beside him supporting him in a right sided position. R22 was noted to have a sensor alarm on the floor beside his bed.	2 505		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 505	Continued From page 6 R22 was observed attempting to turn onto his back while lying in bed and reaching to attempt to remove the pillow from behind him but was unable to remove it. R22 was visibly agitated that he was unable to move the pillows and change his positioning. During review of R22's medical record the nurses notes identified R22 was able to wheel himself at times and did attempt to get out of his wheelchair and bed at times. The following documentation was identified in the progress notes: -On 7/27/2015, at 11:01 a.m. resident had wheeled self to the front lobby from the dining room where he had refused to eat breakfast. He was noted to be sleeping in front of the television. Staff were alerted by his clip alarm sounding and resident yelling "help me". He was found sitting on his footrests and said he couldn't take it anymore. Staff lowered resident to his right side on the ground. He was than hoyered with assist of 3 staff back to his wheelchair and taken to his room where range of motion (ROM) was completed and vital signs (VS) taken. At this time he was changed to a rock-n-go chair for safety. -On 8/2/2015, at 9:29 p.m. resident sat up on side of bed at 9 p.m. setting off his motion sensor. -On 8/6/2015, at 12:19 p.m. resident trying to climb out of recliner this morning. Resident kicking at writer when she was putting eucerin cream on his lower extremities and ace wrapping his lower legs. -On 8/15/2015, at 4:33 p.m. resident wheeled himself to Old Wing. Staff brought him back.	2 505		

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2 505	Continued From page 7 -On 8/20/2015, at 3:43 a.m. resident restless (pounding on wall, crawling out of bed and yelling out for help). Call light in reach, bed in low position, floor alarm on. The progress notes demonstrated R22 was capable of wheeling himself, capable of sitting up in bed and capable of attempting to transfer self out of his wheelchair. During interview with NA-A on 8/26/15 at 10:17 a.m. NA-A stated staff were directed to recline R22 in his wheelchair to keep him from trying to transfer out of it and stated the body pillow utilized when he was in bed was to keep R22 from attempting to self transfer from bed. NA-A stated she knew R22 at times attempted to get out of bed but had not observed him attempting to stand out of his chair. During interview with NA-C on 8/26/15, at 10:53 a.m. NA-C stated R22 did attempt to get out of his bed and the body pillow kept him from getting out. NA-C stated she had not seen him get out of his chair but stated she had been told to keep his wheelchair reclined so he did not attempt to self transfer and fall. During interview with the director of nursing (DNS) and registered nurse (RN)-C on 8/26/15, at 11:02 a.m. they confirmed R22's care plan had not been developed to identify the use of the body pillow or reclining wheelchair. The DNS stated there had not been an assessment of the reclining wheelchair or the body pillow to assess their restrictive nature as neither were intended to be utilized as restraints. The DNS further stated she was not aware the staff were locking R22 in a	2 505		

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2 505	Continued From page 8 reclined position in his wheelchair and was not aware of the use of body pillows. RN-C verified there had been no assessment of the devices to assess how they might restrict R22.. R22 independence with access to his body and mobility were restricted by the use of the body pillow and reclining chair. R22 was observed to have the ability to wheel himself around in his wheelchair when the wheelchair was not reclined and had the capacity of getting out of the chair, whether safe or not, when it was not reclined. Further, R22 was restricted from free movement in his bed when the body pillow was placed behind him. R2 was visibly agitated when observed to not be able to remove the pillow from behind him and reposition himself to a more comfortable lying position. The facility failed to assess R22's devices as restraints, failed to develop a care plan to direct staff how to utilize devices and failed to ensure R22 was not restricted by the interventions used. The facility's policy Physical restraints, undated, identified residents have a right to be free of physical restraints imposed for the purpose of discipline or staff convenience. Staff would assess the restraint for the least restrictive devise possible for resident's comfort and safety. The policy indicated the following procedures- 1. Staff will identify resident's behavior that is unsafe. (frequent falls, improper body alignment, or injury to self). Attempt different alternatives , chart on the effect of the alternative. Make sure the interdisciplinary team (IDT) is aware of an attempt by making note on 24-hour report sheet. Make sure all falls are reported to the IDT. 2. The resident care coordinator (RCC) will	2 505		

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2 505	Continued From page 9 evaluate use of alternatives and make sure appropriate charting is in residents chart. 3. The RCC will complete a physical restraint assessment, which will include alternatives that have been tried and failed. 4. Obtain a physician order which include, type of restraint, the reason for the restraint , and when the restraint will be used. 5. A safety assessment will be reviewed quarterly at care conferences. Family needs to sign the assessment. Information sheet will be mailed to representative. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee, could provide education to nursing staff about what constitutes a restraint. The DON or designee, could randomly audit resident records to ensure devices that potentially restrain a resident have been assessed to ensure safe and least restrictive restraint use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 505		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557,	2 560		10/5/15

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2 560	Continued From page 10 subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to develop a care plan related to interventions for non-pressure related skin conditions for 2 of 3 residents (R8, R22) in the sample who were reviewed for bruising and skin tears. 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 staff with mobility in the wheelchair. During observations of cares on 8/25/15 at 10:09 a.m. R22 was observed seated in his wheelchair in the hallway in front of the nurses station with his feet dangling from chair unsupported. R14 was noted to have severely bruised bilateral forearms with the bruising encompassing the entire aspect of both forearms. The bruising was of varying colors and healing stages. R22 was also noted to have an Opsite (wound dressing) on the medial aspect of his left arm that was covering a skin tear which was presenting with drainage under the dressing. During review of R22's medical record it was noted R22 had a history of being physically aggressive towards staff and would sometimes have self injurious behaviors such as pounding	2 560	Corrected	

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2 560	Continued From page 11 on walls, wheelchair, or tables. R22's medical record contained multiple notes since his admission related to striking out at staff and objects. R22 had an admission skin assessment conducted on 7/24/15 that identified he was admitted with excessive bruising on bilateral forearms. There was no indication of skin tears identified on the assessment. During further review of R22's record it was noted the medical record lacked a care plan to address risk factors, goals and interventions to reduce the risk of bruising or skin tears. The admission care plan did not identify bruising or non pressure related skin risk factors. During interview with the registered nurse (RN)-C on 8/26/15, at 11:02 a.m. it was verified R22's current care plan did not address risks, goals or interventions for bruising or skin tears. It was further verified there was no ongoing monitoring of the skin tear or bruising as the treatment record lacked any treatments for the skin tear. R8's annual MDS, dated 6/3/15, identified R8 had moderate cognitive impairment, no behaviors and required extensive assistance from staff for all activities of daily living (ADL). During observations on 8/25/15 at 3:19 p.m., R8 was observed to have a large bruise approximately 5 inches in diameter on the top of her left arm and a quarter size bruise on the top of her left hand. During interview with R8 at this time, she stated that she obtained the bruise when she went to visit her sister about 2 weeks ago. R8 further indicated her sisters entry way is narrow and she could have bumped it when	2 560		

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2 560	Continued From page 12 entering the home. R8 further revealed she bruises easily because she is on a blood thinner. Review of an incident report for R8 dated 8/16/15 indicated the resident obtained a bruise to the top of the left arm that measured 7.5 cm by 6.0 cm and a bruise to the right arm that measured 6.0 cm by 4.0 cm. The report indicated the resident bruised easily and the bruise was identified after she had been out of the facility, but was unsure what happened. Review of R8'S current physicians orders included an order for plavix (blood thinner) and aspirin. Review of a physician visit dictation note dated 5/5/15, identified the R8 as bruising easily, heavy bruising and blood clots (with nosebleeds) Review of the most current plan of care did not include R8 as being at risk for bleeding/bruising or the use of a blood thinner. No interventions were listed. Interview with the director of nursing (DON) on 8/27/15 at 8:33 a.m., confirmed R8's bruising should have been monitored and care planned because she was at risk for bruising due to the use of a blood thinner. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could assure the policy and procedures are reviewed, revised as needed, staff trained and systems assessed, monitored and evaluated to assure the comprehensive plan of care is developed and lists measurable objectives and timetables to	2 560		

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2 560	Continued From page 13 meet each residents individual needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the activity needs as directed by the care plan for 2 of 3 residents (R14 and R22) in the sample who were reviewed for activities and failed to provide the nutritional needs as directed by the active care plan for 1 of 3 residents (R14) in the sample who was reviewed for weight loss. Findings include: R14's care plan for activities, dated 7/6/15, identified R14 as a quiet, private lady who like to read romance novels, which she has been not doing. The care plan identified R14 had been watching TV and sleeping more. The care plan further identified R14's interest in activities as: 1. Going through her drawers and looking at what she finds in them. 2. Going to and enjoying Music and Motion program, where she is participating 3-5 days a	2 565	Corrected.	10/5/15

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2 565	Continued From page 14 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. During observations on 8/25/15, at 6 8:05 a.m. R14 was observed in the dining room seated at	2 565		

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2 565	Continued From page 15	2 565		

the dining room table in her wheelchair. R14 was placed at the table in a manner where the edge of the table was at the level of her nose. R14 was observed sleeping at the table. At 8:40 a.m., on 8/25/14 R14 was wheeled out of the dining room and wheeled to her room and left seated in her wheelchair in front of her recliner with the light out and television off. There was no interaction with R14 observed until 11:30 a.m. when R14 was wheeled out of her room and into the dining room for the noon meal at 11:30 a.m. R14 remained in the dining room until approximately 12:30 p.m. when she was wheeled back to her room and transferred from her wheelchair to the recliner in her room. R14 was left in her recliner with light out and no stimulus in room. At 1:49 p.m. on 8/25/15 R14 remained seated with eyes closed in her recliner in her room with no stimulus in the room other than her roommates television on which is out of her visual range. R14 was observed through 3:40 p.m., on 8/25/20 and remained in her recliner in her room with no activity occurring.

During observation of cares on 8/26/15, at 6:40 a.m. R14 was observed in her room in her wheelchair with eyes closed. Roommates television was on but out of the view of R14. On 8/26/15, at 7:30 a.m. R14 was observed seated in her w/c in her room leaning to her left in her wheelchair with no activity occurring in the room. On 8/26/15 at 8:24 a.m. R14 was observed seated in her wheelchair in her room leaning to left with eyes closed. No stimulus noted in room. at 8:40 a.m. R14 was observed to be wheeled out of her room to the main dining room and placed at the dining room table. R14 was observed to be placed at the table in a position where her eye level met the edge of the table. R14 only ate small portions of her meal with full staff

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2 565	Continued From page 16	2 565		

assistance. At 9:38 a.m. R14 was wheeled out of the dining room and into her room then transferred into her recliner. R14 was left in recliner with no stimulus in the room. R14 remained in her recliner until the noon meal. At approximately 12:10 pm. R14 was transferred out of her recliner and into her wheelchair then wheeled to the dining room. R14 was observed to be served her noon meal and be assisted with eating by staff placing food in her mouth with a spoon. R14 was not social and did not interact at the table. At 1:20 p.m. R14 was observed to be wheeled out of the dining room to her room and was transferred into her recliner in her room. Again R14 was left in the room with light off and no stimulus occurring.

R14's activity attendance logs for the past 4 months identified she attended activities less than 2 times a week. The logs were incomplete to identify why R14 was not attending activities when she did not attend. The facility occasionally indicated R14 refused but multiple dates were left blank. R14's activity log included entries that R14 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R14 had (1) one to one visit so far for the month on 8/18/15 where staff visited with her about her kids and activities she would do with the kids.

On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R14 used to be in one to one activities but had demonstrated improvement and the one to ones were discontinued. The AD stated R14 had recently demonstrated a decline in activity attendance and should be reassessed for need for one to ones again. The AD stated staff ask R14 frequently for

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2 565	Continued From page 17	2 565		

her to attend moves and motion and R22 often refused. The AD verified R14 was not involved in many activities or the facility environment and spent the majority of her time in her room. The AD verified R14 needed to be asked and encouraged to participate in activities she typically enjoyed.

R22's activity care plan, dated 8/4/15, identified R22 as dependent on staff for activities, cognitive stimulation and social interaction due to his disease process and dementia. the care plan further identified R22 could be hard to keep focused for long periods of time. He was identified as a military veteran who enjoyed singing and watching watching ball games on television. The care plan identified a goal for R22 to attend/participate in 3-5 activities of choice weekly. Interventions were identified as follows:
1. assist/escort to activity functions.
2. Invite to activities
3. R22 is to have 1 to 1 bedside/in-room visits and activities if unable to attend out of room events.
4. R22 prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as Music & Motion
5. When R22 chooses not to participate in organized activities, turn on TV, music in room to provide sensory stimulation

During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station except for brief periods when he was wheeled into his room for personal cares and meal times.

During observation of morning cares on 8/25/15,

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2 565	Continued From page 18 at 8:40 a.m. R14 was observed to be served breakfast after being assisted out of bed;. After R22 consumed his breakfast R22 was observed to wander around the dining room and hallways near the dining room by wheeling himself in his wheelchair. At 9:43 a.m. staff wheeled R22 out of the dining room and placed him in front of the nurses station reclined in his wheelchair. At approximately 10:00 a.m. R22 was wheeled to his room for a short period then wheeled back to the the hallway in front of the nurses station at 10:09 a.m. R22 remained seated in his reclining wheelchair until 11:35 a.m. at which time he was wheeled into the dining room. After the noon meal at approximately 12:50 p.m. R22 was wheeled out of the dining room and into his room. R22 was left beside his bed in the room with no activity. At 1:40 p.m. NA-E and D entered R22's room and attached his lift sling to the mechanical lift and transferred him into bed. At 2:35 p.m. R22 remained in bed. R22 was not observed to be encouraged to participate or attend any activities. At 3:37 p.m. R22 remained in his bed while group activities were occurring. During observation of cares on 08/26/2015 at 6:47 a.m. R22 was observed lying in his bed on his back with eyes closed. At approximately 8:05 a.m. R22 was transferred out of bed with the use of a mechanical lift and two staff. At 8:20 a.m. R22 was wheeled into the dining room and served his breakfast meal. R22 remained in the dining room until 9:43 a.m. at which time he was wheeled out of the dining room and to the hallway in front of the nurses station. At 9:49 a.m. R22 was wheeled to his room by staff to change his shirt as it was heavily soiled with breakfast foods and liquids. At 9:55 a.m. R22 was observed to be seated in his wheelchair in his room beside his bed. There was no activity occurring in the room.	2 565		

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2 565	Continued From page 19 R22's activity attendance logs for the past month, since admission, identified he attended formal activities less than 1 time a week. The logs were incomplete to identify why R22 was not attending activities when he did not attend. The facility occasionally indicated R22 refused but multiple dates were left blank. R22's activity log included entries that R22 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R22 had (2) one to one visit so far for the month. on 8/10/15 activity staff documented on R22's activity log that R22 was visited with in the hallway,"wasn't making much sense, couldn't understand what he was talking about." On 8/19/15 activity staff documented on R22's activity log that they assisted him open a package from his family and talked about the "goodies" he received. There were no further one to one visits noted. On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R22 was difficult to get involved in activities. The AD stated R22 was on 1 to 1 activities but was unable to locate his one to one logs. The AD also stated R22 was asked if he wanted to attend activities but often declined. The AD further stated she agreed R22 was not involved in the facility environment and spent the majority of his time in his room or positioned outside the nurses station. The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30	2 565		

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	00037	A. BUILDING: _____ B. WING _____	08/27/2015

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2 565	Continued From page 20	2 565		

a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30 p.m., Rosary.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice.

The facility staff failed to implement R14's nutritional care plan

R14's care plan, dated 7/6/15, identified R14 required extensive assist with eating at times. The care plan identified R14's diet as consisting of regular small portions diet with the NIP. Other interventions included:
1. Serve meals in the dining room.
2. Offer extra fluids between meals and in room.
3. Honor noted likes and dislikes.

During observation of R14 at the breakfast meal on 8/26/15, at 8:44 a.m. R14 was observed to be served a whole boiled egg, two (2) 1/2 slices of cinnamon raison toast with milk juice and water beverages. R14 was observed to need assistance with eating and nursing assistant (NAR)-C was observed to feed R14 by spooning food into R14's mouth. R14 had her eyes closed during most of the meal time. R14 was also noted positioned in her wheelchair at the table in a manner where her nose was in line at level with the edge of the table. R14 was observed to be fed approximately 50% of her breakfast foods and consumed approximately 10% of her liquids.

On 8/26/15 at 8:57 a.m. an interview was conducted with dietary aide (DA)-A related to any special interventions for R14. DA-A stated she was not aware of any special interventions and

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2 565	Continued From page 21 stated some residents were on the Nutritional Improvement Program (NIP) and named off residents in the dining room on the program but did not include R14. DA-A stated residents with the NIP intervention would have received Karo syrup in their juice to add calories to the meal. When asked if R14 had received the added calories DA-A stated, "No." On 8/26/15, at 12:17 p.m. R14 was observed to be seated at the dining room table being assisted with eating by NA-C. R14 was served (2) 1/2 slices of bread covered with brown gravy, mashed potatoes and cooked carrots. NA-C was observed to attempt to encourage R14 to eat and spoon food into R14's mouth. R14 was seated with her eyes closed during most of the meal. R14 was served chocolate milk, juice and water for liquids. R14 was observed to consume approximately 50% of the bread and gravy and approximately 25% of her mashed potatoes. On 8/26/15, at 12:22 p.m. DA-B was questioned about R14 receiving any supplemental nutrition. DA-B stated R14 had not received any extra foods or supplements. When DA-B was asked if there was a list of residents who received the NIP diet, DA-B retrieved a list in a plastic sleeve at the food service area which identified residents on the NIP. DA-B looked at the list and stated,"Oh, I didn't know she was supposed to get the NIP", responding to R14's name which was on the list. DA-B stated R14 should have received extra butter with her mashed potatoes for the NIP. During interview with the certified dietary manager (CDM) on 8/26/15 12:30 p.m. the CDM stated the staff were supposed to follow the NIP for residents identified on the program. The CDM	2 565		

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2 565	Continued From page 22 verified R14 had been placed on program but did not know exactly when and verified R14 was at risk for malnutrition related to her poor intake. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures. The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by:	2 830		10/5/15

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2 830	Continued From page 23 Based on observation, interview and document review the facility failed to provide services based on a comprehensive assessment to develop interventions to reduce the risk of bruising and skin tears for 2 of 3 residents (R8, R22) reviewed 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 staff with mobility in the wheelchair. During observations of cares on 8/25/15 at 10:09 a.m. R22 was observed seated in his wheelchair in the hallway in front of the nurses station with his feet dangling from chair unsupported. R14 was noted to have severely bruised bilateral forearms with the bruising encompassing the entire aspect of both forearms. The bruising was of varying colors and healing stages. R22 was also noted to have an Opsite (wound dressing) on the medial aspect of his left arm that was covering a skin tear which was presenting with drainage under the dressing. During observation of cares on 8/25/15 at 1:40 p.m. NAR's E and D PM were observed to enter R22's room and transfer him into bed with the use	2 830	Corrected	

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2 830	Continued From page 24 of a mechanical lift. When interviewed about the skin tear on R22's arm NAR-D stated R22 sometimes would strike out at staff and she thought that was how the skin tear occurred. NAR-E verified R22 would strike out at staff or just strike out at the walls or whatever was around him. During review of R22's medical record it was noted R22 had a history of being physically aggressive towards staff and would sometimes have self injurious behaviors such as pounding on walls, wheelchair, or tables. R22's medical record contained multiple notes since his admission related to striking out at staff and objects. R22 had an admission skin assessment conducted on 7/24/15 that identified he was admitted with excessive bruising on bilateral forearms. There was no indication of skin tears identified on the assessment. During further review of R22's record it was noted the medical record lacked a care plan to address risk factors, goals and interventions to reduce the risk of bruising or skin tears. The admission care plan did not identify bruising or non pressure related skin risk factors. During interview with the registered nurse (RN)-C on 8/26/15, at 11:02 a.m. it was verified R22's care plan had not been developed to address skin concerns and there was no current care planned risks, goals or interventions for bruising or skin tears. It was further verified there was no ongoing monitoring of the skin tear or bruising as the treatment record lacked any treatments for the skin tear.	2 830		

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2 830	Continued From page 25 R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation. 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 multiple occasions R14 was observed leaning to her left side with her head resting on either the armrest of her wheelchair or recliner. During observations at the meal times R14 was observed to be positioned at the table in a manner where her eyes were at the level of the edge of the table. . During observation of cares 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. During observation of the evening meal on 8/24/15, at 5:45 p.m. R14 was observed seated at the dining room table in her wheelchair leaning to the left and her eye level was at table edge. R14's wheelchair was too large for her with excessive space noted on bilateral sides when she was seated in the wheelchair. During observation of the breakfast meal on 8/25/15, at 8:00 a.m. R14 was observed seated in the dining room at the dining room table in her wheelchair with the edge of the table at her eyes. During observations on 8/25/15, at 9:44 a.m. R14 was observed seated in her wheelchair in her	2 830		

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2 830	Continued From page 26 room with eyes closed. At 10:41 a.m. R14 remained seated in her wheelchair in her room leaning to the left with head resting on her left wheelchair armrest. During phone interview with R14's family member on 8/25/15, at 9:56 a.m. the family member voiced a concern about R14's positioning. The family member stated there had been communication with the staff about looking at a new wheelchair for R14 but nothing had ever been done. The family member stated R14 was frequently in her room in her wheelchair with not much being offered to her for activities or care. On 8/26/15, at 6:40 am R14 was observed up in her wheelchair in her room sleeping. R14 was observed sleeping in her wheelchair leaning to left, resting her elbow on left armrest with her face in her hand. R14's wheelchair is a high back chair which is too large for her, and too wide to support R14 in good upright positioning. R14 remained seated in her wheelchair in her room until 8:43 a.m. at which time she was wheeled into the dining room for breakfast. On 8/26/15, at 8:44 a.m. R!4 was observed seated at dining room table and positioned at table where height of table left the edge at R14's nose level. Resident does not feed self but positioning does not enable resident to be in a social posture at table. During interview with the activity aide-A on 8/26/15 10:25 a.m. the activity aide stated when R14 did attend activities she would often be leaning to the left in her wheelchair and activity staff would have to ask nursing staff to come in to reposition her.	2 830		

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2 830	Continued From page 27 During interview with the director of nursing (DNS) and registered nurse (RN)-C on 8/26/15, at 11:02 a.m. RN-C stated she was sure that there had been some evaluation of R14's positioning and she would talk to physical therapy to see what they had done in relation to evaluation R14's positioning. RN-C verified she was aware of R14's leaning at times. R14's annual MDS assessment, dated 6/25/15 identified R14 required extensive assistance of 1 to 2 staff with all activities of daily living (ADL), had severe cognition impairment, and needed staff support with balance when transferring or walking. During interview with the DNS on 8/27/15 at 10:30 a.m. the DNS verified she was unable to obtain any documentation that R14's positioning had been assessed. The DNS verified R14's medical record lacked any evidence of a comprehensive assessment for her positioning needs. The facility policy for Wheelchair Positioning, dated 5/5/10, identified residents who utilized wheelchairs for seating will be properly positioned to maintain optimum comfort and well-being. The procedure identified on the policy indicate: 1. The therapy department will routinely assess for wheelchair positioning if the resident is receiving Medicare Part A or Part B benefits. 2. The resident care coordinator will determine if a resident who is not receiving Medicare Part A or Part B benefits is in need of a wheelchair positioning assessment. A physician order will be obtained for residents in need of a wheelchair positioning evaluation. 3. Proper wheelchair positioning will be evaluated	2 830		

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2 830	Continued From page 28 quarterly at time of the quarterly care conference Observations of R8 on 8/25/15 at 3:19 p.m., was observed to have a large bruise approximately 5 inches in diameter on the top of her left arm and a quarter size bruise on the top of her left hand. During interview with the resident at this time, she stated that she obtained the bruise when she went to visit her sister about 2 weeks ago. R8 further indicated her sisters entry way is narrow and she could have bumped it when entering the home. R8 further revealed she bruises easily because she is on a blood thinner. Review of an incident report for R8 dated 8/16/15 indicated the resident obtained a bruise to the top of the left arm that measured 7.5 cm by 6.0 cm and a bruise to the right arm that measured 6.0 cm by 4.0 cm. The report indicated the resident bruises easily and the bruise was identified after she was at her sisters, but was unsure what happened. Review of R8'S current physicians orders included an order for plavix (blood thinner) and aspirin. Review of a physician visit dictation note dated 5/5/15, identified the R8 as bruising easily, heavy bruising and blood clots (with nosebleeds). Review of R8's current plan of care, revised 6/25/15, did not include R8 as being at risk for bleeding/bruising or the use of a blood thinner. No interventions were listed. Interview with the director of nursing (DON) on 8/27/15 at 8:33 a.m., confirmed R8's bruising should have been monitored and care planned because she was at risk for bruising due to the	2 830		

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2 830	Continued From page 29 use of a blood thinner. Review of the facility policy for bruises dated 7/12/15, included; the residents bruises will be identified, cause determined, documented and monitored; enter treatment/observation schedule on treatment sheet, notify physician and family. SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designee could establish procedures, educate staff and audit to ensure that residents individualized needs are being met. The director of nursing or designee, could review and revise policies and procedures related to non pressure related skin conditions and positioning, conduct assessments and could provide staff education related to the care of resident. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.	2 965		10/5/15

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2 965	Continued From page 30 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide the necessary nutritional needs based on comprehensive assessment for 1 of 3 residents (R14) reviewed for weight loss. Findings include: R14's annual Minimum Data Set (MDS) assessment dated 6/25/15 identified R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation. The MDS identified R22 required extensive assistance of one staff for mobility. R14's nutritional Care Area Assessment, dated 6/26/15, identified R14 had no problems with chewing/swallowing, had no functional problems 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% weight loss in the last 6 months, house supplement was not given and would get that correct to start giving her 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 overwhelm R14 with food portions. The diet would include fortified foods (NIP) as accepted. The goal was identified to keep R14's weight between 103-113 pounds. During review of R14's medical record it was noted R14 had sustained a fifteen (15) pound weight loss in the past 6 months which was 14.2	2 965	Corrected	

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2 965	Continued From page 31	2 965		

% loss of total body weight, a significant weight loss. R14's weight on 2/22/15 was identified at 121 pounds and her current recorded weight, dated 8/23/15 was 106 pounds.

R14's care plan, revised 7/14/15, identified R14 required extensive assist with eating at times. The care plan identified R14's diet as consisting of regular small portions diet with NIP.
Other interventions included:
1. Serve meals in the dining room.
2. Offer extra fluids between meals and in room.
3. Honor noted likes and dislikes.

During observation of R14 at the breakfast meal on 8/26/15, at 8:44 a.m. R14 was observed to be served a whole boiled egg, two (2) 1/2 slices of cinnamon raison toast with milk juice and water beverages. R14 was observed to need assistance with eating and nursing assistant (NAR)-C was observed to feed R14 by spooning food into R14's mouth. R14 had her eyes closed during most of the meal time. R14 was also noted positioned in her wheelchair at the table in a manner where her nose was in line at level with the edge of the table. R14 was observed to be fed approximately 50% of her breakfast foods and consumed approximately 10% of her liquids.

On 8/26/15 at 8:57 a.m. an interview was conducted with dietary aide (DA)-A related to any special interventions for R14. DA-A stated she was not aware of any special interventions and stated some residents were on the nutritional improvement program (NIP) and named off residents in the dining room on the program but did not include R14. DA-A stated residents with the NIP intervention would have received Karo syrup in their juice to add calories to the meal. DA-B confirmed R14 had not received Karo syrup

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2 965	Continued From page 32 in juice for the breakfast meal. On 8/26/15, at 12:17 p.m. R14 was observed to be seated at the dining room table being assisted with eating by NA-C. R14 was served (2) 1/2 slices of bread covered with brown gravy, mashed potatoes and cooked carrots. NA-C was observed to attempt to encourage R14 to eat and spoon food into R14's mouth. R14 was seated with her eyes closed during most of the meal. R14 was served chocolate milk, juice and water for liquids. R14 was observed to consume approximately 50% of the bread and gravy and approximately 25% of her mashed potatoes. On 8/26/15, at 12:22 p.m. DA-B was questioned about R14 receiving any supplemental nutrition. DA-B stated R14 had not received any extra foods or supplements. DA-B provided a list of residents in a plastic sleeve at the food service area which identified residents on the NIP. DA-B looked at the list and stated,"Oh, I didn't know she was supposed to get the NIP", responding to R14's name which was on the list. DA-B stated R14 should have received extra butter with her mashed potatoes for the NIP. During interview with the certified dietary manager (CDM) on 8/26/15 12:30 p.m. the CDM stated she expected staff to follow the NIP for residents identified on the program. The CDM verified R14 had been placed on program but did not know exactly when and verified R14 was at risk for malnutrition related to her poor intake. The facility failed to provide dietary services as assessed to met the nutritional needs for R14. The facility failed to implement the NIP as directed by the care plan on a routine basis as directed.	2 965		

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2 965	Continued From page 33 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. The administrator or designee could conduct audits for compliance and review with the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		

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21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. 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. Findings include: R14's annual Minimum Data Set (MDS) assessment dated 6/25/15 identified R14 had diagnoses that included major depression, dementia, anemia and atrial fibrillation. The MDS identified R22 required extensive assistance of one staff for mobility. The MDS further indicated it was somewhat important for R14 to do group activities with others, keep up with news, do her favorite activities and very important to listen to music she likes and going outside. R14's quarterly Activity Assessment, dated	21435	Corrected	10/5/15

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6/26/15, identified R14 participated in activities 3-5 times a week. The assessment identified R14 needed reminders and assistance to attend activities and identified she demonstrated appropriate behaviors while in activities.

R14's Care Plan for activities, dated 7/6/15, identified R14 had liked to read romance novels, which she has been not doing. The care plan identified R14 had been watching TV and sleeping more. The care plan further identified R14's interest in activities as:
1. Going through her drawers and looking at what she finds in them.
2. Going to and enjoying Music and Motion program, where she is participating 3-5 days a 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.

R14's care plan goal was identified for her to join activities at least 3-5 times weekly. Interventions for activity were identified as: Keep informed of activity schedule, Invite and encourage her to attend activities of interest (music and special programs), assist to and from activity, visit for socialization, and check to see if resident has materials for independent activity (i.e.. romance novels).

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

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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 attempted 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 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.

During observations on 8/25/15, at 8:05 a.m. R14 was observed in the dining room seated at the dining room table in her wheelchair. R14 was placed at the table in a manner where the edge of the table was at the level of her nose. R14 was observed sleeping at the table. At 8:40 a.m., on 8/25/14 R14 was wheeled out of the dining room to her room and left seated in her wheelchair in front of her recliner with the light out and television off. There was no interaction with R14 observed until 11:30 a.m. when R14 was wheeled out of her room and into the dining room for the noon meal at 11:30 a.m. R14 remained in the dining room until approximately 12:30 p.m. when she was wheeled back to her room and transferred from her wheelchair to the recliner in her room. R14 was left in her recliner with light out and no stimulus in room. At 1:49 p.m. on 8/25/15 R14 remained seated with eyes closed in her recliner in her room with no stimulus in the room other than her roommates television on

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which is out of her visual range. R14 was observed through 3:40 p.m., on 8/25/15 and remained in her recliner in her room with no activity occurring.

During phone interview with R14's family member on 8/25/15, at 9:56 a.m. the family member voiced a concern about R14's involvement in the facility environment. The family member stated R14 was frequently in her room in her wheelchair with not much being offered to her for activities or care.

During observation of cares on 8/26/15, at 6:40 a.m. R14 was observed in her room in her wheelchair with eyes closed. Roommates television was on but out of the view of R14. On 8/26/15, at 7:30 a.m. R14 was observed seated in her w/c in her room leaning to her left in her wheelchair with no activity occurring in the room. On 8/26/15 at 8:24 a.m. R14 was observed seated in her wheelchair in her room leaning to left with eyes closed. No stimulus noted in room. at 8:40 a.m. R14 was observed to be wheeled out of her room to the main dining room and placed at the dining room table. At 9:38 a.m. R14 was wheeled out of the dining room and into her room then transferred into her recliner. R14 was left in recliner with no stimulus in the room. R14 remained in her recliner until the noon meal. At approximately 12:10 pm. R14 was transferred out of her recliner and into her wheelchair then wheeled to the dining room. R14 was observed to be served her noon meal and be assisted with eating by staff placing food in her mouth with a spoon. R14 was not social and did not interact at the table. At 1:20 p.m. R14 was observed to be wheeled out of the dining room to her room and was transferred into her recliner in her room. Again R14 was left in the room with light off and

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21435	Continued From page 38 no stimulus occurring. The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30 a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30 p.m., Rosary. The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice. Review of R14's activity attendance logs for the months of May, June, July and August 2015 revealed R22 had documentation of attendance in activities consistently less than 2 times a week. R14's activity log identified R14 had independent activities such as resting, wheeling/walking in halls and watching television. The documentation revealed at times R14 refused a activity, however, the logs did not include why R14 was not attending activities when she did not attend nor any other activities that had been offered. Review of R14's One to One Activity Log revealed a note on 8/2015 identified R14 had (1) one to one visit where staff visited with her about her kids and activities she would do with the kids. No other documentation of one to one visits was provided by the facility. On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R14 used to	21435		

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be in one to one activities but had demonstrated improvement and the one to ones were discontinued. The AD stated R14 had recently demonstrated a decline in activity attendance and should be reassessed for need for one to ones again. The AD confirmed the monthly attendance longs and stated staff ask R14 frequently for her to attend moves and motion and R22 often refused. The AD verified R14 was not involved in many activities or the facility environment and spent the majority of her time in her room. The AD verified R14 needed to be asked and encouraged to participate in activities she typically enjoyed.

The facility failed to provide the necessary activity needs for R14 as evidenced by their failure to provide services as directed by the care plan for one to one and group activities and failed to encourage R14 to attend activities which she identified as important or somewhat important to her. The facility did not reassess R14's activities needs when they identified her activity preference and attendance has significantly changed. During the three days of observation 8/24/15 through 8/26/14, during times when formal activities were being conducted at the facility, R14 was not observed to be encouraged to attend or be actively involved in any formal activities. R14 was observed to spend the majority of the observation time in her room with the lights out and no stimulus (I.e.. television, radio, or staff interaction).

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

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21435	Continued From page 40 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 staff with mobility in the wheelchair. R22's Activity assessment dated 8/10/15 identified R22 with past and current activity interests that included: cards, games, crafts, exercises, reading, music, sports, religion, shopping, outdoors, watching television, gardening and keeping current with news. Further, the assessment identified R22 enjoyed attending activities both morning and afternoon, loved bingo and enjoyed watching ball games on TV. R22's activity care plan, dated 8/4/15, identified R22 as dependent on staff for activities, cognitive stimulation and social interaction due to his disease process and dementia. The care plan further identified R22 could be hard to keep focused for long periods of time. He was identified as a military veteran who enjoyed singing and watching ball games on television. The care plan identified a goal for R22 to attend/participate in 3-5 activities of choice weekly. Interventions were identified as follows: 1. assist/escort to activity functions. 2. Invite to activities 3. R22 is to have 1 to 1 bedside/in-room visits and activities if unable to attend out of room events. 4. R22 prefers activities which do not involve overly demanding cognitive tasks. Engage in simple, structured activities such as Music & Motion 5. When R22 chooses not to participate in organized activities, turn on TV, music in room to	21435		

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21435	Continued From page 41 provide sensory stimulation During observation of R22 on 8/24/15, from 1:30 p.m. to 7:30 p.m. R22 was observed seated in his reclining wheelchair in front of the nurses station except for brief periods when he was wheeled into his room for personal cares and meal times. During observation of morning cares on 8/25/15, at 8:40 a.m. R14 was observed to be served breakfast after being assisted out of bed;. After R22 consumed his breakfast R22 was observed to wander around the dining room and hallways near the dining room by wheeling himself in his wheelchair. At 9:43 a.m. staff wheeled R22 out of the dining room and placed him in front of the nurses station reclined in his wheelchair. At approximately 10:00 a.m. R22 was wheeled to his room for a short period then wheeled back to the the hallway in front of the nurses station at 10:09 a.m. R22 remained seated in his reclining wheelchair until 11:35 a.m. at which time he was wheeled into the dining room. After the noon meal at approximately 12:50 p.m. R22 was wheeled out of the dining room and into his room. R22 was left beside his bed in the room with no activity. At 1:40 p.m. NA-E and NA-D entered R22's room and with the use of a mechanical lift transferred him into bed. At 2:35 p.m. R22 remained in bed. R22 was not observed to be encouraged to participate or attend any activities. At 3:37 p.m. R22 remained in his bed while group activities were occurring. During observation of cares on 08/26/2015 at 6:47 a.m. R22 was observed lying in his bed on his back with eyes closed. At approximately 8:05 a.m. R22 was transferred out of bed with the use of a mechanical lift and two staff. At 8:20 a.m. R22 was wheeled into the dining room and	21435		

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served his breakfast meal. R22 remained in the dining room until 9:43 a.m. at which time he was wheeled out of the dining room and to the hallway in front of the nurses station. At 9:49 a.m. R22 was wheeled to his room by staff to change his shirt as it was heavily soiled with breakfast foods and liquids. At 9:55 a.m. R22 was observed to be seated in his wheelchair in his room beside his bed. There was no activity occurring in the room.

An activity note dated 8/12/2015, at 11:53 a.m. identified a care conference was held with the interdisciplinary team and R22's family member. The note identified R22 as dependent on staff for activities, cognitive stimulation and social interaction.

The activity schedule for 8/24/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., happy hour; 4:00 p.m., men's group.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Trivia; 10:30 a.m., Bible study; 11:00 a.m., Techniques; 11:30 a.m. music and motion; 2:00 p.m., craft; 3:30 p.m., Rosary.
The activity schedule for 8/25/15 was as follows: 9:30 a.m., Exercises; 10:00 a.m. Brain games; 11:00 a.m., Techniques; 11:30 a.m., music and motion; 2:00 p.m., social; 2:15 p.m. Bingo; 4:00 p.m., Discard it dice.

On 08/26/2015 at 10:25 a.m. the activity director (AD) was interviewed. The AD stated R22 was difficult to get involved in activities. The AD stated R22 was on one to one activities but was unable to locate his one to one logs. The AD also stated R22 was asked if he wanted to attend activities but often declined. The AD further stated she

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confirmed R22 was not involved in the facility environment and spent the majority of his time in his room or positioned outside the nurses station.

R22's activity attendance logs for the past month, since admission, identified he attended formal activities less than 1 time a week. The logs were incomplete to identify why R22 was not attending activities when he did not attend. The facility occasionally indicated R22 refused but multiple dates were left blank. R22's activity log included entries that R22 would do independent activities such as resting, wheeling/walking in halls and watching television. The one to one activity log for 8/2015 identified R22 had (2) one to one visit so far for the month. on 8/10/15 activity staff documented on R22's activity log that R22 was visited with in the hallway,"wasn't making much sense, couldn't understand what he was talking about." On 8/19/15 activity staff documented on R22's activity log that they assisted him open a package from his family and talked about the "goodies" he received. There were no further one to one visits noted.

The facility failed to provide the necessary activity needs for R22 as evidenced by their failure to provide services as directed by the care plan for one to one and group activities and failed to encourage R22 to attend activities which he identified as important or somewhat important to himself. The facility staff frequently positioned R22 outside the activity room by the nurses station or in his room when organized activities were occurring and R22 was not observed to be offered to participate. When R22 was left in his room he was left with no activity or environmental stimulus occurring in his room. He was observed throughout the survey in his room beside his bed or in bed with no television, radio or staff

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21435	Continued From page 44 interaction. SUGGESTED METHOD OF CORRECTION: The activities director or designee could review and revise policies and programming related to the cognitively impaired. The activities director or designee could educate staff on individualized activities programming, and conduct audits to ensure activities being provided reflect resident interests and abilities. The audits could be referred to the quality assurance committee to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain security of pharmacological's in the treatment cart. This had the potential to affect all residents with independent mobility who reside in the facility. Findings include: During observation of a medication administration pass with trained medication assistant (TMA)-A on 8/14/15 at 6:10 p.m., a treatment cart was	21610	Corrected	10/5/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 45 observed to be stored in a tub room unsecured. There was a drawer that was pulled open with several vials of insulin and syringes in view from the hallway. The unlocked cart also contained several eye drops and treatment creams. TMA-A indicated the treatment cart should be locked, but proceeded to walk away from the unlocked/unattended storage cart to continue passing medications in the dining room. The unattended cart remained unsecured until 6:35 p.m. while several staff and residents had walked/wheeled by the cart. At 6:35 p.m., TMA-A confirmed the cart remained unsecured, and indicated she would notify the nurse who was in charge of the treatment cart. Interview with licensed practical nurse (LPN)-A on 8/14/15 at 6:40 p.m. confirmed she was in charge of the unlocked treatment cart. LPN-A indicated she usually stored the cart in the locked medication room, but placed it in the tub room so she could assist residents to the dining room for supper and forgot to lock the cart. Interview with the DON on 8/14/15 at 7:30 p.m. indicated the treatment cart should be locked at all times when unattended. Review of the Policy and Procedure dated 10/1/07 for storage of medications, syringes and needles included; the facility should ensure that all medications and treatment items are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and	21610		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	08/27/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21610	Continued From page 46 consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of properly securing medications. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		

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Protecting, maintaining and improving the health of all Minnesotans

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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, BLUE EARTH, MN 56065**		
Telephone Number: F6 **507-524-3315**	State/County Code: **MN / BLUE EARTH**	State/Region Code: **MN / 05**
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 Corporation**		
Owned or leased by Multi-Facility Organization: F13 **No** Name of Multi-Facility Organization: F14		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0**	

Head Trama F19 **0** Hospice F20 **0**
Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **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 members of residents? F25	**Yes**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

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.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

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

		A	B	C	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**

Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		0	0	0
Nurses with Admin Duties	F40		0	0	0
Registered Nurses	F41		473	0	0
Licensed Practical/ Vocational Nurses	F42		73	62	0
Certified Nurse Aides	F43		1199	752	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		175	26	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		0	0	0
Food Service Workers	F49		160	581	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No No	0	0	10
Occupational Therapy Assistant	F52		0	0	75
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No No	0	0	20
Physical Therapy Assist	F55		0	0	88
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes No No	0	0	17
Therapeutic Recreation Spec.	F58	No No No	0	0	0
Qualified Activities Prof.	F59	No No No	0	0	0
Other Activities Staff	F60	Yes No No	83	118	0
Qualified Social Workers	F61	No No No	0	0	0

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: **08/28/15**

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See also > Compliance Monitoring Home

For questions about this page, please contact our Compliance Monitoring Division: health.fpc-web@state.mn.us

- Certificates & Records
- Data & Statistics
- Diseases & Conditions
- Emergency Preparedness
- Environments & Your Health
- Facilities & Professions
- Health Care & Coverage
- Injury, Violence & Safety
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- Prevention & Healthy Living
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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. **245362**	Medicare F75 **4**	Medicaid F76 **28**	Other F77 **25**	Total Residents F78 **57**

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

A. Bowel/Bladder Status	**B. Mobility**
F94 **6** With indwelling or external catheter. F95 Of total number of residents with catheters, **5** were present on admission.	F100 **0** Bedfast all or most of time.. F101 **48** In chair all or most of time. F102 **9** Independently ambulatory.

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.

F122 **0** Receiving dialysis.	F130 **12** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **16** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **8** Receiving respiratory treatment.	F132 **12** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	
F126 **0** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **33** Receiving any psychoactive medication.	F140 **11** With unplanned significant weight loss/gain.
F134 **3** Receiving antipsychotic medications.	F141 **0** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **5** Receiving antianxiety medications.	F142 **0** Who use non-oral communicationdevices.
F136 **31** Receiving antidepressant medications.	F143 **21** With advance directives.
F137 **0** Receiving hypnotic medication.	F144 **50** Received influenza immunization.
F138 **10** Receiving antibiotics.	F145 **52** Received pneumococcal vaccine.
F139 **40** On pain management program.	

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245362	MAPLETON COMMUNITY HOME

Type of Survey (select all that apply):

I					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	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 Hours (H)	Off-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 31767	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.								

Total Supervisory Review Hours	11.50
Total Clerical/Data Entry Hours.....	3.25
Was Statement of Deficiencies given to the provider on-site at completion of the survey?	Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245362	MAPLETON COMMUNITY HOME

Type of Survey (select all that apply):

H	I	K			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	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 Hours (H)	Off-Site Report Preparation Hours (I)
1. 34764	08-25-2015	08-25-2015	1.00	0.00	3.00	0.00	4.00	0.00
2. Team Leader 35482	08-25-2015	08-25-2015	1.00	0.00	3.00	0.00	1.50	1.50
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.75

Total Clerical/Data Entry Hours..... 0.25

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	FACILITY NAME	SURVEY DATE
K1 245362	**MAPLETON COMMUNITY HOME**	*K4 **08/25/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 01

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [3] K56: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

F5362023

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

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245362	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
MAPLETON COMMUNITY HOME	A. BUILDING 01 MAIN B. WING C. FLOOR K3	301 TROENDLE ST. MAPLETON, MN 56065	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	8/25/2015 K4	K6	5. [✔] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ( ) ENTIRE FACILITY 2. (●) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 60	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 60	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 60	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID_____

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) EQUIVALENCIES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD

K9

SURVEYOR *(Signature)* Kimberly Swenson	TITLE	OFFICE	DATE
SURVEYOR ID 35482/34764 K10	DEPUTY FIRE MARSHAL	FIRE MARSHAL DIVISION	8/25/2015
FIRE AUTHORITY OFFICIAL *(Signature)*	TITLE	OFFICE	DATE
	Interim Fire Safety Supervisor	FIRE MARSHAL DIVISION	09/01/2015

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K12-Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction.
	BUILDING CONSTRUCTION				
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	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) — Not over two stories with complete automatic sprinkler system.				
	5 ◉ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic 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.*				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	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)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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 1/28 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* A	◉	○		
	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* A	◉	○		
	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
K16	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				
K17	2000 EXISTING 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	◉	○		
	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: ☑ (a) The required manual fire alarm system and ☑ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (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.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: 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				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	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				
K29	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	○	◉	○	K 29 NOT MET: The door on the oxygen cylinder storage room needs to latch into the frame upon closing.

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	✔	✔	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT 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 ¾ 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
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			
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 not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor 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	☐	☐	☐

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.				

ID PREFIX		MET	NOT 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) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • 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	◉	○		

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.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
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				
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 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	○	○	◉	

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 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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				
K60	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				
K56	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.				
K154	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. 2/12/2015				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. OLYMPIC				
	C. Note the source of water supply for the automatic sprinkler system. city				
	(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)	◉	○	○	K66-SMOKE FREE FACILITY

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 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 **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** 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 **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** 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	○	○	◉	

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 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				
K73	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	◉	○	○	
K74	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.	◉	○	○	
K75	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/ft^2 (20.4 L/m^2). A	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) 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	○	○	○	
	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 PREFIX		MET	NOT MET	N/A	REMARKS
	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	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (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	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (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. 4-3.1.2.2 (NFPA 99)	○	○	◉	
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)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	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				
K106	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)	○	○	◉	
K107	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			☑	
K144	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)	○	◉	○	K 144 NOT MET: A separate Monthly Test Log for the Emergency Generator was not available for review.
K145	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 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	Office	Date
Fire Authority Official *(Signature)*	Title	Office	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 CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

K0180

A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* 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 HOME**	*K4 **08/25/2015**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 02

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [13] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [3] K56: [3]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

F5362023

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

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245362	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
MAPLETON COMMUNITY HOME	A. BUILDING 01 MAIN B. WING C. FLOOR K3	301 TROENDLE ST. MAPLETON, MN 56065	A. ( ) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. (•) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✔] MEDICARE [✔] MEDICAID	8/25/2015 K4	K6	5. [ ] 2000 EXISTING 6. [✔] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. ( ) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. ( ) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. ( ) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 60	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 60	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 60	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID_____

7. A. ( ) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. ( ) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) EQUIVALENCIES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD

K9 SURVEYOR *(Signature)* kimberly Swenson	TITLE	OFFICE	DATE
SURVEYOR ID 35482/34764 K10	DEPUTY FIRE MARSHAL	FIRE MARSHAL DIVISION	8/25/2015
FIRE AUTHORITY OFFICIAL *(Signature)*	TITLE	OFFICE	DATE
	Interim Fire Safety Supervisor	FIRE MARSHAL DIVISION	09/01/2015

ID PREFIX					MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES							
	BUILDING CONSTRUCTION							
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-Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction.
K12	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)	Not over two stories with complete automatic sprinkler system.				
	5		V (111)					
	6		IV (2HH)					
	7		II (000)					
	8		III (200)	Not over one story with complete automatic sprinkler system.				
	9		V (000)					
	☐ 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.*							

ID PREFIX			MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.		○	○	○	
	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)	Not over one story with complete automatic sprinkler system.				
	4 ○ V (111)					
	5 ○ IV (2HH)					
	6 ○ II (000)					
	7 ○ III (200)	Not Permitted				
	8 ○ V (000)					
	☐ 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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 1/28 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* A	○	○		
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* A	○	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	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				
K17	2000 EXISTING 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				
	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: ☑ (a) The required manual fire alarm system and ☑ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (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.	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	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	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7				
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	○	○	○	
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7				
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: 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	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	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				
K29	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				K 29 NOT MET: The door on the oxygen cylinder storage room needs to latch into the frame upon closing.

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			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT 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 ¾ 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
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	✔	✔	
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 not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor 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			

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.				

ID PREFIX		MET	NOT 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) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • 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				

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.)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
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				
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 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				

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 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 PREFIX		MET	NOT MET	N/A	REMARKS
	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				
K60	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				
K56	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.	○	○	○	
K154	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. 2/12/2015				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. OLYMPIC				
	C. Note the source of water supply for the automatic sprinkler system. citv				
	(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)	○	○	○	K66-SMOKE FREE FACILITY

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 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 **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** 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 **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** 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				

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 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				
K73	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	○	○	○	
K74	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.	○	○	○	
K75	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/ft^2 (20.4 L/m^2). A	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) 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	○	○	○	
	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 PREFIX		MET	NOT MET	N/A	REMARKS
	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	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	○	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	○	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (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	○	○	○	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (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. 4-3.1.2.2 (NFPA 99)	○	○	○	
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)	○	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	○	
K143	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				
K106	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)	○	○	○	
K107	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	◉	○	○	
K144	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)	○	○	○	K 144 NOT MET: A separate Monthly Test Log for the Emergency Generator was not available for review.
K145	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 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	Office	Date
Fire Authority Official *(Signature)*	Title	Office	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 CONSTRUCTION

TOTAL NUMBER OF BUILDINGS _____

NUMBER OF THIS BUILDING _____

☐

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786R	2000 EXISTING
13	2786R	2000 NEW

ASC Form		
14	2786U	2000 EXISTING
15	2786U	2000 NEW

ICF/MR Form		
16	2786V, W, X	2000 EXISTING
17	2786V, W, X	2000 NEW

* K7 ☐ SELECT NUMBER OF FORM USED FROM ABOVE

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: ☐ 1 PROMPT 2 SLOW 3 IMPRACTICAL

LARGE

K8: ☐ 4 PROMPT 5 SLOW 6 IMPRACTICAL

APARTMENT HOUSE

K8: ☐ 7 PROMPT 8 SLOW 9 IMPRACTICAL

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X and Y.)

K29: ☐ K56: ☐

ENTER E – SCORE HERE

K5: ☐ e.g. 2.5

*K9: FACILITY MEETS LSC BASED ON *(Check all that apply)*

A1. ☐ (COMP. WITH ALL PROVISIONS)

A2. ☐ (ACCEPTABLE POC)

A3. ☐ (WAIVERS)

A4. ☐ (FSES)

A5. ☐ (PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC

B. ☐

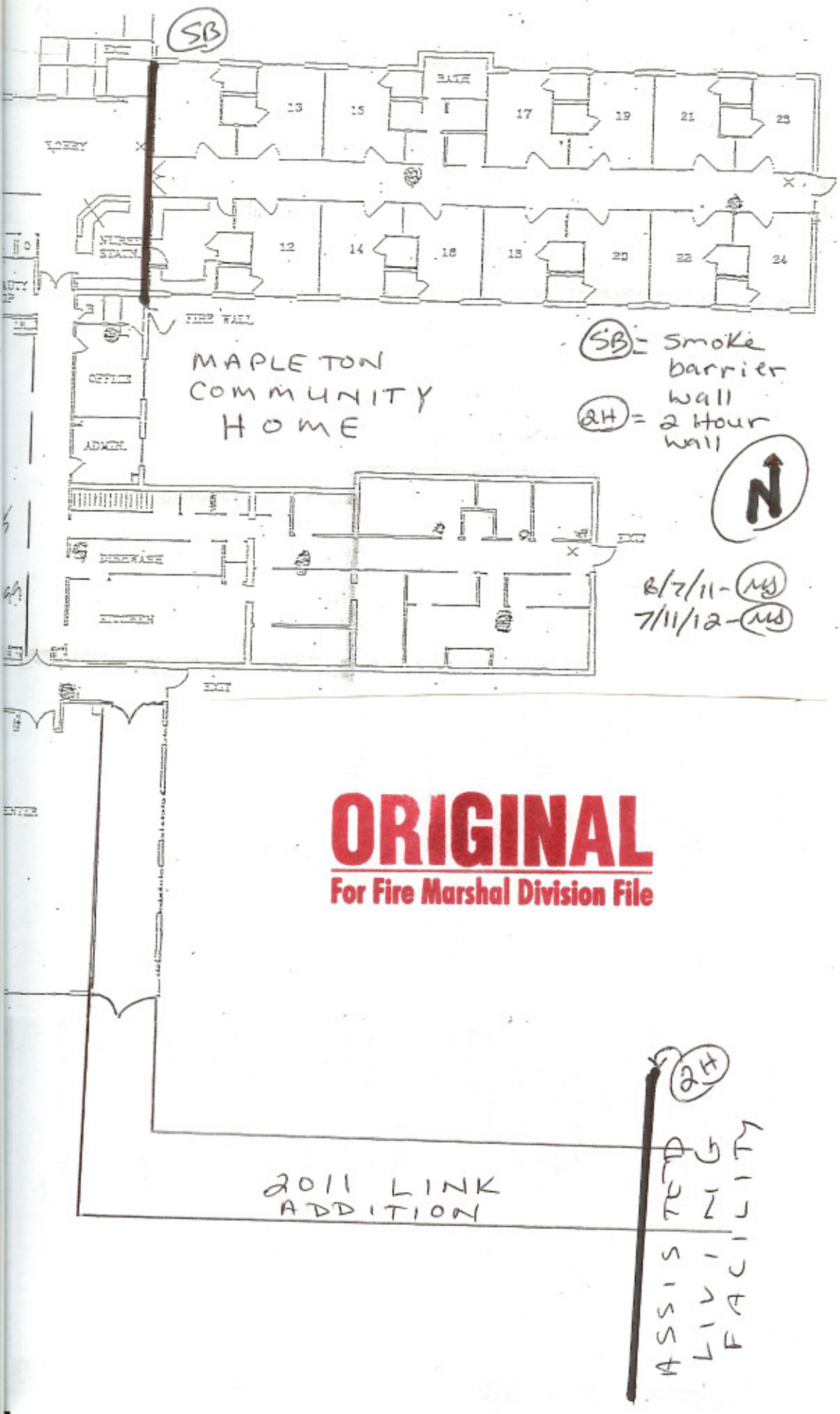
K0180

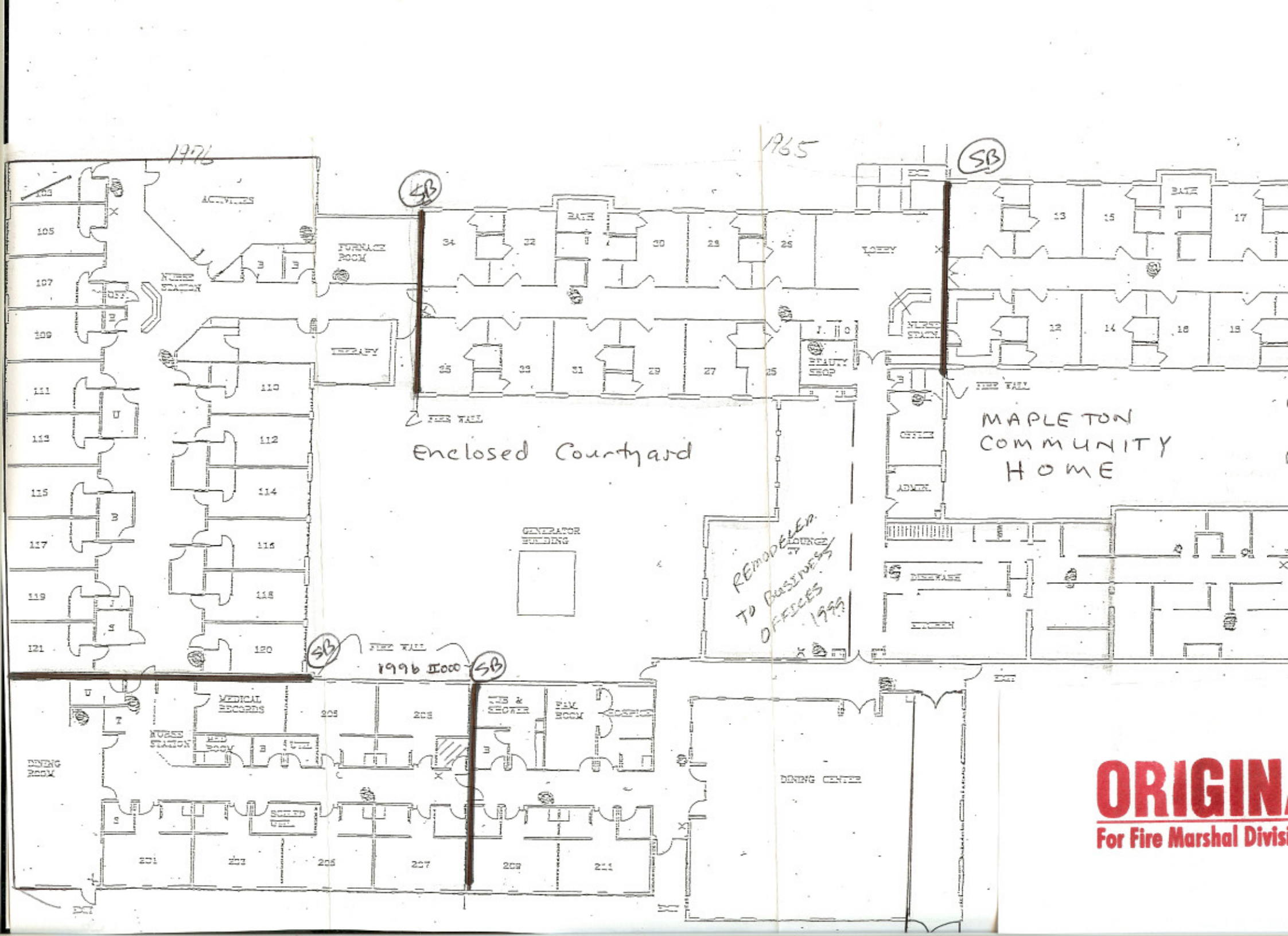
A. ☐ FULLY SPRINKLERED (All required areas are sprinklered)

B. ☐ PARTIALLY SPRINKLERED (Not all required areas are sprinklered)

C. ☐ NONE (No sprinkler system)

* MANDATORY




1976
1965
SB
ACTIVITIES
NURSE STATION
FURNACE ROOM
THERAPY
BATH
LOBBY
BEAUTY SHOP
FIRE WALL
Enclosed Courtyard
GENERATOR BUILDING
MAPLETON COMMUNITY HOME
REMODELED TO BUSINESS OFFICES 1995
LOUNGE
OFFICE
ADMIN
DINING ROOM
KITCHEN
1996
MEDICAL RECORDS
SOILED
DINING CENTER
ORIGINA
For Fire Marshal Divisi

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5362023	Mapleton Community Home, Mapleton	08/25/2015

Administrator: F5362023 Phone Number: 245362

Email address:
rgosson@mapletoncommunityhome.com dshaefer@mapletoncommunityhome.com

State Fire Inspector: Larry Gannon (651) 769-7779

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to:** ☑ **SNF/NF** ☐ **Hospital** ☐ **ICFMR** ☐ **ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
K 11 S/S=D	Cable penetrations above the lay-in ceiling at the 2 hour fire wall between the Nursing Home and the Assisted Living need to be sealed.
K 29 S/S=D	The door on the oxygen cylinder storage room needs to latch into the frame upon closing.
K 144 S/S=D	A separate Monthly Test Log for the Emergency Generator was not available for review.

S5362023

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

Email for ADMINISTRATOR: rgosson@mapletoncommunityhome.com

National Provider Identifier (NPI) Number: 1194730853

One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

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: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____

Address: _____

City/State/Zip: _____

SIGNATURE

Completed by: Raylene Rosson

Title: Administrator

Date: 8/24/15