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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R3ZR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00396

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245570**
2.STATE VENDOR OR MEDICAID NO.
(L2) **235842500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE LAWN SENIOR CARE**
(L4) **400 SEVENTH STREET**
(L5) **FULDA, MN** (L6) **56131**

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 **09/14/2015** (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 **58** (L18)

13.Total Certified Beds **58** (L17)

10.THE FACILITY IS CERTIFIED AS:
X 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
	58			
(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 :
Kathryn Serie, Unit Supervisor 09/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/24/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 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
08/01/1991
(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
09/08/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245570

September 24, 2015

Mr. Arlan Swanson, Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, Minnesota 56131

Dear Mr. Swanson:

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

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

Effective September 8, 2015 the above facility is certified for:

58 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 58 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
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 24, 2015

Mr. Arlan Swanson, Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, Minnesota 56131

RE: Project Number S5570025

Dear Mr. Swanson:

On August 14, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 30, 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 September 14, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 8, 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 extended survey, completed on July 30, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 8, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 30, 2015, effective September 8, 2015 and therefore remedies outlined in our letter to you dated August 14, 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
245570	A. Building B. Wing	9/14/2015

Name of Facility	Street Address, City, State, Zip Code
MAPLE LAWN SENIOR CARE	400 SEVENTH STREET FULDA, MN 56131

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **09/04/2015**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **09/04/2015**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **09/04/2015**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **09/04/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **09/04/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **09/04/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **09/04/2015**	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	09/24/2015	03048	09/14/2015
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
7/30/2015			

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 A. Building B. Wing	(Y3) Date of Revisit
245570	01 - MAIN BUILDING 01	9/8/2015

Name of Facility	Street Address, City, State, Zip Code
MAPLE LAWN SENIOR CARE	400 SEVENTH STREET FULDA, MN 56131

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0048	Correction Completed 09/08/2015	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 09/08/2015	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 09/08/2015
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	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	Date:	Signature of Surveyor:	Date:
	GS/kfd	09/24/2015	35482	09/08/2015
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
7/29/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: R3ZR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00396

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245570**
2.STATE VENDOR OR MEDICAID NO.
(L2) **235842500**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLE LAWN SENIOR CARE**
(L4) **400 SEVENTH STREET**
(L5) **FULDA, MN** (L6) **56131**

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 **07/30/2015** (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 **58** (L18)

13.Total Certified Beds **58** (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

X 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
	58			
(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 :
Pamela Manzke, HFE NE II 08/27/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 09/04/2015 (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
08/01/1991
(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
August 14, 2015

Mr. Arlan Swanson, Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, Minnesota 56131

RE: Project Number S5570025

Dear Mr. Swanson:

On July 30, 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. 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), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Rochester Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: gary.nederhoff@state.mn.us

Telephone: (507) 206-2731
Fax: (507) 206-2711

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 September 8, 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 October 30, 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 January 30, 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.

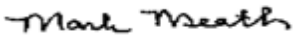
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@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, 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
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).	F 225		9/4/15

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

Electronically Signed | 08/20/2015

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
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 1 The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to report injuries of unknown origin immediately to the designated state agency for 1 of 3 resident (R41) who had experienced an unwitnessed fall with hip fracture needing surgery. Findings include: R41 had a fall and sustained a fracture in her room and no one witnessed the fall according to the Fall Scene Investigation Report (FSI) dated 7/11/15 at 8:10 p.m. Re-creation of the scene before the fall identified R41 as being very confused and asking for help a lot before the fall. The nursing assistant who discovered R41 documented, "I was outside her room and could hear her rustling around and I rushed in and found her on the floor." At that time resident complained of hitting her head and hip pain. R41's left hip was rotated outward. R41 was sent to the hospital where she was diagnosed with a hip fracture which required surgery. The falls	F 225	The following provider responses are neither an admission of nor agreement with the herein alleged deficiencies, and they should not be read nor construed as such. _____ F 225 Action Plan: An appropriate report for R41 was made to the OHFC web portal. Other Residents: Other recent incident reports will be reviewed to ensure reporting is in compliance with our policy. Changes/Monitoring: Our Abuse Prohibition policy has been reviewed and updated where necessary.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 team meeting note on the incident report identified, "mental status has declined last few weeks." This incident had not been reported immediately to the designated state agency. Review of the care plan with a revision date of 6/25/15 identified R 41 as having diagnosis including senile dementia,memory loss, Alzheimer's Disease and psychosis. The care plan also identified R41 as having impaired decision making skills, impaired vision and being unaware of safety needs as well as being at risk for falls due to a history of falls/injury, non-compliance with mobility and an unsteady gait . The quarterly Minimum Data Set (MDS) dated 6/16/15 identified a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment) and needed the assistance of one staff with walking and transferring. Review of the hospital history and physical dated 7/11/15, identified, R41 as being unable to provide details of the unwitnessed fall as she is confused and is not aware of her immediate surroundings. Review of the consultation report from physician dated 7/13/15 indicated, "on 7/11/15, she [R41] was found in her room after an unwitnessed fall." An interview with the director of nursing on 7/28/15, at 3:33 p.m. verified that the fall was unwitnessed and R41 could not accurately report what had actually happened. The director of nursing stated, "She wouldn't have been able to tell us what happened, her mental status had declined." The facility policy for prohibition Maltreatment and Implement the Vulnerable Adults Act effective date 8/1/2012 read, "6. ...that an injury is unexplained, then the Director will immediately notify the Common Entry Point and the Minnesota Department of Health via their secure web site."	F 225	Our staff will be retrained on our policy including reporting, definitions and what constitutes a reportable incident. Administrator is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to implement their policy related to the immediate reporting of injuries of unknown origin to the designated state agency for 1 of 3 residents (R41) reviewed who experienced an unwitnessed fall resulting in a hip fracture which required surgery. Findings include: The facility policy for prohibition Maltreatment and Implement the Vulnerable Adults Act effective date 8/1/2012 read, "6. ...that an injury is unexplained, then the Director will immediately notify the Common Entry Point and the Minnesota Department of Health via their secure web site." R41 had a fall and sustained a fracture in her room and no one witnessed the fall according to the Fall Scene Investigation Report (FSI) dated 7/11/15 at 8:10 p.m. Re-creation of the scene before the fall identified R41 as being very confused and asking for help a lot before the fall. The nursing assistant who discovered R41 documented, "I was outside her room and could hear her rustling around and I rushed in and found her on the floor." At that time resident complained of hitting her head and hip pain. R41's left hip was rotated outward. R41 was sent to the hospital where she was diagnosed with a	F 226	F 226 Action Plan: An appropriate report for R41 was made to the OHFC web portal. Other Residents: Other recent incident reports will be reviewed to ensure reporting is in compliance with our policy. Changes/Monitoring: Our Abuse Prohibition policy has been reviewed and updated where necessary. Our staff will be retrained on our policy including reporting, definitions and what constitutes a reportable incident. Administrator is responsible.	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 4 hip fracture which required surgery. The falls team meeting note on the incident report identified, "mental status has declined last few weeks." This incident had not been reported immediately to the designated state agency. Review of the care plan with a revision date of 6/25/15 identified R 41 as having diagnosis including senile dementia,memory loss, Alzheimer's Disease and psychosis. The care plan also identified R41 as having impaired decision making skills, impaired vision and being unaware of safety needs as well as being at risk for falls due to a history of falls/injury, non-compliance with mobility and an unsteady gait . The quarterly Minimum Data Set (MDS) dated 6/16/15 identified a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment) and needed the assistance of one staff with walking and transferring. Review of the hospital history and physical dated 7/11/15, identified, R41 as being unable to provide details of the unwitnessed fall as she is confused and is not aware of her immediate surroundings. Review of the consultation report from physician dated 7/13/15 indicated, "on 7/11/15, she [R41] was found in her room after an unwitnessed fall." An interview with the director of nursing on 7/28/15, at 3:33 p.m. verified that the fall was unwitnessed and R41 could not accurately report what had actually happened. The director of nursing stated, "It should have been reported to MDH [Minnesota Department of Health].	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 5 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for 1 of 3 residents (R41) who was reviewed for non pressure related skin conditions. Findings include: R41 had been observed and interviewed on 7/27/15, at 6:30 p.m. R41 was observed sitting in her wheelchair in the lobby. R41 had a large bruise on the top of her left hand as well as multiple small bruises on both arms. R41 was unable to tell me how the bruises occurred. R41 stated, "I don't know, maybe I bumped something." Resident was observed on 7/28/15, at 1:00 p.m. sitting in the recliner in the lobby and the large bruise on top of her left hand remained	F 280	F 280 Action Plan: The Plan of Care for resident R41 was revised as appropriate. Other Residents: A review will be conducted to ensure other residents with fragile skin conditions have appropriate Care Plans. Changes/Monitoring: We will review/revise our skin condition policy in coordination with our care plan policy and train staff on changes. Revisions to resident care plans related to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 6 unchanged and there was also noted a new nickel size dark purple bruise to R41's right wrist. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/16/15, R41 was identified as having a BIMS (brief interview for mental status) of 3 indicating severe cognitive impairment. The MDS identified R41 as needing extensive assistance with bathing, dressing and grooming. Nursing note from 7/28/15, at 12:48 p.m. read, "Bare skin observed with bath. Incision clean and healing with very minimal redness and no draining noted." No other nursing notes in past month mentioned bruise on top of left hand or multiple bruising on arms. Review of the care plan revised 12/23/14, did not address risk for bruising. During interview on 7/29/15, at 1:27 p.m. director of nursing (DON) was shown the bruised areas on R41's left hand and right wrist. She stated the bruising should have been addressed on the care plan as R41 has fragile skin and bruises easily and that R41 is in her wheel chair more now due to hip fracture and bumps into things more. She verified that the care plan should have been updated to reflect R41's fragile skin and prone to bruising. During interview on 7/30/15, at 9:18 a.m. the DON stated the nursing assistants should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime staff see bruises on a resident they should be documenting it and informing the nurse.	F 280	skin condition will be audited for consistency with policy. Director of Nursing Services is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 7 The facility policy titled Skin Conditions dated 5/4/12, read, Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described in a narrative note and those requiring weekly follow-up are measured. Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues. Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to nursing assistants registered as needed. Any suspicious bruise/wound is reported immediately to DON or designee for follow-up.	F 280		
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.	F 282		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the plan of care related to bruising for 1 of 3 residents (R2) reviewed for non-pressure related skin issues. Findings include: R2 had been observed and interviewed on 7/27/15, at 3:46 p.m. R2 was observed sitting in her recliner and she had a large round purple bruise on the top of her left hand, a round purple bruise on the top of her right hand, six round purple bruises of different sizes on her left forearm, and a fading purple bruise under her left eye. R2 stated she bruises easily due to being on a blood thinner. During observation and interview on 7/28/15 at 2:05 p.m. R2 was sitting in her recliner visiting with family (F)-S and R2 had a new large oblong deep purple bruise covering the upper 1/2 (one half) of her right forearm. R2 stated whenever I bump against something I bruise. Review of the 30-day Minimum Data Set (MDS) assessment dated 7/9/15, indicated R2 required extensive assistance with transfer, dressing, toilet use, personal hygiene, and locomotion on unit. The brief interview for mental status (BIMS) scored 15 indicating intact cognition. Review of the care plan last revised 7/13/15, identified R2 was at risk for bleeding related to daily aspirin intake. The interventions included: "Monitor for bruising or bleeding. Monitor for blood in urine or stool."	F 282	F 282 Action Plan: Skin condition for resident R2 was reviewed by staff according to her plan of care. Other Residents: A review will be conducted to ensure other residents with fragile skin conditions have appropriate Care Plans and that their plan of care is being followed by staff. Changes/Monitoring: Staff members will be retrained on skin observation and documentation procedures for plan of care reporting. Routine audits will be performed to confirm staff are following the care plan for skin related issues. Director of Nursing Services is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 9	F 282		

Review of the plan of care (POC) skin observation form dated 7/17/15 to 7/30/15, indicated the nursing assistants (NA) failed to document R2's bruises as indicated in the care plan.

Review of the nurses note dated 7/24/15, indicated: "Bare skin assessed with bath, lower legs weeping. (R) lower leg shinny and hard. No other areas of concerns noted."

Review of the daily skin assessment form dated 7/30/15, indicated no documentation of R2's bruises.

Review of the treatment administration record (TAR) dated July 2015 indicated no monitoring of bruises for R2.

During interview on 7/30/15, at 8:47 a.m. NA-C stated she didn't know if they had to document any bruises found on R2.

During interview on 7/30/15, at 9:03 a.m. registered nurse (RN)-A stated bruises are monitored and recorded on a skin assessment form and also documented in the nurses notes.

During interview on 7/30/15, at 9:08 a.m. RN-A stated there should have been documentation of R2's bruises on the skin assessment form and nurses note dated 7/24/15.

During interview on 7/30/15, at 9:18 a.m. director of nursing (DON) stated the NA's should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 stated anytime any staff sees bruises on a resident they should be documenting it and informing the nurse. The facility policy titled Skin Conditions dated 5/4/12, indicated: Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described in narrative notes and those requiring weekly follow-up are measured. Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues. Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to NARs as needed. Any suspicious bruise/wound is reported immediately to DON or designee for follow-up.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 11 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 assess and monitor bruising for 2 of 3 residents (R41 & R2) reviewed for non-pressure related skin issues. Findings include: R41 had been observed and interviewed on 7/27/15, at 6:30 p.m. R41 was observed sitting in her wheelchair in the lobby. R41 had a large bruise on the top of her left hand as well as scattered small bruises on both arms. R41 was unable to tell me how the bruises occurred. She stated, "I don't know, maybe I bumped something." Resident was observed on 7/28/15, at 1:00 p.m. sitting in the recliner in the lobby and the bruise on top of her left hand remained unchanged and there was also noted a new nickel size dark purple bruise to R41's right wrist. Review of the quarterly Minimum Data set (MDS) assessment dated 6/16/15, R41 was identified as having a BIMS (brief interview for mental status) of 3 indicating severe cognitive impairment. The MDS identified R41 as needing extensive assistance with bathing, dressing and grooming. Review of the nursing notes for past month did not identify the bruising on R41's hands. Nursing	F 309	F 309 Action Plan: Skin Integrity assessments have been completed on residents R2 and R41. Their monitoring plans have been revised. Other Residents: A review will be conducted to ensure other residents with fragile skin conditions have appropriate assessments and monitoring. Changes/Monitoring: Procedures for skin assessment reports and monitoring will be revised as necessary and staff will be retrained on our procedures. Random auditing of new skin issues will be done to ensure reporting and monitoring has begun. Director of Nursing Services is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 12 note from 7/28/15, at 12:48 p.m., "Bare skin observed with bath. Incision clean and healing with very minimal redness and no draining noted." On 7/29/15 registered nurse A (RN-A) measured the bruised areas. The area to the right wrist measured 1.6 cm by 1.4 cm. The area to the top of the left hand measured 5 cm by 4 cm. During interview on 7/29/15, at 1:27 p.m. director of nursing (DON) was shown the bruised areas on R41's left hand and right wrist. She stated the bruising should have been addressed on the care plan as R41 has fragile skin and bruises easily and that R41 is in her wheel chair more now due to hip fracture and bumps into things more. During interview on 7/30/15, at 9:18 a.m. the DON stated the nursing assistants (NAs) should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime any staff sees bruises on a resident they should be documenting it and informing the nurse. R2 had been observed and interviewed on 7/27/15, at 3:46 p.m. R2 was observed sitting in her recliner and she had a large round purple bruise on the top of her left hand, a round purple bruise on the top of her right hand, six round purple bruises of different sizes on her left forearm, and a fading purple bruise under her left eye. R2 stated she bruises easily due to being on a blood thinner. During observation and interview on 7/28/15 at 2:05 p.m. R2 was sitting in her recliner visiting with family (F)-S and she had a new large oblong deep purple bruise covering the upper 1/2 (one	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 13	F 309		

half) of her right forearm. R2 stated whenever I bump against something I bruise.

Review of the 30-day Minimum Data Set (MDS) assessment dated 7/9/15, indicated R2 required extensive assistance with transfer, dressing, toilet use, personal hygiene, and locomotion on unit. The brief interview for mental status (BIMS) scored 15 indicating intact cognition.

Review of the care plan last revised 7/13/15, identified R2 was at risk for bleeding related to daily aspirin intake. The interventions included: "Monitor for bruising or bleeding. Monitor for blood in urine or stool."

Review of the physician's order dated 6/25/15, indicated ASA (Aspirin) 325 milligrams (mg) was ordered for blood thinner.

Review of the plan of care (POC) skin observation form dated 7/17/15 to 7/30/15, indicated the NA failed to document R2's bruises as indicated in the care plan.

Review of the nurses note dated 7/24/15, read, "Bare skin assessed with bath, lower legs weeping. (R) lower leg shinny and hard. No other areas of concerns noted."

Review of the daily skin assessment form dated 7/30/15, indicated no documentation of R2's bruises.

Review of the treatment administration record (TAR) dated July 2015 indicated no monitoring of bruises for R2.

During interview on 7/30/15, at 8:47 a.m. NA-C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 14 stated she didn't know if they had to document any bruises found on R2. During interview on 7/30/15, at 9:03 a.m. RN-A stated bruises are monitored and recorded on a skin assessment form and also documented in the nurses notes. During interview on 7/30/15, at 9:08 a.m. RN-A stated there should have been documentation of R2's bruises on the skin assessment form and nurses note dated 7/24/15. During interview on 7/30/15, at 9:18 a.m. DON stated the NAs should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime any staff sees bruises on a resident they should be documenting it and informing the nurse. The facility policy titled Skin Conditions dated 5/4/12, indicated: Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described narrative and those requiring weekly follow-up are measured. Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 15 Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to NARs as needed. Any suspicious bruise/wound is reported immediately to DON or designee for follow-up.	F 309		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to monitor for side effects when antipsychotic medications were administered for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include: R17's electronic medical record indicated R17 was admitted on 3/26/14, with diagnoses (from eMAR [computerized charting system]-medical diagnosis) including but note limited to: anxiety disorder, episodic mood disorder, major depressive disorder-recurrent episode, insomnia; hx recurrent pneumonia, morbid obesity, diabetes type II; anxiety, peripheral neuropathy, depressive disorder, schizophrenia, and obstructive sleep apnea. Review of R17's signed physician orders dated 6/15/15, indicated R17 was receiving three psychotropic medications: Seroquel 100 milligram (mg) by mouth (PO) at bedtime (HS) ordered for diagnosis of major depressive disorder (discontinued on 4/30/14 and restarted on 6/15/15), Geodon 60 mg PO two times daily (BID) for the diagnosis of schizophrenia(discontinued on 11/17/14 and restarted on 6/15/15); and Abilify 5 mg PO QD ordered for the diagnosis of schizophrenia started on 11/15/14 and continuing as ordered. The most recent assessment to monitor for the	F 329	F 329 Action Plan: Appropriate DISCUS assessments for R17 will be completed according to procedure. Other Residents: A review of other residents at risk of Dyskinesia will be made to ensure compliance with our procedure. Changes/Monitoring: Our procedure for monitoring residents at risk of Dyskinesia will be reviewed and revised as necessary. D.O.N. and consultant pharmacist will cooperatively audit at-risk residents for compliance. Staff will be retrained on proper procedure. Director of Nursing Services is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 17 side effects of antipsychotic medications -Dyskinesia Identification System: Condensed User Scale (DISCUS) was dated 6/30/14, and indicated a score of one. This indicated minimal (abnormal movements are difficult to detect or movements are easy to detect but occur only once or twice in a short non-repetitive manner). No additional DISCUS assessments were available in either the paper or electronic medical record (eMAR). Review of the consultant pharmacist's monthly reviews dated during the period of 12/2014 through 7/2015 made no reference to assessments for Tardive Dyskinesia (DISCUS) (monitoring for potential side effects of psychotropic medications). During an interview on 7/30/15, at 10:38 a.m. registered nurse (RN)-A and RN-B verified the medication Seroquel was discontinued in April 30 of 2014 and restarted 6/15/15. RN-A and RN-B verified a DISCUS assessment (to monitor for the side effects) should have been completed at the time Seroquel and Geodon were discontinued; in addition to a one and two month post discontinuation assessment. It was further verified a baseline DISCUS should have been completed prior to the restart of the two medications dated 6/15/15. RN-A and RN-B indicated a yearly DISCUS should have been completed when the medication Abilify was administered and this had not been done. In addition a DISCUS assessment should have been completed as a baseline prior to restarting the medications on 6/15/15. An annual DISCUS assessment should have been completed with the ongoing use of the psychotropic medication Abilify in March 2015. RN-A and RN-B verified	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 18 these assessments were not completed. During an interview with the director of nursing (DON) on 7/30/15, at 11:09 a.m. it was verified she would have expected a DISCUS assessment to be completed prior to restart of the medications Seroquel and Geodon physician ordered on 6/15/15. The DON further verified she would have expected DISCUS assessments to be completed at the time an antipsychotic medication was discontinued and for two additional months following discontinuation in addition to the annual assessment completed for a resident receiving psychotropic medications. The consultant pharmacist was interviewed via telephone on 7/30/15, at 12:09 p.m. and confirmed the most recent pharmacy review was completed on 7/16/15 and that R17 was receiving three psychotropic medications (Seroquel, Geodon & Abilify). It was further verified she was not aware DISCUS assessments had not been conducted for R17's and she would have expected an assessment (DISCUS) to have been completed prior to restarting the medications. Review of the undated facility policy titled, Dyskinesia Monitoring Policy indicated the following: Of particular concern with the use of antipsychotic medications is the development of dyskinesia which may be persistent and irreversible. [the facility] recognizes the necessity and responsibility to monitor patients for dyskinesia. The procedure identified the following schedule of rating codes (DISCUS monitor): Code 1- prescribed antipsychotic medication-one rating every 6-months; Code 2- antipsychotic medication discontinued- one rating 1, 2 and 3 months after discontinuation; if at	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 19 3-month rating TD (tardive dyskinesia) is present assign to code 3; if not present assign to code 4; Code 3- not currently prescribed antipsychotic medication but TD diagnoses- one rating once per year; and Code 4- not currently prescribed antipsychotic medication and no TD diagnosis- no ratings necessary. Dyskinesia ratings shall be entered on the DISCUS form which is filed in the patient's personal file. Examples of neuroleptics (also referred to as antipsychotic or major tranquilizers) were listed as: Ability, Seroquel, Risperdal, Clozaril, Zyprexa.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the need for ongoing monitoring for severe side effects of antipsychotic medications use for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include:	F 428	F 428 Action Plan Appropriate DISCUS assessments for R17 will be completed according to procedure. Other Residents A review of other residents at risk of	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 20 R17's electronic medical record indicated R17 was admitted on 3/26/14, with diagnoses (from eMAR [electronic medication administration record]-medical diagnosis) including but note limited to: anxiety disorder, episodic mood disorder, major depressive disorder-recurrent episode, insomnia; hx recurrent pneumonia, morbid obesity, diabetes type II; anxiety, peripheral neuropathy, depressive disorder, schizophrenia, and obstructive sleep apnea. Review of R17's signed physician orders dated 6/15/15, indicated R17 was receiving three psychotropic medications: Seroquel 100 milligram (mg) by mouth (PO) at bedtime (HS) ordered for diagnosis of major depressive disorder (discontinued on 4/30/14 and restarted on 6/15/15), Geodon 60 mg PO two times daily (BID) for the diagnosis of schizophrenia(discontinued on 11/17/14 and restarted on 6/15/15); and Abilify 5 mg PO QD ordered for the diagnosis of schizophrenia started on 11/15/14 and continuing as ordered. The most recent assessment to monitor for the side effects of antipsychotic medications -Dyskinesia Identification System: Condensed User Scale (DISCUS) was dated 6/30/14, and indicated a score of one. This indicated minimal (abnormal movements are difficult to detect or movements are easy to detect but occur only once or twice in a short non-repetitive manner). No additional DISCUS assessments were available in either the paper or electronic medical record (eMAR). Review of the consultant pharmacist's monthly reviews dated during the period of 12/2014 through 7/2015 made no reference to	F 428	Dyskinesia will be made to ensure compliance with our procedure. Changes/Monitoring Our procedure for monitoring residents at risk of Dyskinesia will be reviewed and revised as necessary. D.O.N. and consultant pharmacist will cooperatively audit at-risk residents for compliance. Staff will be retrained on proper procedure. Director of Nursing Services is responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 21 assessments for Tardive Dyskinesia (DISCUS) (monitoring for potential side effects of psychotropic medications). During an interview on 7/30/15, at 10:38 a.m. registered nurse (RN)-A and RN-B verified the medication Seroquel was discontinued in April 30 of 2014 and restarted 6/15/15. RN-A and RN-B verified a DISCUS assessment (to monitor for the side effects) should have been completed at the time Seroquel and Geodon were discontinued; in addition to a one and two month post discontinuation assessment. It was further verified a baseline DISCUS should have been completed prior to the restart of the two medications dated 6/15/15. RN-A and RN-B indicated a yearly DISCUS should have been completed when the medication Abilify was administered and this had not been done. In addition a DISCUS assessment should have been completed as a baseline prior to restarting the medications on 6/15/15. An annual DISCUS assessment should have been completed with the ongoing use of the psychotropic medication Abilify in March 2015. RN-A and RN-B verified these assessments were not completed During an interview with the director of nursing (DON) on 7/30/15, at 11:09 a.m. it was verified she would have expected a DISCUS assessment to be completed prior to restart of the medications Seroquel and Geodon physician ordered 6/15/15. The DON further verified she would have expected DISCUS assessments to be completed at the time a psychotropic medication was discontinued and for two additional months following discontinuation in addition the the annual assessment completed for a resident receiving psychotropic medication. The DON	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 22 verified the Consultant Pharmacist had last reviewed R17's medication record on a monthly basis from 12/2014 -7/16/15 and no recommendations had been received referencing completion of DISCUS assessments. The consultant pharmacist was interviewed via telephone on 7/30/15, at 12:09 p.m. and confirmed the most recent pharmacy review was completed on 7/16/15 and that R17 was receiving three psychotropic medications (Seroquel, Geodon & Abilify). It was further verified she was not aware DISCUS assessments had not been conducted for R17's and she would have expected an assessment (DISCUS) to have been completed prior to restarting the medications. Review of the undated facility policy titled, Dyskinesia Monitoring Policy indicated the following: Of particular concern with the use of antipsychotic medications is the development of dyskinesia's which may be persistent and irreversible. [the facility] recognizes the necessity and responsibility to monitor patients for dyskinesia. The procedure identified the following schedule of rating codes (DISCUS monitor): Code 1- prescribed antipsychotic medication-one rating every 6-months; Code 2- antipsychotic medication discontinued- one rating 1, 2 and 3 months after discontinuation; if at 3-month rating TD (tardive dyskinesia) is present assign to code 3; if not present assign to code 4; Code 3- not currently prescribed antipsychotic medication but TD diagnoses- one rating once per year; and Code 4- not currently prescribed antipsychotic medication and no TD diagnosis- no ratings necessary. Dyskinesia ratings shall be entered on the DISCUS form which is filed in the patient's personal file. Examples of neuroleptics	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 23 (also referred to as antipsychotic or major tranquilizers) were listed as: Ability, Seroquel, Risperdal, Clozaril, Zyprexa.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 July 25, 2015. At the time of this survey, Building 01 of Maple Lawn Nursing 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 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 St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/20/2015

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
	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1	K 000		

By email to:
Marian.Whitney@state.mn.us
<mailto:Marian.Whitney@state.mn.us> and
Angela.Kappenman@state.mn.us
<mailto:Angela.Kappenman@state.mn.us>

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency.

Maple Lawn Nursing Home was constructed as follows:
The original building was constructed in 1964, 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 1991, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 2nd Addition was constructed in 2001, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 3rd Addition was constructed in 2004, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction.

Building 01 consists of the original 1964 building,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 and, the 1991 and 2001 building additions. 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 62 beds and had a census of 51 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 048 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: NFPA 101 (2000) LIFE SAFETY CODE SURVEY REGULATION - There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7 This STANDARD is not met as evidenced by: Based upon a review of available documentation, the facility's fire safety plan did not provide for all eight (8) of the required elements at NFPA 101 (00) Chapter 19, Section 19.7.2.2. This deficient practice could adversely affect 51 of 51 residents, staff and visitors. FINDINGS INCLUDE: On 07/29/2015 at 9:30 AM, during a review of the facility's emergency plan, it was confirmed that not all of the required elements existed in the	K 048	K 048 Action Plan The Fire Safety Plan will be updated to better delineate the elements required by the NFPA Administrator is responsible.	9/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 048	Continued From page 3 Facilities Fire Safety Plan, in accordance with NFPA 101 (00) Chapter 19, Section 19.7.2.2 (7). This finding was confirmed with the chief building engineer (Mike).	K 048		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on documentation review and interview with staff, the facility has failed to properly inspect and maintain the automatic sprinkler system in accordance with NFPA 101 LSC (00) section 19.7.6, 4.6.12. This deficient practice does not ensure that the fire sprinkler system is functioning properly and is fully operational in the event of a fire and could negatively affect all 51 residents. Findings include: On 7/29/2015, at 9:30 AM, observation revealed: 1. A review of documentation and interview with the Chief Building Engineer , revealed the facility failed to provide documentation of the quarterly fire sprinkler flow tests inspections required by NFPA 13(99) and NFPA 25(98).The lst inspection documentation available for review was dated 11/05/2014.	K 062	K 062 Action Plan: The calendar tickler file system for sprinkler flow testing has been revised to improve consistency. Maintenance Supervisor is responsible.	9/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 4 This finding was confirmed with the Chief Building Engineer (Mike) at the time of discovery.	K 062		
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 staff interview, the facility failed to inspect the emergency generator in accordance with the requirements of 2000 NFPA 101 - 9.1.3 and 1999 NFPA 110 Chapter 6-4.1. The deficient practice could affect all 51 residents. Findings include: On facility tour between 9:00 AM and 10:30 AM on 07/29/2015, documentation review of the weekly inspection logs for the diesel emergency generator revealed that the weekly operational inspection were missed for the weeks of 01/19/15 and 01/26/2015. This deficient practice was confirmed by the Facility Maintenance Director (Mike) at the time of discovery.	K 144	K 144 Action Plan: The calendar tickler file system for generator operational inspections has been revised to improve consistency. Maintenance Supervisor is responsible.	9/8/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING **02 - ACTIVITY ROOM A** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on July 29, 2015. At the time of this survey, Building 02 of Maple Lawn Nursing Home was found 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. Maple Lawn Nursing Home was constructed as follows: The original building was constructed in 1964, 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 1991, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction; The 2nd Addition was constructed in 2001, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd Addition was constructed in 2004, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction. The 2004 building addition is identified as Buidling 02, and consists of an activities room, a new building entrance and an elevator, with no patient sleeping or treatment areas. 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	EPOC	

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

Electronically Signed | 08/20/2015

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
	245570	A. BUILDING **02 - ACTIVITY ROOM A** B. WING _____	**07/29/2015**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 department notification. The facility has a capacity of 62 beds and had a census of 51 at time of the survey.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
August 14, 2015

Mr. Arlan Swanson, Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, Minnesota 56131

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5570025

Dear Mr. Swanson:

The above facility was surveyed on July 27, 2015 through July 30, 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 Gary Nederhoff at (507) 206-8731 or email: gary.nederhoff@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
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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 July 27th, 28th, 29th and 30th, 2015 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.	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
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 follow the plan of care related to bruising for 1 of 3 residents (R2) reviewed for non-pressure related skin issues. Findings include: R2 had been observed and interviewed on 7/27/15, at 3:46 p.m. R2 was observed sitting in her recliner and she had a large round purple bruise on the top of her left hand, a round purple bruise on the top of her right hand, six round purple bruises of different sizes on her left forearm, and a fading purple bruise under her left eye. R2 stated she bruises easily due to being on a blood thinner. During observation and interview on 7/28/15 at 2:05 p.m. R2 was sitting in her recliner visiting with family (F)-S and R2 had a new large oblong deep purple bruise covering the upper 1/2 (one	2 565	Corrected	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 3 half) of her right forearm. R2 stated whenever I bump against something I bruise. Review of the 30-day Minimum Data Set (MDS) assessment dated 7/9/15, indicated R2 required extensive assistance with transfer, dressing, toilet use, personal hygiene, and locomotion on unit. The brief interview for mental status (BIMS) scored 15 indicating intact cognition. Review of the care plan last revised 7/13/15, identified R2 was at risk for bleeding related to daily aspirin intake. The interventions included: "Monitor for bruising or bleeding. Monitor for blood in urine or stool." Review of the plan of care (POC) skin observation form dated 7/17/15 to 7/30/15, indicated the nursing assistants (NA) failed to document R2's bruises as indicated in the care plan. Review of the nurses note dated 7/24/15, indicated: "Bare skin assessed with bath, lower legs weeping. (R) lower leg shinny and hard. No other areas of concerns noted." Review of the daily skin assessment form dated 7/30/15, indicated no documentation of R2's bruises. Review of the treatment administration record (TAR) dated July 2015 indicated no monitoring of bruises for R2. During interview on 7/30/15, at 8:47 a.m. NA-C stated she didn't know if they had to document any bruises found on R2. During interview on 7/30/15, at 9:03 a.m.	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 4 registered nurse (RN)-A stated bruises are monitored and recorded on a skin assessment form and also documented in the nurses notes. During interview on 7/30/15, at 9:08 a.m. RN-A stated there should have been documentation of R2's bruises on the skin assessment form and nurses note dated 7/24/15. During interview on 7/30/15, at 9:18 a.m. director of nursing (DON) stated the NA's should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime any staff sees bruises on a resident they should be documenting it and informing the nurse. The facility policy titled Skin Conditions dated 5/4/12, indicated: Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described in narrative notes and those requiring weekly follow-up are measured. Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues. Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is	2 565		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 565	Continued From page 5 investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to NARs as needed. Any suspicious bruise/wound is reported immediately to DON or designee for follow-up. SUGGESTED METHOD FOR CORRECTION: The DON or designee could establish procedures, educate staff and audit to ensure that residents individualized needs are being met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan for	2 570	Corrected	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 6 1 of 3 residents (R41) who was reviewed for non pressure related skin conditions. Findings include: R41 had been observed and interviewed on 7/27/15, at 6:30 p.m. R41 was observed sitting in her wheelchair in the lobby. R41 had a large bruise on the top of her left hand as well as multiple small bruises on both arms. R41 was unable to tell me how the bruises occurred. R41 stated, "I don't know, maybe I bumped something." Resident was observed on 7/28/15, at 1:00 p.m. sitting in the recliner in the lobby and the large bruise on top of her left hand remained unchanged and there was also noted a new nickel size dark purple bruise to R41's right wrist. Review of the quarterly Minimum Data Set (MDS) assessment dated 6/16/15, R41 was identified as having a BIMS (brief interview for mental status) of 3 indicating severe cognitive impairment. The MDS identified R41 as needing extensive assistance with bathing, dressing and grooming. Nursing note from 7/28/15, at 12:48 p.m. read, "Bare skin observed with bath. Incision clean and healing with very minimal redness and no draining noted." No other nursing notes in past month mentioned bruise on top of left hand or multiple bruising on arms. Review of the care plan revised 12/23/14, did not address risk for bruising. During interview on 7/29/15, at 1:27 p.m. director of nursing (DON) was shown the bruised areas on R41's left hand and right wrist. She stated the bruising should have been addressed on the care plan as R41 has fragile skin and bruises easily	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 7	2 570		

and that R41 is in her wheel chair more now due to hip fracture and bumps into things more. She verified that the care plan should have been updated to reflect R41's fragile skin and prone to bruising. During interview on 7/30/15, at 9:18 a.m. the DON stated the nursing assistants should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime staff see bruises on a resident they should be documenting it and informing the nurse.

The facility policy titled Skin Conditions dated 5/4/12, read,
Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described in a narrative note and those requiring weekly follow-up are measured.

Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues.

Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to nursing assistants registered as needed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 570	Continued From page 8 SUGGESTED METHOD OF CORRECTION: Any suspicious bruise/wound is reported immediately to DON or designee for follow-up. The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
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: Based on observation, interview and document review the facility failed to assess and monitor bruising for 2 of 3 residents (R41 & R2) reviewed	2 830	Corrected	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 9 for non-pressure related skin issues. Findings include: R41 had been observed and interviewed on 7/27/15, at 6:30 p.m. R41 was observed sitting in her wheelchair in the lobby. R41 had a large bruise on the top of her left hand as well as scattered small bruises on both arms. R41 was unable to tell me how the bruises occurred. She stated, "I don't know, maybe I bumped something." Resident was observed on 7/28/15, at 1:00 p.m. sitting in the recliner in the lobby and the bruise on top of her left hand remained unchanged and there was also noted a new nickel size dark purple bruise to R41's right wrist. Review of the quarterly Minimum Data set (MDS) assessment dated 6/16/15, R41 was identified as having a BIMS (brief interview for mental status) of 3 indicating severe cognitive impairment. The MDS identified R41 as needing extensive assistance with bathing, dressing and grooming. Review of the nursing notes for past month did not identify the bruising on R41's hands. Nursing note from 7/28/15, at 12:48 p.m., "Bare skin observed with bath. Incision clean and healing with very minimal redness and no draining noted." During interview on 7/29/15, at 1:27 p.m. director of nursing (DON) was shown the bruised areas on R41's left hand and right wrist. She stated the bruising should have been addressed on the care plan as R41 has fragile skin and bruises easily and that R41 is in her wheel chair more now due to hip fracture and bumps into things more. During interview on 7/30/15, at 9:18 a.m. the DON stated the nursing assistants (NAs) should document any bruises and inform the nurse who	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 10 should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime any staff sees bruises on a resident they should be documenting it and informing the nurse. R2 had been observed and interviewed on 7/27/15, at 3:46 p.m. R2 was observed sitting in her recliner and she had a large round purple bruise on the top of her left hand, a round purple bruise on the top of her right hand, six round purple bruises of different sizes on her left forearm, and a fading purple bruise under her left eye. R2 stated she bruises easily due to being on a blood thinner. During observation and interview on 7/28/15 at 2:05 p.m. R2 was sitting in her recliner visiting with family (F)-S and she had a new large oblong deep purple bruise covering the upper 1/2 (one half) of her right forearm. R2 stated whenever I bump against something I bruise. Review of the 30-day Minimum Data Set (MDS) assessment dated 7/9/15, indicated R2 required extensive assistance with transfer, dressing, toilet use, personal hygiene, and locomotion on unit. The brief interview for mental status (BIMS) scored 15 indicating intact cognition. Review of the care plan last revised 7/13/15, identified R2 was at risk for bleeding related to daily aspirin intake. The interventions included: "Monitor for bruising or bleeding. Monitor for blood in urine or stool." Review of the physician's order dated 6/25/15, indicated ASA (Aspirin) 325 milligrams (mg) was ordered for blood thinner.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 Review of the plan of care (POC) skin observation form dated 7/17/15 to 7/30/15, indicated the NA failed to document R2's bruises as indicated in the care plan. Review of the nurses note dated 7/24/15, read, "Bare skin assessed with bath, lower legs weeping. (R) lower leg shinny and hard. No other areas of concerns noted." Review of the daily skin assessment form dated 7/30/15, indicated no documentation of R2's bruises. Review of the treatment administration record (TAR) dated July 2015 indicated no monitoring of bruises for R2. During interview on 7/30/15, at 8:47 a.m. NA-C stated she didn't know if they had to document any bruises found on R2. During interview on 7/30/15, at 9:03 a.m. RN-A stated bruises are monitored and recorded on a skin assessment form and also documented in the nurses notes. During interview on 7/30/15, at 9:08 a.m. RN-A stated there should have been documentation of R2's bruises on the skin assessment form and nurses note dated 7/24/15. During interview on 7/30/15, at 9:18 a.m. DON stated the NAs should document any bruises and inform the nurse who should then measure the bruise and start a flow sheet so the bruise can be monitored to make sure it heals and doesn't worsen. The DON also stated anytime any staff sees bruises on a resident they should be	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 12 documenting it and informing the nurse. The facility policy titled Skin Conditions dated 5/4/12, indicated: Upon admission and during weekly bath an unclothed skin assessment is completed and documented. Wound/bruises are described narrative and those requiring weekly follow-up are measured. Upon admission and per MDS schedule each resident is assessed and care planned for any risks for skin breakdown/bruising. These risks may include 1) medication side effects (Coumadin, ASA therapy, steroids, asthma meds) 2) disease side effects (liver disease) 3) age related skin issues. Resident skin condition is monitored daily as staff provide cares. Any new or worsening skin condition is reported orally to the appropriate nurse for follow-up. Cause of skin breakdown is investigated and remedied as able. Occurrence is charted in nurses notes. Any follow-up treatment is to be completed by nursing is recorded on TAR and completed until resolved. Other follow-up treatments are communicated to NARs as needed. Any suspicious bruise/wound is reported immediately to DON or designee for follow-up. SUGGESTED METHOD FOR CORRECTION: The DON or designee could establish procedures, educate staff and audit to ensure that residents individualized needs are being met. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to perform a 2-Step tuberculin skin test (TST) per current Center for Disease Control and Prevention (CDC) recommendations and per facility policy for 5 of 5 employees who were nursing assistants (NA-C, NA-E, NA-E, NA-F, NA-G & NA-H) reviewed for Tuberculosis Prevention and Control. This had the potential to affect all 51 residents residing in the facility. Findings include:	21426	Corrected	8/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 14 NA-C had a start date of 7/8/15 and had the tuberculosis screening and first TST application on 7/6/15. There is no evidence of a second TST application. NA-E had a start date of 5/4/15 and had the tuberculosis screening and first TST application on 5/4/15. There is no evidence of a second TST application. NA-F had a start date of 7/8/15 and had the tuberculosis screening and first TST application on 7/6/15. There is no evidence of a second TST application. NA-G had a start date of 6/25/15 and had the tuberculosis screening and first TST application on 6/23/15/15. There is no evidence of a second TST application. NA-H had a start date of 6/18/15 and had the tuberculosis screening and first TST application on 5/14/15. There is no evidence of a second TST application. During a telephone interview on 7/31/15, at 12:11 p.m. the business office manager verified there was only one TST application for the above listed employees stating, "We quit doing the 2-Step application when we had the shortage." However, the shortage has been resolved for many months. During a telephone interview on 7/31/15, at 12:40 p.m. the administrator verified they were only doing one step during the shortage of tuberculin but never resumed to the 2-step when the shortage was over. Review of the policy Tuberculin Skin Testing (TST) Protocol for Screening Health Care	21426		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21426	Continued From page 15 Workers and last reviewed and updated 7/25/13, specified if the first TST was negative, administer a second TST 7-21 days later. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could review and update procedures and educate staff to ensure that current CDC recommendations for Tuberculosis are practiced. TIME PERIOD FOR CORRECTION: Seven (7) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the	21530		9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 16 pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified the need for ongoing monitoring for severe side effects of antipsychotic medications use for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include: R17's electronic medical record indicated R17 was admitted on 3/26/14, with diagnoses (from eMAR [electronic medication administration record]-medical diagnosis) including but note limited to: anxiety disorder, episodic mood disorder, major depressive disorder-recurrent episode, insomnia; hx recurrent pneumonia, morbid obesity, diabetes type II; anxiety, peripheral neuropathy, depressive disorder, schizophrenia, and obstructive sleep apnea. Review of R17's signed physician orders dated 6/15/15, indicated R17 was receiving three	21530	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 17	21530		

psychotropic medications: Seroquel 100 milligram (mg) by mouth (PO) at bedtime (HS) ordered for diagnosis of major depressive disorder (discontinued on 4/30/14 and restarted on 6/15/15), Geodon 60 mg PO two times daily (BID) for the diagnosis of schizophrenia(discontinued on 11/17/14 and restarted on 6/15/15); and Abilify 5 mg PO QD ordered for the diagnosis of schizophrenia started on 11/15/14 and continuing as ordered.

The most recent assessment to monitor for the side effects of antipsychotic medications -Dyskinesia Identification System: Condensed User Scale (DISCUS) was dated 6/30/14, and indicated a score of one. This indicated minimal (abnormal movements are difficult to detect or movements are easy to detect but occur only once or twice in a short non-repetitive manner). No additional DISCUS assessments were available in either the paper or electronic medical record (eMAR).

Review of the consultant pharmacist's monthly reviews dated during the period of 12/2014 through 7/2015 made no reference to assessments for Tardive Dyskinesia (DISCUS) (monitoring for potential side effects of psychotropic medications).

During an interview on 7/30/15, at 10:38 a.m. registered nurse (RN)-A and RN-B verified the medication Seroquel was discontinued in April 30 of 2014 and restarted 6/15/15. RN-A and RN-B verified a DISCUS assessment (to monitor for the side effects) should have been completed at the time Seroquel and Geodon were discontinued; in addition to a one and two month post discontinuation assessment. It was further verified a baseline DISCUS should have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 18	21530		

completed prior to the restart of the two medications dated 6/15/15. RN-A and RN-B indicated a yearly DISCUS should have been completed when the medication Abilify was administered and this had not been done. In addition a DISCUS assessment should have been completed as a baseline prior to restarting the medications on 6/15/15. An annual DISCUS assessment should have been completed with the ongoing use of the psychotropic medication Abilify in March 2015. RN-A and RN-B verified these assessments were not completed

During an interview with the director of nursing (DON) on 7/30/15, at 11:09 a.m. it was verified she would have expected a DISCUS assessment to be completed prior to restart of the medications Seroquel and Geodon physician ordered 6/15/15. The DON further verified she would have expected DISCUS assessments to be completed at the time a psychotropic medication was discontinued and for two additional months following discontinuation in addition the the annual assessment completed for a resident receiving psychotropic medication. The DON verified the Consultant Pharmacist had last reviewed R17's medication record on a monthly basis from 12/2014 -7/16/15 and no recommendations had been received referencing completion of DISCUS assessments.

The consultant pharmacist was interviewed via telephone on 7/30/15, at 12:09 p.m. and confirmed the most recent pharmacy review was completed on 7/16/15 and that R17 was receiving three psychotropic medications (Seroquel, Geodon & Abilify). It was further verified she was not aware DISCUS assessments had not been conducted for R17's and she would have expected an assessment (DISCUS) to have been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21530	Continued From page 19 completed prior to restarting the medications. Review of the undated facility policy titled, Dyskinesia Monitoring Policy indicated the following: Of particular concern with the use of antipsychotic medications is the development of dyskinesia's which may be persistent and irreversible. [the facility] recognizes the necessity and responsibility to monitor patients for dyskinesia. The procedure identified the following schedule of rating codes (DISCUS monitor): Code 1- prescribed antipsychotic medication-one rating every 6-months; Code 2- antipsychotic medication discontinued- one rating 1, 2 and 3 months after discontinuation; if at 3-month rating TD (tardive dyskinesia) is present assign to code 3; if not present assign to code 4; Code 3- not currently prescribed antipsychotic medication but TD diagnoses- one rating once per year; and Code 4- not currently prescribed antipsychotic medication and no TD diagnosis- no ratings necessary. Dyskinesia ratings shall be entered on the DISCUS form which is filed in the patient's personal file. Examples of neuroleptics (also referred to as antipsychotic or major tranquilizers) were listed as: Ability, Seroquel, Risperdal, Clozaril, Zyprexa. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to ensure that residents drug regimen is free of irregularities and contraindication and appropriate monitoring is being completed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 20	21540		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to monitor for side effects when antipsychotic medications were administered for 1 of 5 residents (R17) reviewed for unnecessary medications. Findings include: R17's electronic medical record indicated R17 was admitted on 3/26/14, with diagnoses (from eMAR [computerized charting system]-medical	21540	Corrected	9/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 21 diagnosis) including but note limited to: anxiety disorder, episodic mood disorder, major depressive disorder-recurrent episode, insomnia; hx recurrent pneumonia, morbid obesity, diabetes type II; anxiety, peripheral neuropathy, depressive disorder, schizophrenia, and obstructive sleep apnea. Review of R17's signed physician orders dated 6/15/15, indicated R17 was receiving three psychotropic medications: Seroquel 100 milligram (mg) by mouth (PO) at bedtime (HS) ordered for diagnosis of major depressive disorder (discontinued on 4/30/14 and restarted on 6/15/15), Geodon 60 mg PO two times daily (BID) for the diagnosis of schizophrenia(discontinued on 11/17/14 and restarted on 6/15/15); and Abilify 5 mg PO QD ordered for the diagnosis of schizophrenia started on 11/15/14 and continuing as ordered. The most recent assessment to monitor for the side effects of antipsychotic medications -Dyskinesia Identification System: Condensed User Scale (DISCUS) was dated 6/30/14, and indicated a score of one. This indicated minimal (abnormal movements are difficult to detect or movements are easy to detect but occur only once or twice in a short non-repetitive manner). No additional DISCUS assessments were available in either the paper or electronic medical record (eMAR). Review of the consultant pharmacist's monthly reviews dated during the period of 12/2014 through 7/2015 made no reference to assessments for Tardive Dyskinesia (DISCUS) (monitoring for potential side effects of psychotropic medications).	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 22 During an interview on 7/30/15, at 10:38 a.m. registered nurse (RN)-A and RN-B verified the medication Seroquel was discontinued in April 30 of 2014 and restarted 6/15/15. RN-A and RN-B verified a DISCUS assessment (to monitor for the side effects) should have been completed at the time Seroquel and Geodon were discontinued; in addition to a one and two month post discontinuation assessment. It was further verified a baseline DISCUS should have been completed prior to the restart of the two medications dated 6/15/15. RN-A and RN-B indicated a yearly DISCUS should have been completed when the medication Abilify was administered and this had not been done. In addition a DISCUS assessment should have been completed as a baseline prior to restarting the medications on 6/15/15. An annual DISCUS assessment should have been completed with the ongoing use of the psychotropic medication Abilify in March 2015. RN-A and RN-B verified these assessments were not completed. During an interview with the director of nursing (DON) on 7/30/15, at 11:09 a.m. it was verified she would have expected a DISCUS assessment to be completed prior to restart of the medications Seroquel and Geodon physician ordered on 6/15/15. The DON further verified she would have expected DISCUS assessments to be completed at the time an antipsychotic medication was discontinued and for two additional months following discontinuation in addition to the annual assessment completed for a resident receiving psychotropic medications. The consultant pharmacist was interviewed via telephone on 7/30/15, at 12:09 p.m. and confirmed the most recent pharmacy review was completed on 7/16/15 and that R17 was receiving	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 23 three psychotropic medications (Seroquel, Geodon & Abilify). It was further verified she was not aware DISCUS assessments had not been conducted for R17's and she would have expected an assessment (DISCUS) to have been completed prior to restarting the medications. Review of the undated facility policy titled, Dyskinesia Monitoring Policy indicated the following: Of particular concern with the use of antipsychotic medications is the development of dyskinesia which may be persistent and irreversible. [the facility] recognizes the necessity and responsibility to monitor patients for dyskinesia. The procedure identified the following schedule of rating codes (DISCUS monitor): Code 1- prescribed antipsychotic medication-one rating every 6-months; Code 2- antipsychotic medication discontinued- one rating 1, 2 and 3 months after discontinuation; if at 3-month rating TD (tardive dyskinesia) is present assign to code 3; if not present assign to code 4; Code 3- not currently prescribed antipsychotic medication but TD diagnoses- one rating once per year; and Code 4- not currently prescribed antipsychotic medication and no TD diagnosis- no ratings necessary. Dyskinesia ratings shall be entered on the DISCUS form which is filed in the patient's personal file. Examples of neuroleptics (also referred to as antipsychotic or major tranquilizers) were listed as: Ability, Seroquel, Risperdal, Clozaril, Zyprexa. SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, educate staff and audit to ensure that residents drug regimen is free of irregularities and contraindications and appropriate monitoring is being completed.	21540		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 24 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report injuries of unknown origin immediately to the designated state agency for 1 of 3 resident (R41) who had experienced an unwitnessed fall with hip fracture needing surgery. Findings include: R41 had a fall and sustained a fracture in her room and no one witnessed the fall according to the Fall Scene Investigation Report (FSI) dated 7/11/15 at 8:10 p.m. Re-creation of the scene	21990	Corrected	8/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 25 before the fall identified R41 as being very confused and asking for help a lot before the fall. The nursing assistant who discovered R41 documented, "I was outside her room and could hear her rustling around and I rushed in and found her on the floor." At that time resident complained of hitting her head and hip pain. R41's left hip was rotated outward. R41 was sent to the hospital where she was diagnosed with a hip fracture which required surgery. The falls team meeting note on the incident report identified, "mental status has declined last few weeks." This incident had not been reported immediately to the designated state agency. Review of the care plan with a revision date of 6/25/15 identified R 41 as having diagnosis including senile dementia,memory loss, Alzheimer's Disease and psychosis. The care plan also identified R41 as having impaired decision making skills, impaired vision and being unaware of safety needs as well as being at risk for falls due to a history of falls/injury, non-compliance with mobility and an unsteady gait . The quarterly Minimum Data Set (MDS) dated 6/16/15 identified a Brief Interview for Mental Status (BIMS) score of 3 (severe cognitive impairment) and needed the assistance of one staff with walking and transferring. Review of the hospital history and physical dated 7/11/15, identified, R41 as being unable to provide details of the unwitnessed fall as she is confused and is not aware of her immediate surroundings. Review of the consultation report from physician dated 7/13/15 indicated, "on 7/11/15, she [R41] was found in her room after an unwitnessed fall." An interview with the director of nursing on 7/28/15, at 3:33 p.m. verified that the fall was unwitnessed and R41 could not accurately report what had actually happened. The director of	21990		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	07/30/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21990	Continued From page 26 nursing stated, "She wouldn't have been able to tell us what happened, her mental status had declined." The facility policy for prohibition Maltreatment and Implement the Vulnerable Adults Act effective date 8/1/2012 read, "6. ...that an injury is unexplained, then the Director will immediately notify the Common Entry Point and the Minnesota Department of Health via their secure web site." SUGGESTED METHOD FOR CORRECTION: The DON or administrator could establish procedures, update policies and educate staff to ensure that state and federal requirements are being met for VA reporting. TIME PERIOD FOR CORRECTION: Seven (7) days.	21990		