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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKR7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245362**

2. STATE VENDOR OR MEDICAID NO. (L2) **106540800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **8/1/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

x A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 8/3/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 8/3/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245362

August 3, 2016

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

Dear Ms. Gosson:

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

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

Effective July 11, 2016 the above facility is certified for:

60 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 3, 2016

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

RE: Project Number S5362024

Dear Ms. Gosson:

On July 1, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 17, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 1, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 1, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 11, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 17, 2016, effective July 11, 2016 and therefore remedies outlined in our letter to you dated July 1, 2016, 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
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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245362 Y1	A. Building B. Wing Y2	8/1/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0280	Correction	ID Prefix F0323	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25(h)	Completed
LSC	07/11/2016	LSC	07/06/2016	LSC	07/08/2016
ID Prefix F0325	Correction	ID Prefix F0329	Correction	ID Prefix F0371	Correction
Reg. # 483.25(i)	Completed	Reg. # 483.25(l)	Completed	Reg. # 483.35(i)	Completed
LSC	07/08/2016	LSC	07/06/2016	LSC	06/20/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	KS/kfd	8/3/2016	03048	8/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/17/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245362 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	8/1/2016 Y3

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0011	06/20/2016	LSC K0025	06/20/2016	LSC K0062	07/04/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0069	07/04/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/3/2016	36536	8/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
6/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245362	A. Building 02 - 2011 ADDITION B. Wing	8/1/2016

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

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0011	Correction Completed 06/20/2016	ID Prefix Reg. # NFPA 101 LSC K0062	Correction Completed 07/04/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/kfd	8/3/2016	36536	8/1/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
6/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VKR7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00037

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245362**

2. STATE VENDOR OR MEDICAID NO. (L2) **106540800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **06/17/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **09/30**

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

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

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

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : Susan Kalis, HFE NE II 07/14/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 07/27/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 1, 2016

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

RE: Project Number S5362024

Dear Ms. Gosson:

On June 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Health Regulation Division
Minnesota Department of Health
1400 E. Lyon Street
Marshall, Minnesota 56258
Email: Kathryn.serie@state.mn.us
Office: (507) 476-4233 Fax: (507) 537-7194

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 July 27, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 27, 2016 the following remedy will be imposed:

- Per instance civil money penalty. (42 CFR 488.430 through 488.444)

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.

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 September 17, 2016 (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 December 17, 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 electronic 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING _____ B. WING _____	06/17/2016

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

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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 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156		7/11/16

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

Electronically Signed | 07/11/2016

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R24) reviewed for liability notices, received the required Notice of Medicare Non-Coverage Centers for Medicare and Medicaid Services (CMS) Form 10123, informing them of their rights to an appeal and expedited review of their Medicare coverage, 48 hours prior to discontinuation of skilled services. Findings include: R24 was admitted 3/1/16 with Medicare as the payer source. Medicare remained R24's payer source until 4/30/16, when no longer qualified for Medicare and payor source became private pay. R24 was issued a CMS form 10123 for skilled physical therapy (PT) and occupational therapy	F 156	The Medicare policy was found from 2006 and rewritten to include increased communication of discharge planning throughout the interdisciplinary team. All residents will now sign Medicare notices of pending non-coverage two days prior to completion of skilled services, whether discharging or not, unless discharge is unplanned. Verbal communication with families is done if family representative is not in the building and notices need to be sent to family via certified mail by Medicare team at least two days prior to completion of skilled service. This communication is also charted in Progress Notes. Results of audits of timely submitted denials will be brought to the QA meeting	

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F 156	Continued From page 3 (OT) ending 4/29/16. The notice was not signed by the resident's son until 5/2/16. Nursing progress notes were reviewed and lacked any documentation of notification to R24 and/or her family. Notification of discontinuation was not provided at least 48 hours prior to skilled therapy service ending. R24 was discharged home on 5/6/16, per the nursing progress notes. During interview on 6/16/16, at 2:51 p.m. registered nurse (RN)-A confirmed she was responsible for issuing the CMS form 10123. RN-A stated R24's original discharge plan was to leave on 4/30/16, and since R24's last covered day was 4/29/16, she did not complete a denial. RN-A confirms the denial was not given within 48 hours of discontinuation of skilled services as it should have been. A policy was requested but facility did not have one to provide.	F 156	and reviewed. Resident R24 has since been discharged from Skilled Nursing Facility.	
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 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	F 280		7/6/16

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F 280	Continued From page 4 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 record review, the facility failed to revise the plan of care to include updated interventions for 1 of 3 residents reviewed for pressure ulcers. The findings include: R59 was observed on 6/16/16 at 2:56 p.m. to be laying in bed sleeping. The resident's heels were observed to be floated off the bed on a pillow. During an additional observation on 6/17/16 12:07 p.m., R59 was observed during care of a wound to the heel. The wound appeared to have dark eschar on in. At the time of the observation, registered nurse (RN)-C stated the wound was measured on the evening shift and that the wound was painted with betadine twice a day. R59 was admitted to the facility from the hospital on 5/11/16, following a repair for a left neck femur fracture. Additional pertinent diagnoses obtained from the history and physical included: Atherosclerotic heart disease, coronary artery disease without angina; hypertension, chronic kidney disease, hemiplegia and hemiparesis following cerebrovascular accident -unspecified side, and anemia.	F 280	Skin integrity management program policy and procedure was rewritten and implemented. On 7/6/2016, education was provided to nurses at a meeting that trained on the new protocols that included frequency and requirements of description of charting and updating of careplans along with continual documenting of progress on careplans. Assistant Director of Nursing will monitor all charting of wounds by nurses and ensure that the wounds are measured and recorded weekly. If found to not be healing, nursing will review plan of care for revision and all revisions will be updated in the care plan. Results of audits will be reviewed quarterly at the Quality Assurancce Meeting. R59 has since discharged from Skilled Nursing Facility on 6/25/16 with healed pressure ulcer.	

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F 280	Continued From page 5 A progress note documented on 5/27/16 by registered nurse (RN)-E indicated R59 had a water filled blister identified to the left heel during his bath. According to the progress note, RN-E had applied Betadine and was going to continue to monitor. A physician's progress note documented 6/2/16 included: Left heel water blister, treatment Betadine BID (two times per day) to heel ulcer. Neither the resident's treatment administration record (TAR), nor care plan were updated to indicate the presence of the blister to the resident's left heel. Nor was the use of Betadine twice daily added to the medication administration record, TAR and/or care plan. The TAR for June 2016, included a daily schedule to monitor a left heel blister. The treatment record does not include the order for treatment, or intervention. The current plan of care indicated the resident had "potential for pressure ulcer development r/t (related to) immobility. Small open area on left buttock healed." The goal included: "The resident will have intact skin, free of redness, blisters or discoloration." Interventions identified on the plan of care indicated care to prevent breakdown on the resident's buttock area, but the care plan had not been updated to reflect interventions to monitor/treat the pressure related areas to the resident's feet.	F 280		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives	F 323		7/8/16

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F 323	Continued From page 6 adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess 1 of 3 residents (R12) reviewed for falls, in order to determine and implement timely interventions to prevent further falls. Findings include: R12's quarterly Minimum Data Set (MDS) assessment dated 3/31/16, included active diagnoses of heart failure and hypertension. The Brief Interview for Mental Status (BIMS) score indicated R12 had scored 13 out of 15, indicating the resident was cognitively intact with no indicators of delirium. The MDS also identified R12 required extensive assistance of two staff for transfers and was unsteady, unable to balance self without physical support for moving from the seated to standing position. R12's Care Area Assessment (CAA) related to falls dated 1/14/16, indicated risk factors of difficulty maintaining sitting balance, impaired balance during transitions, diuretic use, heart disease, arthritis, hearing impairment, and incontinence. The CAA also indicated the risk for falls would be care planned, and that R12 needed encouragement to use the call light rather than pick things up himself. R12's current care plan dated 4/21/16, identified	F 323	Careplans are reviewed quarterly and upon all significant changes. Fall interventions and prevention measures will be evaluated in more detail in the morning meeting that includes the entire interdisciplinary team along with Charge nurses on that shift. Fall interventions and prevention measures will then be updated on the Resident's careplan. Frequent falls will then be reviewed at the quarterly Quality Assurance meeting and any further interventions discussed will be updated on the careplan as needed. The Director of Nursing will be responsible to monitor all fall reports, interventions and updates to careplans. R12 was seen by Physician on 6/16/16 and no changes were made at that time to Resident's Plan of Care. Occupational Therapy evaluated R12 and began treatment on 6/23/16 and is currently working with R12 to determine needs. This new system began June 20, 2016.	

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the resident had a self-care deficit related to weakness due to illness and falls. Interventions identified on the care plan included: pressure sensor alarm in bed, alarm in wheelchair and clip alarm in the recliner. The care plan also indicated R12 should be encouraged to use the call light, had slid out of his recliner, did not like to wait for staff to transfer from the wheelchair to the recliner, and to review use of grabber to pick things up off of floor.

A Safety Risk Evaluation dated 1/10/13, from R12's original admission to the facility, indicated R12 had a history of falls, decline in functional status, hypertension, unsteady gait, pain, arthritis, utilized antihypertensive's and listed no physical devices in use.

R12's nursing progress notes included the following incidents:

-10/22/15- R12's alarm was sounding and was answered by staff. Found resident lying on his back. R12 indicated at this time that he was reaching down to pick up a devotional and fell out of his chair. An Accident Report dated 10/22/15, indicated there were no injuries, and immediate interventions identified included: range of motion (ROM) to extremities, Hoyer (a type of mechanical lift) lifted into bed, then into wheelchair. No other interventions were listed.

-2/21/16-Staff called to R12's room and found him lying on his left side. R12 stated he had been leaning forward in his wheelchair reaching for a pop can that had fallen on the floor and fell out of his wheelchair. The Accident Report, also dated 2/21/16, indicated an immediate action of assisting R12 into his recliner with a Hoyer lift and

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indicated there were no injuries.

-3/7/16-R12 was found on the floor on his right side and had been in his wheelchair trying to pick something up off the floor. The report indicated R12 had sustained an abrasion to the right side of his head and had reported shoulder pain at the time. The Accident Report, also dated 3/7/16, indicated injuries of an abrasion to the right side of head and that R12 had reported "a little right shoulder pain." According to the report, the immediate action taken included: assess for injuries, Hoyer off floor. Measures/interventions to prevent further accidents included to reinforce to resident that he is not to pick things up off the floor.

-4/3/16-R12 tried to get himself out of bed, coaxed by staff back into bed without any issues.

-4/10/16-R12 was found by a nursing assistant (NA) sitting on the floor in front of his wheelchair R12 had stated, "I shouldn't be trying to reach for stuff." R12 subsequently told staff he was trying to pick up his calendar. The Accident Report also dated 4/10/16, indicated the resident had sustained no injuries, and immediate action taken included: assisting the resident back into the wheelchair with assist of three. In addition, the report indicated staff had instructed resident to use the call light when he needed help. Measures/interventions included for the family to bring in a "reacher."

-4/25/16-R12 was found lying face down on the floor in the South hallway, had been leaning forward in his wheelchair to pick something up off the ground, which staff thought may have been a tissue. R12 had a pool of blood under him

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coming from his nose and forehead and a hematoma on the forehead. R12 was sent via ambulance to the hospital and returned later the same evening. The Accident Report also dated 4/25/16, indicated R12 had sustained injuries including a laceration and hematoma to the forehead and nose, and skin tears to the right wrist and hand. Immediate actions identified included: neuro checks and mechanically lifting the resident into a chair. Follow up interventions included having therapy assess for trunk flexibility. Subsequently, orders for OT (occupational therapy) and PT (physical therapy) were received on 4/29/16.

-5/28/16- documentation indicated R12 had sat up on edge of bed twice during shift attempting to call someone to go fishing with. Floor alarm not triggered by feet swinging off edge of bed, pressure sensor added to bed at this time and a clip alarm was implemented to be used in the chair with a floor sensor still in use.

-6/9/16-R12's alarm was sounding in his room. A NA [nursing assistant] observed R12 lying on the left side in front of his recliner chair with it elevated in the high position. R12 reported he was trying to reach for Kleenex on the floor. An ice pack was provided to the forehead due to swelling. A subsequent progress note indicated R12 had bruising to the left side of the face and by the eye. The Accident Report also dated 6/9/16, indicated R12 had sustained injuries including; a hematoma to the forehead, and bruising to the right elbow and left eyelid. Immediate interventions implemented included: range of motion, neuro's, vital signs, mechanically lifted from floor to the wheelchair, and an ice pack to the forehead. Measures to prevent future

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accidents included keeping the remote for the recliner out of reach.

R12's therapy documentation included the following:

-4/25/16 - R12 referred to therapy (PT) due to a fall from wheelchair when reaching for something causing him to hit his head and have abrasions on his right hand. R12 demonstrated difficulty following directions and demonstrates left neglect with following a finger when asked to follow finger with his eyes. Goals included: setting up a restorative program for strengthening, working on safer transfers from the chair, and indicated a risk factor for injury of frequent intermittent sleeping when up. The PT discharge summary, dated 5/26/16, indicated R12 had improved with overall strength, was being placed on restorative nursing, but remained at risk for falls.

-5/12/16-OT plan of care indicated a short term goal of modifying R12's wheelchair in order to attach reacher to it to serve as a visual cue/reminder for R12 to use it when retrieving items off the floor. The OT discharge summary dated 6/7/16, indicated R12 was able to use the reacher while self-propelling in the wheelchair to pick things off the floor, however didn't like having it attached to the chair.

Observation of R12 throughout the course of the survey from 6/14 to 6/15/16, revealed R12 frequently slept in his recliner with fall alarms in use, or was up in the wheelchair. R12 was also observed to require staff assistance to be taken into and out of the dining room, and was observed to have a bruise under the left eye that was dark purple in color.

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During interview on 6/17/16, at 10:39 a.m. registered nurse (RN)-A stated a fall assessment was only completed for residents at admission and that staff referred residents to therapy based on incident reports.

During interview on 6/17/16, at 11:37 a.m. PT-A stated therapy evaluated and treated residents based on falls documented by nursing, and orders received from doctors when residents were admitted to the facility. PT-A also stated RN-A attended morning meetings everyday and reviewed the residents with therapy, and would request additional orders if someone was falling. PT-A verified R12 had been discharged from PT on 5/25/16, and that R12 had received PT due to a fall from the wheelchair with a head strike. PT-A stated there had been a goal for R12 to see whether he could follow an exercise program, to evaluate his primary deficits, and to attempt to determine what had caused the falls. PT-A said R12 was determined to have poor balance, and then OT had trialed a reacher for R12 from 5/12/16 to 6/7/16, however R12 had refused to use it. PT-A said that's when alarms had been added to the bed. In addition, PT-A stated R12 had been utilizing a reacher at the time of his fall in October 2015.

During interview on 6/17/16, at 12:08 p.m., the director of nursing (DON) indicated sometimes falls interventions were discussed but not necessarily included on the Accident Reports. The DON verified R12's care plan had not been updated to include all interventions, and confirmed fall assessments were being conducted at the time of a resident's admission, but not after each incident/accident. The DON

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MAPLETON COMMUNITY HOME	301 TROENDLE STREET MAPLETON, MN 56065

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F 323	Continued From page 12 confirmed that other than the PT/OT evals, there had been no further fall assessments conducted since R12's admission in January 2013. The facility's Falls Policy and Procedure dated 3/15/11, indicated each resident at risk for falls would be identified. The policy also indicated a plan of care would be developed to include measures to aid in prevention of falls, and that fall risk assessments would be completed on admission. In addition, the policy indicated an Accident Report would be filled out by the charge nurse following a fall and given to the resident care coordinator, who would bring the report to the interdisciplinary team meeting. The team was then responsible to review the fall and determine whether the current plan was adequate, or if other interventions should be put into place.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify, assess and	F 325	Reviewed current weight policy and at this time we are revising policy to include:	7/8/16

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F 325	Continued From page 13 monitor weight loss for 1 of 3 residents (R59) in the sample who had a significant weight loss. Findings include: R59's admission history and physical indicated the resident had been admitted to the facility 5/11/16, and had diagnoses including: hemiplegia, coronary artery disease, anemia, history of bowel obstruction, fracture of the left femur and kidney disease. Review of the facility's weight log indicated R59's weights as follows: 5/11/16-162.8# 5/15/16-163.5# 5/23/16-162.6# 6/13/16-151.8# 6/16/16-152.6# Review of R59's Nutritional Assessment completed by the certified dietary manager (CDM)dated 5/13/16, indicated the resident had a history of weight loss. "Wt (weight) [down arrow] since Feb (February) to March when he was here before. Now weight back up 12.1#..." The resident's current care plan included: "Goal: ...maintain weight within 5# of 162.6" and to continue to eat/drink at least 75-100%. Interventions included: "Serve regular diet..Monitor resident's nutritional interventions at least quarterly, monitor weights monthly or as ordered..." Review of R59's food intake log since admission, revealed the resident generally consumed 100% of breakfast, and from 50-100% at lunch and supper.	F 325	Weigh resident on admission and next 3 days, then day 7, day 13 and continue monthly and/or weigh more often per physician order. Nursing staff will weigh Resident monthly unless otherwise indicated either by standing or in wheelchair, based on Resident's abilities. A 3# weight change in one week now requires a re-weigh by nursing within 24 hours. Nursing will notify the physician and family when there is a significant loss or gain of 5% in 30 days or a 10% loss or gain in 180 days. Nursing will document any changes or reasons for change. Nursing will also notify the Certified Dietary Manager who will then notify the Dietitian when significant weight changes have occurred; a nutrition evaluation and assessment are to be completed. Dietary interventions for weight loss will include but are not limited to Nutrition Intervention Program (NIP), house supplement and high calorie snacks will be initiated. Routinely monitor meal intakes and weight. Care Plan updated. Nutrition/dietary progress notes completed at least monthly to evaluate performance of the interventions. The identified Resident has since discharged from our facility. Audited	

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F 325	Continued From page 14 On 6/16/16 at 8:35 a.m. registered nurse (RN)-C was interviewed regarding R59's 10# weight loss from 5/23-6/13/16. RN-C stated she was unaware of the weight loss and would request that the nursing assistant (NA) reweigh the resident. After reweighing the resident the nursing assistant communicated to RN-C the weight to be 152.6. At that time, it was observed RN-C had to enter the resident's weight into the electronic record at which time the documentation indicated the resident had sustained a 6.2% loss since 5/23/16. On 6/16/16 at 10:36 a.m., R59 and his wife were interviewed. R59's wife stated she had not been aware that R59 had lost 10#. She stated R59 had utilized Boost (a nutritional supplement) at home. On 6/17/16 at 8:38 a.m., during interview with the facility's Registered/Licensed Dietitian (RD/LD) weights were reviewed. The RD/LD acknowledged the resident's weight loss and stated she'd realized the weight loss on 6/15/16 when she'd reviewed his chart, but verified she had not initiated any new interventions to address the weight loss. The RD/LD further stated normal interventions for an individual with significant weight loss would include: initiate a supplement, fortified foods, and a program to add extra calories such as additional butter, gravy, planned snacks. The RD/LD stated she would review R59's situation and develop a plan to address his weight loss.	F 325	weights of all other residents to see if anyone else met the criteria to be evaluated and reviewed for weight changes.	
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		7/6/16

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F 329	Continued From page 15 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to document indications for use and adequate monitoring for side effects of antipsychotic medications; failed to attempt non-pharmacological interventions and failed to monitor laboratory results for a cholesterol lowering medication to determined efficacy of medications used for 4 of 5 residents (R57, R35, R51, R19) reviewed for unnecessary medications.	F 329	Reviewed and re-educated Nursing at 7/6/16 meeting importance of reviewing behavior sheets consistently and monitoring that Nursing Assistants are documenting all behaviors exhibited by Residents. Pharmacy review every six months is given to the Physician. Behaviors and need for medications will be considered at this time, along with dose reduction or	

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F 329	Continued From page 16 Findings include: During observation on 6/14/16, 6/15, and 6/16 resident did not exhibit any behaviors. Resident attended activities and sat in her wheelchair in the hallway when she was not napping. No wandering, aggressive behavior or paranoia were observed. Review of R57's medication administration record (MAR) identified that R57 received Risperidone (antipsychotic medication) 1 milligram (mg) everyday and Zoloft (antidepressant medication) 200 mg every day. Review of the annual Minimum Data Set (MDS) assessment dated 5/24/16, identified diagnosis including anxiety, Alzheimer disease and other dementia's, a Brief Interview for Mental Status (BIMS) score of 4 (indicating severe cognitive impairment), a PHQ 9 (Patient Health Questionnaire) score of 3 (indicating minimal depression). The Care Area Assessment (CAA) identified R57 had wandered 4-6 days during the assessment period. The CAA also identified the use of antidepressant and antipsychotic medication and that R57 had stated she was tired all the time and identified that she does move throughout the building in her wheelchair. Review of the psychiatry evaluation dated 11/9/15, identified that R57 had not exhibited any paranoid behavior in the last year and wanders around the nursing home but does not go into other resident rooms or attempt to "escape". Active problems identified included dementia of the Alzheimer's type. The evaluation also identified R57 had been started on the antipsychotic medication Seroquel about 1 year	F 329	discontinuation of medication. Psychopharmacological medication changes will be recorded in Care Plans. Tardive Dyskinesia (TD) program using Aims testing was developed and put in place. Education was provided on TD program at the 7/6/16 nurses meeting. MDS Coordinator will monitor for Residents that need to have a TD assessment completed. ADON will assure completion by floor nurse. Antipsychotic medication policy was reviewed and updated to include: 1). Monitoring and documenting of behaviors in chart. 2). Attempt non-pharmacological interventions (i.e. take Resident to a quiet room, play quiet music, use oil therapy, etc.) and monitor outcomes of such interventions with the interdisiplinary team (QA meeting) and interventions tried before addressing any medication changes. 3). Refer to out patient services and follow their recommendations as needed. 4). Refer to in-house Pharmacologist Consultant to address any possible non-pharmacologic interventions and follow his recommendation as needed. Pharmacology notes are currently sent along with each Resident to all Psychiatry appointments. Doctor/Physician Assistant will review lab monitoring during regulatory nursing home visits.	

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F 329	Continued From page 17 ago and the psychiatric evaluation identified that the daughter reported staff stated she was not on the medication. (Review of the medical record by the surveyor confirmed that R57 had not received Seroquel). At this time R57's Zoloft was increased from 100 mg to 150 mg everyday and R57 was started on the antipsychotic medication Risperidone 0.5 mg. R57 was again seen by psychiatry on 1/27/16. The referral form identified under nurses comments that R57 had cried more often than was charted and wheeled around stated she wanted to go home. The physician stated, "Please send a family member or staff with patient to get appointment. She did not know why she was here or where she was. I cannot obtain proper information at this time to make an assessment. Increase Risperidone to 1 mg at bedtime. Increase Zoloft to 200 mg daily." Review of the aide target behaviors sheets for March, April and May included the following: crying, wandering, paranoia, holding food in mouth, looking afraid. Review of nurses notes from 3/18/16 to 6/16/16, lacked any documentation related to any of these identified behaviors. No non pharmacological interventions were documented noor was medication monitoring evident in the medical record. The care plan revised 6/25/15, identified impaired thought process related to Alzheimer's diagnosis with interventions including provide program of activities that accommodate her abilities and will keep her mind active and out of bed, keep her routine consistent. The plan of care identified R57receives antidepressant medication with interventions to give psych med's as ordered, monitor and document side effects and effectiveness and monitor/document /report to physician signs symptoms of depression.	F 329	R19 had a lipid panel collected on 6/29/16 and will have a lipid panel drawn yearly while on medication. R57, R51 and R35's careplans are being updated to include specific non-pharmacologic interventions relevant to each Resident. Director of Nursing and ADON will monitor compliance along with doing audits regularly to ensure that non-pharmacological interventions are being used.	

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F 329	Continued From page 18 Review of the pharmacist behavior medication monitoring form dated 11/19/15, identified the use of Zoloft 150 mg and Risperidone 0.5 mg. The pharmacist recommendation was as noted: there is no clear documentation which indicates the rationale ongoing use of a major tranquilizer. Risperidone 0.5 mg was added but no documentation of behaviors or non med interventions identified. The pharmacist questioned why Risperidone was needed. A note under physician psych progress note and orders dated 12/10/15, identified the psychiatrist increased the Zoloft to 150 mg and added the medication, Risperdone 0.5 mg on 11/9/15. Another pharmacist behavior medication monitoring form dated 12/22/15, again identified: no clear documentation which indicates ongoing use of a major tranquilizer and no documentation of behaviors or non med interventions. Documentation located under nursing staff-identified the family requests no changes and the medication was added by psychiatrist. The physician assistant (PA) note on the form dated 1/28/16, identified: defer management of psych med's to psychiatry. A pharmacy monthly drug review report dated 2/18/16, identified the increase of the Zoloft and Risperidone, no significant behaviors document and questioned again why Risperdone was needed. Written under these comments was "seen by psych." The PA note identified that other med's were managed by psych. During interview on 06/16/2016, at 10:43 a.m. the director of nursing (DON) stated that non pharmacological interventions were only used if a medication was a prn (as needed) and that psychotropic monitoring was done by the	F 329		

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F 329	Continued From page 19	F 329		

mood/behavior sheets. She verified there was no monitoring on the behavior sheets and that behaviors should have been documented in the nurses notes. She also verified that staff has not contacted the psychiatrist regarding the pharmacist recommendations and concerns related to the justification of the anti-psychotic medication, Risperidone.

R51 had diagnoses in the electronic medical record of dementia, Alzheimer's, delusional disorder, major depression and anxiety.

R51's significant change in status Minimum Data Set (MDS) assessment dated 4/29/16, indicated a severe cognitive impairment. It also identified R51 as having delusions. A psychotropic drug use care area assessment (CAA) dated 4/29/16, noted R51 took Risperidone (antipsychotic) 0.5 milligrams (mg) by mouth (PO) twice daily. It also noted R51 was still experiencing some paranoia, and would consult with psych about medications next appointment and watch for adverse reactions.

Physician orders dated 6/9/16, indicated R51 was prescribed Risperidone 0.5 mg PO twice daily for behaviors.

The current care plan did not include that R51 was receiving an antipsychotic medication nor include the monitoring for use of the Risperidal.

During interview on 6/17/16, at 11:59 a.m. director of nursing (DON) confirmed R51's care plan lacked the antipsychotic medication use and monitoring for the Risperidal. The DON confirmed it should have been included as part of the plan of care. She also verified R51 lacked a completed Abnormal Involuntary Movement Scale (AIMS) or tardive dyskinesia (TD) assessment. DON stated "the previous DON was in charge of doing them", then indicated the previous DON had left abruptly and did not know where she kept them.

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F 329	Continued From page 20	F 329		

R35 was admitted 9/9/15, and had diagnoses identified in the electronic medical record which included multiple sclerosis (MS), dementia, restlessness and agitation, anxiety disorder, dysthymic disorder (mood disorder) and depression.

R35's quarterly MDS dated 3/15/16, indicated R35 had moderately impaired cognition and behavior symptoms not directed towards others one to three days. R35's CAA dated 9/18/15, indicated R35 had behaviors with incontinent bowel movements (BM's) and indicated behavior may be due to staff approach and recent admission into a new setting. It further identified R35 received Seroquel (antipsychotic) 50 mg every morning and 75 mg at bedtime for a depressive disorder with an increase on 9/17/15 due to the move into a new facility.

Physician orders dated 6/3/16, indicated R35 was prescribed Seroquel 50 mg PO every morning and 75 mg PO every evening. On 6/9/16, Seroquel was increased to 100 mg PO every bedtime per physician orders for behaviors.

The current plan of care indicated R35 was receiving an antipsychotic medication related to behavior management. It included interventions to monitor/record occurrence of target behaviors symptoms and violent behaviors but had no non-pharmacological interventions identified.

When interviewed on 6/15/16, at 3:52 p.m. nursing assistant (NA)-D stated "you can tell by the look in his face" "I can't explain it" in regards to the behaviors R35 exhibits; NA-D indicated she leaves him alone and will reapproach at a later time when this behavior occurs.

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F 329	Continued From page 21 During interview on 6/16/16, at 12:58 p.m. NA-B stated its all in the approach and who is working with him. NA-B further indicated staff can't be loud or overshadowing as R35 needs patience and "space" when assisting him with cares. When interviewed on 6/17/16, at 8:56 a.m. registered nurse (RN)-A confirmed the care plan lacked non-pharmacological behavior interventions and it should have been included. When interviewed on 6/17/16, at 11:59 a.m. the DON confirmed R35's careplan lacked non-pharmacological interventions and should have been included. The DON was unable to provide a completed AIMS and/or TD assessment for R35. DON stated "the previous DON was in charge of doing them" but since the previous DON had left abruptly, she was unaware of the location the assessments were filed. The DON confirmed both an AIMS or TD assessment should have been completed. A policy for the use of antipsychotic medications was requested but not provided. Review of R19's medical record revealed diagnose including: congestive heart failure, diabetes, chronic obstructive coronary disease, peripheral vascular disease, history of deep vein thrombosis, and hyperlipidemia, per the care plan dated 4/4/16.	F 329		

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F 329	Continued From page 22 Review of the physician orders included an order for atorvastatin (a cholesterol lowering medication) 10 mg by mouth at bedtime. Further review of the medical record did not include a lipid panel to monitor effectiveness of the medication. When interviewed on 6/17/16, at 1:45 p.m. the director of nursing (DON) confirmed R19's medical record did not include evidence of a lipid panel being performed nor rationale indicating why it not been completed. Although a request was made for the most recent lipid panel performed, none was provided.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to store and maintain the large industrial mixer used for food preparation in a sanitary manner. This had the potential to affect 59 out of 60 residents. Findings include:	F 371	The daily cleaning and sanitation list has been updated more specifically to individual mixers for staff awareness, although mixers were on the original cleaning and sanitation list. Staff will initial the task when completed taking responsibility for their work. Staff education is being conducted on	6/20/16

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F 371	Continued From page 23 The initial kitchen tour conducted on 6/14/16, at 11:45 a.m. with dietary assistant (DA)-A. It was observed that the large industrial mixer was stored with a large plastic bag covering the unit. When the cover was removed, dried food debris was noted on the armature of the mixer which could easily be removed and a black substance was observed on the beater holder. This substance could also be easily removed and had the potential to fall into food when mixed. DA-A confirmed the above findings. It was again observed on 6/17/16, 12:16 p.m. that the industrial mixer was stored with a large plastic bag covering the entire unit. Upon further inspection it was noted debris was evident on the large armature and above the mixer beaters. This was confirmed by the dietary manager (DM). At this time, the DM confirmed the mixer should have been cleaned prior to storage with the large plastic bag. The policy titled Cleaning Procedure-Mixer presented by the dietary manager on 6/17/16, indicated the following: Policy: The mixer will be maintained in a safe and sanitary condition. The procedure identified that after each use the following steps would be implemented: (1.) Unplug the unit, then remove the beaters and the bowl. Wash, rinse, and sanitize the beaters and the bowl in 3 compartment sink; allow them to air dry. (2.) Wipe the machine including the legs and underside of the shaft with warm water-detergent solution prepared according to manufacturer instructions. (3.) Clean the table or floor under the mixer, particularly around legs of mixer and the wheels	F 371	appropriate cleaning and sanitation of all equipment. The Certified Dietary Manager and Assistant Dietary Manager will complete formal audits of this cleaning each week and will then report any sanitation violation findings at the Quarterly Assurance Meeting quarterly.	

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F 371	Continued From page 24 of mixer stand. (4.) Rinse the mixer stand with warm water and clean cloth. (5.) Wipe mixer stand dry and replace bowl and beaters. (6.) Cover clean mixer with clear plastic bag when it is not in use. Review of the Daily Assigned Cleaning schedules for the dates 5/30/16 thru 6/5/16. and 6/6/16 thru 6/12/16, did not include cleaning of the industrial mixer.	F 371		

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MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 15, 2016. At the time of this survey, Building 01 of Mapleton Community Home was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2016**

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MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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K 000	Continued From page 1 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. Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2016**

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

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K 000	Continued From page 2 department notification. The facility has a capacity of 60 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 FINDINGS INCLUDE: On 06/15/2016 between 10:30 AM and 1:30 PM, during the inspection a penetration was observed around cables above the ceiling tiles in the 2 hour fire separation between the Skilled Nursing Facility and the Assisted Living Building. This deficient practice was verfied by the Maintenance Supervisor.	K 011	Penetrations were caulked shut with fire rated caulk. This work was completed 6/20/16. In the future an inspection will be completed with any Contractors before they exit to ensure that they have sealed any penetrations. This work was completed by Dan Schaefer - Environmental Services Director. Inspections will be done by Dan Schaefer - Environmental Services Director.	6/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2016**

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K 025 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 FINDINGS INCLUDE: During Facility Inspection on June 14, 2016, between the hours of 10:30 AM and 1:30 PM, observation revealed penetrations above the lay-in ceiling around wires in the South Park smoke barrier wall at the Hall #1 and Hall #3 smoke barrier wall. This deficient practice was verfied by the Maintenance Supervisor.	K 025	Penetrations were caulked shut with fire rated caulk. This work was completed 6/20/16. In the future an inspection will be completed with any Contractors before they exit to ensure that they have sealed any penetrations. This work was completed by Dan Schaefer - Environmental Services Director. Inspections will be done by Dan Schaefer - Environmental Services Director	6/20/16
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: Required automatic sprinkler systems are	K 062	The Life Safety Code book will be	7/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/15/2016**

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MAPLETON COMMUNITY HOME	**301 TROENDLE STREET** **MAPLETON, MN 56065**

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K 062	Continued From page 4 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 FINDINGS INCLUDE: During Facility Inspection on June 15, 2016, between 10:30 AM and 1:30 PM, documentation could not be provided to indicate that the fire sprinkler quarterly inspection had occurred during January-March, 2016. This deficient practice was verfied by the Maintenance Supervisor.	K 062	checked the 1st week of the month and any required work (including the Quarterly fire sprinkler inspection) will be scheduled at that time to ensure that it is done on time. This was started the 1st week of July 2016. This will be done by Dan Schaefer - Environmental Services Director.	
K 069 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 FINDINGS INCLUDE: During Facility Inspection on June 15, 2016, between 10:30 AM and 1:30 PM, documentation reviewed indicated that the semi-annual kitchen fire suppression system had not been conducted within the required time frame. Documentation had inspection dates of July 14, 2015 and April 13, 2016. This deficient practice was verfied by the Maintenance Supervisor.	K 069	A new Contractor has been hired to perform semi annual inspections of the kitchen hood. They schedule their work to ensure that it is in compliance. We will also monitor it with our checking of the Life Safety Code book the 1st week of each month. This was started the 1st week of July 2016 and will be done by Dan Schaefer - Environmental Services Director.	7/4/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/15/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 15, 2016. At the time of this survey, Building 02 of Mapleton Community Home was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101-5145, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/11/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/15/2016**

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K 000	Continued From page 1 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. Building 02 of Mapleton Community Home consists of the 2011 nursing home addition, which included a link to an assisted living facility. The link incorporates a barber/beauty shop, storage rooms and staff office space. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 59 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 011	NFPA 101 LIFE SAFETY CODE STANDARD	K 011		6/20/16

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	245362	A. BUILDING **02 - 2011 ADDITION** B. WING _____	**06/15/2016**

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K 011 SS=E	Continued From page 2 If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 11/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 This STANDARD is not met as evidenced by: If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1 1/2 hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2 FINDINGS INCLUDE: On 06/15/2016 between 10:30 AM and 1:30 PM, during the inspection a penetration was observed around cables above the ceiling tiles in the 2 hour fire separation between the Skilled Nursing Facility and the Assisted Living Building. This deficient practice was verfied by the Maintenance Supervisor.	K 011	Penetrations were caulked shut with fire rated caulk. This work was completed 6/20/16. In the future an inspection will be completed with any Contractors before they exit to ensure that they have sealed any penetrations. This work was completed by Dan Schaefer - Environmental Services Director. Inspections will be done by Dan Schaefer - Environmental Services Director	
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K 062	Continued From page 3 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 FINDINGS INCLUDE: During Facility Inspection on June 15, 2016, between 10:30 AM and 1:30 PM, documentation could not be provided to indicate that the fire sprinkler quarterly inspection had occurred during January-March, 2016. This deficient practice was verfied by the Maintenance Supervisor.	K 062	checked the 1st week of the month and any required work (including the Quarterly fire sprinkler inspection) will be scheduled at that time to ensure that it is done on time. This was started the 1st week of July 2016. This will be done by Dan Schaefer - Environmental Services Director.	