Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2023

Administrator
Mapleton Community Home
301 Troendle Street SW
Mapleton, MN 56065

RE: CCN: 245362
Cycle Start Date: September 21, 2023

Dear Administrator:

On September 21, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite 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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, 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, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or

Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by December 21, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by March 21, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

Please note that the failure to complete the informal dispute resolution process will not delay the dates

specified for compliance or the imposition of remedies.

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	245362	A. BUILDING: _____ B. WING _____	**9/21/2023**

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) 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/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN, form CMS-1005) to 2 of 3 residents (R26 and R38) reviewed whose Medicare A coverage ended and the residents remained in the facility. Findings include: R26's admission record dated 9/20/23, indicated R26 was admitted on 8/11/23, diagnoses included hypertension (high blood pressure), type 2 diabetes, acute embolism, and thrombosis (blood clot) of deep veins of right upper extremity, muscle weakness, and heart failure. R26's medical record identified on 8/30/23, R26 received and signed the Notice of Medicare-Non-Coverage (CMS-10123) form. The form indicated R26's coverage of current skilled services would end on 9/1/23, and

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 582	Continued From Page 1 would remain in the facility. R26's record lacked evidence R26 received the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) as required. Review of R26's record indicated a Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) had not been provided to R26 to inform of the estimated cost per day, or an explanation of the extended care services or items to be furnished, reduced, or terminated if R26 stayed in the facility. R26's Census List dated 9/21/23, identified on 9/2/23, R26's payer source changed from Medicare Part A to Medicaid and remained in the facility. R38's admission record dated 9/20/23, indicated R38 was admitted on 3/2/23, diagnoses included heart failure, anxiety disorder, acute pulmonary edema, and atrial fibrillation. R38's medical record identified on 4/3/23, R38 received and signed the Notice of Medicare-Non-Coverage (CMS-10123) form. The form indicated R38's coverage of current skilled services would end on 4/5/23, and would remain in the facility. R38's record lacked evidence R38 received the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN, Form CMS-10055) as required. R38's Census List dated 9/21/23, identified on 4/6/23, R38's payer source changed from Medicare Part A to private pay and remained in the facility. On 9/20/23 at 1:26 p.m., during an interview social services (SS)-A confirmed R26 and R38 had not received The Skilled Nursing Facility Advanced Beneficiary Notice and further indicated it was not the facility's practice to provide the notice. SS-A stated going forward residents will receive the form. On 9/20/23 at 1:31 p.m., an interview with the director of nursing confirmed residents were expected to receive the beneficiary notices and confirmed R26 and R38 were not provided the beneficiary notices. The facility Medicare Part A policy dated 6/06, indicated: Policy: To guarantee that's the right of the resident Medicare benefits are insured. Procedure: 4. If there is no skilled service, complete and have resident or representative sign the denial notice and explain their right to ask that Medicare review their claim. Give Resident original copy. 11. Notice of non coverage is issued and will be signed and completed by the facility representative and also by the resident or the representative.
F 623	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 2

§483.15(c)(3) Notice before transfer.
Before a facility transfers or discharges a resident, the facility must-
(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.
(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental

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ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 3

disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l).
This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure a written notice of transfer was given to 2 of 2 residents (R21 and R24) and/or representatives, upon transfer to the hospital. This deficient practice had the potential to affect all 47 residents residing in the facility.

Finding include:

R24's facesheet printed on 9/20/23, included diagnosis of esophageal obstruction.

R24's significant change Minimum Data Set (MDS) assessment dated 7/29/23, indicated moderately impaired cognition; R24 was understood and could understand and required extensive assistance of one or two staff for most activities of daily living.

Progress note dated 6/15/23 at 2:04 p.m., and written by licensed practical nurse (LPN)-B, indicated R24 had stated he couldn't swallow and complained of chest pain. LPN-B contacted the local clinic and received an order to send R24 to the emergency department.

The facility provided a document titled "Transfer to Hospital," dated 6/15/23, which had been completed when R24 had been transferred to the hospital due to inability to eat or drink fluids on 6/15/23. The form did not indicate if a copy had been given to the resident and/or resident representative.

During an interview on 9/19/23 at 4:16 p.m., the director of nursing (DON), who was new to her role, stated the facility was cited on transfer notices during their last recertification survey in 2021 and did not know why it had not been corrected. The DON explained the facility sent the transfer notice to the hospital with the resident and a copy was sent to the ombudsman, but a copy had not been given to residents and/or resident representatives.

R21's quarterly minimum data set (MDS) assessment dated 8/23/23, indicated R21 diagnoses included non-traumatic brain dysfunction, heart failure, hypertension (high blood pressure), non-Alzheimer's dementia, severe cognitive impairment, and required two person physical assist with bed mobility, transfers, toilet use,

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

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 623	Continued From Page 4

and required one person physical assist with dressing, eating and personal hygiene.

R21's progress notes dated 9/14/23 at 8:03 a.m., indicated R21 was transferred to ED (emergency department via ambulance at 7:45 a.m. bed hold is in place verbally from R21's son.

On 9/21/23 at 8:12 a.m., the DON confirmed when residents were transferred to the hospital, residents and/or resident representatives were not provided a written notice of transfer each time a transfer was initiated. The DON verified R21 or representative was not provided a written notice of transfer when transferred to the hospital on 9/14/23.

The facility Transfer to Hospital procedure revised 9/2022, was a checklist to guide the transfer process. The checklist identified forms to complete and how to disperse them. A step in the process indicated: Make copy of Transfer to Hospital form for the chart. The DON confirmed that step referred to the transfer notice form. The checklist did not indicate how to disperse the form.

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 _____	C 09/21/2023

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(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
E 000	Initial Comments On 9/18/23-9/21/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 9/18/23-9/21/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H5362033C (MN00076984), H53623001C (MN00092604), H53625524C (MN00095113), and H53627778C (MN00090325/MN00090343). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 677	ADL Care Provided for Dependent Residents	F 677		10/19/23

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

Electronically Signed | 10/19/2023

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

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	245362	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 677 SS=D	Continued From page 1 CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, including shaving for 1 of 4 residents (R4) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 7/5/23, indicated R4 had severely impaired cognition and was visually impaired, required extensive assistance from 1 staff for personal hygiene needs. R4's care plan, printed on 9/21/23; indicated R4 had ADL self care performance deficit related to dementia (brain disorder causing impaired memory/thought process) and required 1 staff to assist with personal hygiene needs. During an observation, on 9/18/23 at 1:45 p.m., R4 was observed to have short, white, stiff facial hairs, approximately 0.5 centimeters (cm) in length; present to chin and surrounding sides of upper lip. While interviewed, on 9/18/23 at 1:53 p.m., R4's family member (FM)-C indicated R4 always liked to appear neat and well-groomed, did not like longer facial hairs present. FM-C noticed	F 677	R4 was shaved by nursing staff upon identification of facial hair. For all residents Point of Care updated (CNA charting system) to have a specific block for shaving indicating if the resident presents with unwanted facial hair and will trigger to have CNA complete facial hair removal. Nursing staff re-educated on 10/19/23 at all staff meeting that residents who present with unwanted facial hair will be shaved with personal razor. Education provided verbally regarding new tile in POC to help identify unwanted facial hair to trigger for shaving. Shaving audit to be completed by DON. DON (or in her absence) ADON will complete monthly. Audit of four random residents that require assistance with ADLs. 1. Is the resident free from facial hair? YES NO 2. When was the last time resident was shaven? DATE: _____ 3. CNA caring for resident notified of presence of unwanted facial hair and shaven. NAME:	

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F 677	Continued From page 2 occasionally when visiting R4 presence of facial hairs to chin and lips, FM-C would assist R4 with shaving cares to remove unwanted facial hairs. During an observation and interview, on 9/19/23 at 11:37 a.m., trained medical assistant (TMA)-B, also known as nursing assistant (NA), noted presence of facial hair to R4's chin and lips. TMA indicated awareness R4 did not like facial hair present and required staff assistance with shaving to maintain good personal hygiene. TMA-B stated R4 had a bath earlier in morning, and indicated staff should have noticed longer facial hair to R4's chin and lips, and removed facial hair. While interviewed, on 9/19/23 at 12:39 p.m., the director of nursing (DON) indicated R4 needed staff assistance for personal hygiene needs, including shaving. The DON stated residents could be provided shaving cares anytime, and indicated it was her expectation for staff to be removing resident's facial hair anytime noted or per resident request when providing daily routine cares. The facility ADL Performance Policy undated, indicated ADLs will be completed by nursing staff as directed by the individual care plan. ADLs will be completed in the AM and PM and as needed throughout the day, dependent on resident needs.	F 677	_____ _____ DON will keep records for 12 months. Review of findings will be completed at nurses meeting in November and also at next QAPI meeting.	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		10/17/23

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F 689	Continued From page 3 §483.25(d)(2)Each resident receives 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 monitor ongoing safe smoking practices, and failed to provide an environment and assistive smoking devices to prevent accidents for 1 of 1 resident (R22) reviewed for smoking. Findings include: R22's annual Minimum Data Set (MDS) assessment dated 7/19/23, indicated R22 had intact cognition, displayed no behaviors, required extensive assist of 2 staff with transfers, extensive assist of 1 staff for locomotion on/off unit, had impairment of both lower extremities and left upper extremity, used a wheelchair for mobility, and was a tobacco user. R22's face sheet printed on 9/19/23, indicated diagnoses including hemiplegia/hemiparesis (paralysis of one side of body), tobacco use, heart failure (HF), nuclear cataracts (cloudy vision), anxiety, oxygen dependence, morbid obesity, reduced mobility, major depressive disorder (mood disorder), cerebral infarction (stroke), and type 2 diabetes mellitus ((DM)-abnormal blood sugars). R22's order summary report printed on 9/19/23, indicated orders for no smoking until off oxygen-if resident refuses, remove oxygen 15 minutes before going outside and document refusal.	F 689	Smoking policy updated on 10-16-23 to reflect use ash trays for cigarette ashes. "In the designated smoking area, a large posted cigarette receptacle is available for use. A covered metal cigarette receptacle is located on the glass table for collection of ashes and/or cigarette butts. Ashing is not permitted on the ground. Cigarette ashes and butts must be contained in either the small metal receptacle or in the large posted receptacle". Smoking policy was reviewed with the two residents (R22 and R49) that smoke cigarettes 10-17-23 and their signatures accepting policy were obtained. The new smoking policy has been updated and provided to Social Service director and will be provided at admission. Smoking Observation will be completed by DON, Social Service Director or Therapeutic Recreation Director monthly for residents that smoke to observe them smoking following facility smoking policy. Smoking Audit 1. Does the resident wheel themselves to the designated area safely? YES NO 2. Is the resident able to light and hold cigarette? YES NO 3. Does the resident dispose of ashes	

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	245362	A. BUILDING _____ B. WING _____	C 09/21/2023

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F 689	Continued From page 4 R22's care plan printed on 9/19/23, indicated R22 was a vulnerable adult, would not be able to remove self from harm, was a current smoker, had impaired vision, used supplemental oxygen, was not able to walk- could move wheelchair independently using right leg. Interventions for R22 included for staff to ensure removal of oxygen 15 minutes prior to R22 smoking for safety, ensure R22 wore a smoking apron when outside smoking, and complete smoking safety evaluation yearly and as needed (PRN). R22's smoking assessment completed on 8/9/23, indicated R22 did not have a visual deficit or dexterity problem, smoked 10+ cigarettes per day during morning/afternoon/evening hours, could light own cigarette, needed adaptive equipment-smoking apron while smoking, and plan of care used to assure resident safe while smoking. During an interview on 9/18/23 at 12:32 p.m., R22 indicated he was a smoker, needed to go to nursing station to get cigarettes and lighter when wanting to smoke as nursing staff kept cigarettes and lighter in a locked area, stated he is independent of smoking, and had not had any smoking accidents since facility admission. R22 indicated for smoking safety, he takes off supplemental oxygen 30 minutes before smoking and wears an apron during smoking activity. While observed and interviewed on 9/19/23 at 9:08 a.m., R22 was sitting in his wheelchair at a table outside near facility's front entrance smoking a cigarette, smoking apron observed to be in place at time. While smoking, R22 was visualized flicking ashes from cigarette onto cement ground, as no ashtray was present at table, smoking receptacle was across from R22,	F 689	and cigarette butt into receptacle and not on ground or another surface? YES NO 4. Does the resident return smoking products to the nurse? YES NO	

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F 689	Continued From page 5 approximately 25 ft away. A piece of Kleenex tissue was lying on cement ground next to right back wheel of R22's wheelchair, small amount of cigarette ashes covering top of Kleenex tissue. When R22 was finished smoking cigarette, he rolled cigarette, just under burning tip of cigarette, with first and second fingers of right hand back and forth until the burned tip of ash dropped onto cement, extinguishing cigarette. R22 then folded cigarette butt with right hand and laid on top of plastic table sitting at. R22 observed to sit in wheelchair at table for a few minutes, picked up cigarette butt lying on top of plastic table, and propelled self in wheelchair using right foot over to smoking receptacle, placed cigarette butt into receptacle container, then propelled self into facility entrance door. Cigarette ashes and Kleenex tissue left remaining on cement ground. During an interview on 9/19/23 at 9:34 a.m., trained medical assistant (TMA)-B, also known as nursing assistant (NA), indicated awareness R22 was independent of smoking, had to take oxygen off prior to smoking, needed to wear a smoking apron during smoking activity. TMA-B indicated awareness of smoking receptacle outside near front of facility entrance, was unaware of any smoking assistive devices at table outside of front facility entrance door. TMA-B stated was unaware of R22 extinguishing burning cigarettes with his fingers due to no ash tray available at table, indicated residents' safety to smoke independently and smoking assistive device needs was managed by social services (SS) or the director of nursing (DON). While interviewed on 9/19/23 at 9:37 a.m., SS-A indicated residents' safety to smoke independently was determined based on smoking	F 689		

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F 689	Continued From page 6 safety assessments completed by charge nurse on each unit, any changes in residents' smoking safety assessment should be brought to the DON's attention, as SS-A stated she does not assist in management of smoking safety process. During an interview on 9/19/23 at 9:42 a.m., the DON indicated residents' smoking assessments could be completed by charge nurse on resident unit, activities coordinator, and SS. The DON indicated R22 was safe with smoking independently, just recently had a smoking assessment completed, no changes to his ability to smoke safely and independently. The DON stated unawareness if ash trays were available at table outside of facility's front entrance for residents to smoke at, stated there was a smoking receptacle within area. The DON initially indicated if residents were smoking at table outside of facility's front entrance, it was acceptable for residents to flick cigarette ashes on cement ground if ash tray was not available, later DON confirmed during interview debris lying on cement ground could potentially cause an accidental fire if cigarette ashes encountered, and stated residents should be using an ash tray or smoking receptacle when smoking. The DON indicated unawareness no ash tray available at table outside front building entrance,and R22 was extinguishing burning cigarettes with his fingers. The DON confirmed R22's extinguishing a burning cigarette with his fingers posed a risk for injury. The DON stated a smoking safety reassessment would be completed with R22 to determine his ability to smoke safely unsupervised, and would discuss with administrator implementation of covered ash trays to be placed at table outside front facility entrance to allow residents to smoke at and	F 689		

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F 689	Continued From page 7 prevent accidents from occurring. The facility Mapleton Community Home Smoking Policy dated 5/23, indicated designated smoking area is located outside the building by the main entrance, smoking evaluation must be completed by the charge nurse prior to resident smoking, smoking privileges may be revoked for resident safety at the discretion of Mapleton Community Home. Facility policy for accidents/hazards was requested, not received.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		10/19/23

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F 880	Continued From page 8 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880		

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F 880	Continued From page 9 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19, when during a Covid-19 outbreak, residents and visitors were observed not wearing appropriate personal protective equipment (PPE), specifically masks, for 9 of 41 resident (R2, R5, R8, R10, R14, R22, R24, R25, R35) not in transmission based precautions (TBP). In addition, the facility failed to offer hand-hygiene prior to meals for 4 of 4 residents (R2, R6, R8, R37). Lastly, the facility failed to ensure staff wore wear proper PPE specifically eye protection, when entering the room for 1 of 6 residents (R29) on TPB. This had the potential to affect all 47 residents who resided in the facility. Findings include: Upon survey entrance, on 9/18/23 at 11:30 a.m., observed signs to front doorway entrance indicating masks recommended due to positive Covid-19 as of 9/15/23. Staff noted wearing face masks at front desk, several unknown residents across from front desk in day room without face masks During an observation and interview on 9/18/23 at 4:02 p.m., noted hand sanitizer had not been immediately available outside resident rooms who were in TBP for Covid-19. The director of nursing (DON) stated the facility had made a conscious decision about that and staff were to use the	F 880	Masking: New sign at the main entrance added that displayed a face wearing a mask with the words Mask Required. This sign will be placed when the facility is considered in outbreak status. Masks remain available in the main entrance for visitors. Staff educated on 10-19-23 during all staff meeting that masks are to be offered to all residents when they exit their rooms while the facility is considered an outbreak status. Masks will be available in resident rooms and also at each nurses' station. If a resident is insistent that they do not want to wear a mask it will be indicated in their care plan otherwise masks will continue to be offered and applied. If a visitor enters the facility without a mask during the time of outbreak staff will direct the visitor to the masks or provide the visitor with one. During a Covid 19 outbreak all staff will visually monitor all visitors entering the building to ensure that mask adherence is completed. If mask is not on staff will remind visitor of requirement for masking and request mask is placed properly. If visitor is refusing compliance, staff will notify their direct supervisor who will communicate to DON/ADON the visitor present and attempt to educate visitor. DON to document the encounter and review with QAPI team the audit findings. DON/ADON to complete periodic visual observations of visitor masking in the	

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F 880	Continued From page 10 hand sanitizer dispensers on the walls. The DON stated this was to prevent visitors from taking the bottles of hand sanitizer and was a safety measure for residents with dementia. In a hallway of 13 resident rooms, on OW (Old Wing), only 5 hand sanitizer dispensers were mounted on the wall and available to staff. There were no hand sanitizer dispensers in resident room. During an observation and interview on 9/18/23 at 5:19 p.m., observed a male visitor enter the facility without a mask. Nursing assistant (NA)-E stated visitors did not need to wear a mask. The visitor got further into the building and the DON informed him he needed a mask. The visitor returned to the vestibule of the main entrance and donned a mask. R10's facesheet printed on 9/21/23, included diagnoses of end stage renal disease, diabetes, and dementia. R10's significant change Minimum Data Set (MDS) assessment dated 7/14/23, indicated R10 was cognitively intact; could be understood and could understand others. R10's current care plan with last care plan review date of 8/16/23, did not include precautions for Covid-19, nor if R10 had been assessed for the ability to wear a mask. During an observation on 9/19/23 at 8:55 a.m., R10 was observed with no mask, waiting in a wheelchair next to the nurses station for transportation to dialysis. During an interview on 9/19/23 at 9:02 a.m., R10 had been outside waiting for transportation. R10	F 880	building and review findings with QAPI team. Masking Audit (Visitors) 1. Does the visitor have a mask on? YES NO 2. If NO, was direction provided to visitor to wear mask? YES NO Hand Hygiene: Sani Hands (hand sanitizing wipes) ordered and will be kept and distributed dietary staff to all residents at the time of meal delivery. Dietary staff updated on new policy and procedure on 10-17-23. Hand Hygiene will be audited by either DON or Dietary Director weekly to observe the following 1. Was the resident offered Sani Hand hand-wiped prior to meal? YES NO 2. Did the resident accept hand hygiene from staff? YES NO 3. Was education provided to staff if hand hygiene was not offered? YES NO Results from weekly audits will be compiled and reviewed at quarterly QAPI meeting. PPE: All yellow contact precaution signs removed from Covid PPE carts on 9-19-23. Verbal reviews completed with nursing staff (RN, LPN, CNA) to update signage in carts includes the following: DON/DOF procedure, green droplet procedure, room log and transmission-based precautions	

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F 880	Continued From page 11 stated he had been aware there were residents in the facility who had Covid-19 but no one had informed him he should wear a mask. R10 stated he would wear a mask if asked to. During an observation and interview on 9/19/23 at 9:35 a.m., (NA)-F stated she had not been cleaning her hands immediately when exiting the rooms of residents in TBP for Covid-19. NA-F admitted there had been no hand sanitizer directly outside the room for staff to utilize. NA-F stated staff had to walk to the hand sanitizer dispensers mounted intermittently on the corridor walls, which were approximately 10-12 feet from resident rooms. R24's facesheet printed on 9/21/23, included diagnoses of dementia, asthma, and chronic kidney disease. R24's significant change MDS assessment dated 7/29/23, indicated moderately impaired cognition; could be understood and could understand others. R24's current care plan with last care plan review date of 8/16/23, did not include precautions for Covid-19, nor if R24 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 11:00 a.m., activity aide (AA)-A escorted unmasked R24 from his room on the old wing through the facility to the activity room on the new wing. AA-A was aware the facility was in Covid-19 outbreak, adding "I was told it was their decision if they wanted to wear them [mask]." AA-A stated she did not ask or encourage R24 to wear a mask and thought he could make a decision to	F 880	form with date. All staff meeting held on 10-19-23 and demonstration of application and removal of PPE completed. Review of signage and set up (including garbage can, tray table, Sani -wipes and hand sanitizer). When the facility is experiencing a Covid-19 outbreak the DON/IP will complete randomized audits of staff application and/or removal of PPE. PPE DON/DOF Audit 1. Is proper signage posted outside of room? YES NO 2. Is the staff member entering applying PPE? YES NO 3. Is staff member applying PPE in correct order per sign? YES NO 4. If any of the above steps were not completed list corrective action.	

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F 880	Continued From page 12 wear a mask if asked. R2's facesheet printed on 9/21/23, included diagnosis of Parkinson's disease. R2's significant change MDS assessment dated 6/15/23, indicated R2 had moderately impaired cognition; could be understood and could understand others. R2's current care plan with last care plan review date of 5/17/23, did not include precautions for Covid-19, nor if R2 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 11:30 a.m., trained medication aide (TMA)-A was observed escorting R2 via wheelchair from his room to the dining room without a mask. TMA-A stated she was aware of the Covid-19 outbreak, and stated residents did not need to wear masks outside of their room; they could if they wanted to. On 9/20/23 at 11:20 a.m., NA-D entered R2's room and assisted R2 from his recliner to stand. R2 used a walker and NA-D walked behind R2 in the hallway to the dining room R2 entered the dining room and was assisted by NA-D and seated in his wheelchair at the dining table. R2 was not offered a mask or offered to wash hands prior to exiting his room. On 9/20/23 at 11:25 a.m., NA-D confirmed the facility was in outbreak status and stated residents were not required to wear masks, but should wear a mask. NA-D confirmed R2 was not offered a mask. On 9/20/23 at 11:33 a.m., R2 was seated in a	F 880		

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F 880	Continued From page 13 wheelchair in the dining room. R2 stated he was not offered to wash his hands prior to the meal and stated he would wash his hands when offered. R2 stated was not offered a mask would not wear a mask if not required. On 9/20/23 at 12:57 p.m., NA-D confirmed R2 was not offered to wash hand prior to dining and residents were expected to have hand hygiene prior to meals. R5's facesheet printed on 9/21/23, included diagnosis of cerebral vascular disease (a condition that affects blood flow to the brain). R5's annual MDS assessment dated 6/19/23, indicated moderately impaired cognition, could be understood, and could understand others. R5's current care plan with last care plan review date of 4/12/23, did not include precautions for Covid-19, nor if R5 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 12:12 p.m., R5 was observed self-propelling in her wheelchair from the dining room to her room without a mask. In her room, R5 stated she was unaware anyone in the facility had Covid-19, and stated staff had not asked or encouraged her to wear a mask. R5 stated if they would have, she would wear a mask. R29's quarterly MDS assessment dated 6/12/23, indicated R29 was severely cognitively impaired, no rejection of care, required one person physical assist with dressing and personal hygiene, diagnoses included heart failure, Non-Alzheimer's Dementia, and localized edema (swelling).	F 880		

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F 880	Continued From page 14 R29's progress note dated 9/16/23 at 9:30 a.m., indicated R29 was moved to room 116 r/t (related to) cold symptoms and direct exposure to someone that tested positive for COVID 19. On 9/19/23 at 7:47 a.m., NA-B donned a gown, gloves, and N-95 mask and entered R29's room, without eye protection. The wall outside of R29's room two signs were posted one sign indicated contact precautions and the other sign indicated droplet precautions. The signs indicated details for PPE and included eye protection. On 9/19/23 at 8:15 a.m., NA-B stated she assumed R29 was on contact precautions and would not need to wear eye protection. No garbage was observed outside R29's room to discard dirty PPE. On 9/19/23 at 8:22 a.m., the DON confirmed R29 was on droplet precautions and confirmed staff had not worn proper PPE when protective eye wear was not worn. R14's quarterly MDS assessment dated 7/18/23, indicated no rejection of care, independent with bed mobility, transfer, locomotion and required one person physical assist with dressing and personal hygiene; diagnoses included hypertension (high blood pressure) and Alzheimer's disease. On 9/19/23 at 11:30 a.m., R14 was observed in the hallway and walked to the dining room, R14 stated he had not been asked or educated by staff to wear a mask. R14 stated would wear a mask if offered a mask. R6's quarterly MDS assessment dated 9/5/23,	F 880		

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(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 880	Continued From page 15 indicated two person physical assist with bed mobility, toilet use, and one person physical assist with personal hygiene; diagnoses included non-Alzheimer's dementia, and hemiplegia (paralysis of one side of body). On 9/20/23 at 11:34 a.m., R6 was in the dining room and was eating her meal, and stated she was not offered to wash hands and would if offered. On 9/19/23 at at 8:42 a.m., during an interview with the DON and administrator stated the residents in the facility who were in TBP precautions at the facility were in droplet precautions, and expected staff to wear proper PPE that included gown, glove, N95 mask, face shield and/or goggles. The administrator and DON stated staff were expected to discard the N95 mask when the room was exited and change into a new clean mask. The administrator and DON confirmed a garbage was not outside of residents' room who were on droplet precautions to discard the mask. R22's face sheet printed on 9/19/23, included diagnoses of hemiplegia/hemiparesis (paralysis of one side of body), tobacco use, heart failure (HF), oxygen dependence, cerebral infarction (stroke), and type 2 diabetes mellitus (DM)-abnormal blood sugars). R22's annual MDS assessment dated 7/19/23, indicated R22 had intact cognition, could be understood, and could understand others. R22's current care plan, printed on 9/19/23, did not include precautions for Covid-19, nor if R22 had been assessed for the ability to wear a mask.	F 880		

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 _____	C 09/21/2023

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

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F 880	Continued From page 16 During an observation and interview on 9/18/23 at 12:32 p.m., R22 indicated he came out of room for meals, occasionally to participate in activities, and to go outside to smoke cigarettes. R22 stated he was not exhibiting any signs or symptoms (s/s) of Covid-19 at time, was aware of other residents on unit positive for Covid-19. R22 indicated had not been offered face mask when out of room in common areas, would wear face mask if had to, but preferred not to, but had not been offered face mask per staff. R25's face sheet, printed on 9/20/23 included diagnoses of heart failure (HF), kidney disease, chronic obstructive pulmonary disease (COPD)-lung disease), and history of Covid-19 10/20. R25's quarterly MDS assessment, dated 8/31/23, indicated R25 was cognitively intact, could be understood and could understand others. R25's current care plan, printed on 9/20/23, did not include precautions for Covid-19, nor if R25 had been assessed for the ability to wear a mask. During observation and interview on 9/18/23 at 1:02 p.m., R25 indicated she came out of room for meals and to participate in activities, stated she was not exhibiting any s/s of Covid-19 at time, was aware of other residents on unit positive for Covid-19, indicated had not been offered face mask when out of room in common areas, would wear face mask if offered. Later in survey, on 9/19/23, R25 tested positive for Covid-19 and was isolated to room. R37's admission MDS assessment, dated 6/27/23, indicated R37 had intact cognition, could	F 880		

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	245362	A. BUILDING _____ B. WING _____	C 09/21/2023

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MAPLETON COMMUNITY HOME	301 TROENDLE STREET SW MAPLETON, MN 56065

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F 880	Continued From page 17 be understood and understands others, and required extensive assist of 1 staff for personal hygiene cares. MDS assessment included diagnoses of HF, renal insufficiency, arthritis (joint inflammation), and anxiety. During an observation and interview on 9/20/23 at 7:34 a.m., R37 was observed sitting at a dining table, no hand sanitizer/wipes present to any dining tables in dining room. R37 indicated dining staff do not offer hand sanitizer/wipes before meals, nursing staff occasionally encouraged residents to wash hands prior to meals, typically only after toileting cares would nursing staff encourage/assist with handwashing. R37 stated would hand sanitize if offered per staff. R8's quarterly MDS assessment, dated 8/8/23, indicated R8 had moderately impaired cognition, could be understood and understands others, and was dependent upon staff for personal hygiene cares. MDS assessment included diagnoses of dementia, seizures, anxiety, bipolar disorder (mental disorder), and schizophrenia (mental disorder). While observed and interviewed on 9/20/23 at 11:25 a.m., NA-F was noted to push R8 in wheelchair from 200-unit activity room to dining room. NA-F set R8 at dining table, NA-F placed a clothing protector on R8, NA-F walked away from R8 at table. The table R8 was sitting at had no hand sanitizer/wipes available, R8 stated would hand sanitize if offered per staff. During an interview on 9/20/23 at 11:27 a.m., NA-F indicated had brought R8 directly from 200-unit activity room to dining table. NA-F confirmed did not offer R8 hand hygiene prior to	F 880		

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F 880	Continued From page 18 meal, stated typically only offers/assists residents with hand hygiene after toileting cares. NA-F indicated dining tables used to have hand sanitizer/wipes available for resident hand hygiene prior to meals, no longer available and unsure why, stated hand sanitizer/wipes should be reimplemented. While interviewed, on 9/20/23 at 12:01 p.m., the DON indicated it was her expectation for staff to offer/assist residents with hand hygiene needs, especially after toileting and prior to meals. The DON indicated hand hygiene in dining rooms was one of current performance improvement project (PIP) and quality assurance performance improvement (QUAPI) plans, stated trying to find safest product to use for resident hand hygiene prior to implementing, was continuing to work on plan. When interviewed on 9/21/23 at 10:10 a.m., the DON confirmed providing education and masking of residents during an outbreak was expected of staff. The facility Infection Prevention and Control Manual- Interim policy for Suspected or Confirmed Coronavirus (Covid-19) undated, indicated policy of this facility to minimize exposures to respiratory pathogens, promptly identify residents or healthcare personnel with signs or symptoms of Covid-19 and implement interventions based upon Federal/State/Local recommendations to prevent and/or mitigate the spread of Covid-19; consisted of hand hygiene using alcohol based hand sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE including gloves- ensure ABHR is accessible in all	F 880		

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 _____	C 09/21/2023

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F 880	Continued From page 19 resident-care areas including inside and outside resident rooms. The facility Infection Prevention and Control Manual- Standard Precautions- Hand Hygiene policy dated 2019, indicated appropriate hand hygiene is essential in preventing transmission of infectious agents. Purpose: to cleanse hands to prevent the spread of potentially deadly infections, to provide a clean and healthy environment for residents/staff/visitors, to reduce the risk to the healthcare provider of colonization or infections acquired from a resident. Hand hygiene (HH) (e.g., hand washing and/or alcohol based hand rub (ABHR)) should be completed when hands are visibly soiled, after caring for a resident with known or suspected infections during an outbreak, before eating, and after using the restroom. The facility educational sign per CDC recommendations, Use of Personal Protective Equipment (PPE) when Caring for Patients with Confirmed or Suspected Covid-19 dated 6/3/20, indicated before caring for patients with confirmed or suspected Covid-19, healthcare personnel (HCP) must: receive comprehensive training on when and what PPE is necessary, how to don and doff PPE, limitations of PPE, proper care, maintenance, and disposal of PPE; must demonstrate competency in performing appropriate infection control practices and procedures; doffing method: Remove gloves, remove gown and dispose in trash receptacle; HCP may now exit patient room, perform hand hygiene, remove face shield or goggles, remove and discard respirator- do not touch the front of respirator, perform hand hygiene, put on new	F 880		

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F 880	Continued From page 20 mask.	F 880		

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 _____	**09/21/2023**

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

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 09/21/2023. At the time of this survey, Mapleton Community Home was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Buildingg 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 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	K 000		

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

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

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 _____	**09/21/2023**

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K 000	Continued From page 1 one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and resident rooms, that is monitored for automatic fire department notification. The facility has a capacity of 60 beds and had a census of 49 at the time of the survey.	K 000		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2023

Administrator
Mapleton Community Home
301 Troendle Street Sw
Mapleton, MN 56065

Re: State Nursing Home Licensing Orders
Event ID: VZ1611

Dear Administrator:

The above facility was surveyed on September 18, 2023 through September 21, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement 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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	C 09/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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: On 9/18/23-9/21/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H5362033C (MN00076984), H53623001C (MN00092604), H53625524C (MN00095113), and H53627778C (MN00090325/MN00090343) and NO licensing orders were issued. 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. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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. 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. 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
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	2 830		10/17/23

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2 830	Continued From page 3 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 monitor ongoing safe smoking practices, and failed to provide an environment and assistive smoking devices to prevent accidents for 1 of 1 resident (R22) reviewed for smoking. Findings include: R22's annual Minimum Data Set (MDS) assessment dated 7/19/23, indicated R22 had intact cognition, displayed no behaviors, required extensive assist of 2 staff with transfers, extensive assist of 1 staff for locomotion on/off unit, had impairment of both lower extremities and left upper extremity, used a wheelchair for mobility, and was a tobacco user. R22's face sheet printed on 9/19/23, indicated diagnoses including hemiplegia/hemiparesis (paralysis of one side of body), tobacco use, heart failure (HF), nuclear cataracts (cloudy vision), anxiety, oxygen dependence, morbid obesity, reduced mobility, major depressive disorder (mood disorder), cerebral infarction (stroke), and type 2 diabetes mellitus (DM)-abnormal blood sugars).	2 830	Corrected	

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2 830	Continued From page 4 R22's order summary report printed on 9/19/23, indicated orders for no smoking until off oxygen- if resident refuses, remove oxygen 15 minutes before going outside and document refusal. R22's care plan printed on 9/19/23, indicated R22 was a vulnerable adult, would not be able to remove self from harm, was a current smoker, had impaired vision, used supplemental oxygen, was not able to walk- could move wheelchair independently using right leg. Interventions for R22 included for staff to ensure removal of oxygen 15 minutes prior to R22 smoking for safety, ensure R22 wore a smoking apron when outside smoking, and complete smoking safety evaluation yearly and as needed (PRN). R22's smoking assessment completed on 8/9/23, indicated R22 did not have a visual deficit or dexterity problem, smoked 10+ cigarettes per day during morning/afternoon/evening hours, could light own cigarette, needed adaptive equipment- smoking apron while smoking, and plan of care used to assure resident safe while smoking. During an interview on 9/18/23 at 12:32 p.m., R22 indicated he was a smoker, needed to go to nursing station to get cigarettes and lighter when wanting to smoke as nursing staff kept cigarettes and lighter in a locked area, stated he is independent of smoking, and had not had any smoking accidents since facility admission. R22 indicated for smoking safety, he takes off supplemental oxygen 30 minutes before smoking and wears an apron during smoking activity. While observed and interviewed on 9/19/23 at 9:08 a.m., R22 was sitting in his wheelchair at a table outside near facility's front entrance	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	C 09/21/2023

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2 830	Continued From page 5 smoking a cigarette, smoking apron observed to be in place at time. While smoking, R22 was visualized flicking ashes from cigarette onto cement ground, as no ashtray was present at table, smoking receptacle was across from R22, approximately 25 ft away. A piece of Kleenex tissue was lying on cement ground next to right back wheel of R22's wheelchair, small amount of cigarette ashes covering top of Kleenex tissue. When R22 was finished smoking cigarette, he rolled cigarette, just under burning tip of cigarette, with first and second fingers of right hand back and forth until the burned tip of ash dropped onto cement, extinguishing cigarette. R22 then folded cigarette butt with right hand and laid on top of plastic table sitting at. R22 observed to sit in wheelchair at table for a few minutes, picked up cigarette butt lying on top of plastic table, and propelled self in wheelchair using right foot over to smoking receptacle, placed cigarette butt into receptacle container, then propelled self into facility entrance door. Cigarette ashes and Kleenex tissue left remaining on cement ground. During an interview on 9/19/23 at 9:34 a.m., trained medical assistant (TMA)-B, also known as nursing assistant (NA), indicated awareness R22 was independent of smoking, had to take oxygen off prior to smoking, needed to wear a smoking apron during smoking activity. TMA-B indicated awareness of smoking receptacle outside near front of facility entrance, was unaware of any smoking assistive devices at table outside of front facility entrance door. TMA-B stated was unaware of R22 extinguishing burning cigarettes with his fingers due to no ash tray available at table, indicated residents' safety to smoke independently and smoking assistive device needs was managed by social services (SS) or the director of nursing (DON).	2 830		

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2 830	Continued From page 6 While interviewed on 9/19/23 at 9:37 a.m., SS-A indicated residents' safety to smoke independently was determined based on smoking safety assessments completed by charge nurse on each unit, any changes in residents' smoking safety assessment should be brought to the DON's attention, as SS-A stated she does not assist in management of smoking safety process. During an interview on 9/19/23 at 9:42 a.m., the DON indicated residents' smoking assessments could be completed by charge nurse on resident unit, activities coordinator, and SS. The DON indicated R22 was safe with smoking independently, just recently had a smoking assessment completed, no changes to his ability to smoke safely and independently. The DON stated unawareness if ash trays were available at table outside of facility's front entrance for residents to smoke at, stated there was a smoking receptacle within area. The DON initially indicated if residents were smoking at table outside of facility's front entrance, it was acceptable for residents to flick cigarette ashes on cement ground if ash tray was not available, later DON confirmed during interview debris lying on cement ground could potentially cause an accidental fire if cigarette ashes encountered, and stated residents should be using an ash tray or smoking receptacle when smoking. The DON indicated unawareness no ash tray available at table outside front building entrance,and R22 was extinguishing burning cigarettes with his fingers. The DON confirmed R22's extinguishing a burning cigarette with his fingers posed a risk for injury. The DON stated a smoking safety reassessment would be completed with R22 to determine his ability to smoke safely unsupervised, and would discuss with	2 830		

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2 830	Continued From page 7 administrator implementation of covered ash trays to be placed at table outside front facility entrance to allow residents to smoke at and prevent accidents from occurring. The facility Mapleton Community Home Smoking Policy dated 5/23, indicated designated smoking area is located outside the building by the main entrance, smoking evaluation must be completed by the charge nurse prior to resident smoking, smoking privileges may be revoked for resident safety at the discretion of Mapleton Community Home. Facility policy for accidents/hazards was requested, not received. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure residents who smoke, not on the smoke-free campus, are supervised appropriately for safety. The administrator or designee should also ensure residents are supplied with an appropriate smoking receptacle to discard cigarettes. The facility should re-educate all staff identified to policies and procedures, and audit residents who smoke to determine safety and supervision occurred. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the	2 920		10/19/23

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2 920	Continued From page 8 comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure activities of daily living (ADLs) were provided, including shaving for 1 of 4 residents (R4) reviewed, who needed staff assistance to maintain good personal hygiene. Findings include: R4's quarterly Minimum Data Set (MDS) assessment, dated 7/5/23, indicated R4 had severely impaired cognition and was visually impaired, required extensive assistance from 1 staff for personal hygiene needs. R4's care plan, printed on 9/21/23; indicated R4 had ADL self care performance deficit related to dementia (brain disorder causing impaired memory/thought process) and required 1 staff to assist with personal hygiene needs. During an observation, on 9/18/23 at 1:45 p.m., R4 was observed to have short, white, stiff facial hairs, approximately 0.5 centimeters (cm) in length; present to chin and surrounding sides of upper lip. While interviewed, on 9/18/23 at 1:53 p.m., R4's family member (FM)-C indicated R4 always liked to appear neat and well-groomed, did not like	2 920	Corrected	

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2 920	Continued From page 9 longer facial hairs present. FM-C noticed occasionally when visiting R4 presence of facial hairs to chin and lips, FM-C would assist R4 with shaving cares to remove unwanted facial hairs. During an observation and interview, on 9/19/23 at 11:37 a.m., trained medical assistant (TMA)-B, also known as nursing assistant (NA), noted presence of facial hair to R4's chin and lips. TMA indicated awareness R4 did not like facial hair present and required staff assistance with shaving to maintain good personal hygiene. TMA-B stated R4 had a bath earlier in morning, and indicated staff should have noticed longer facial hair to R4's chin and lips, and removed facial hair. While interviewed, on 9/19/23 at 12:39 p.m., the director of nursing (DON) indicated R4 needed staff assistance for personal hygiene needs, including shaving. The DON stated residents could be provided shaving cares anytime, and indicated it was her expectation for staff to be removing resident's facial hair anytime noted or per resident request when providing daily routine cares. The facility ADL Performance Policy undated, indicated ADLs will be completed by nursing staff as directed by the individual care plan. ADLs will be completed in the AM and PM and as needed throughout the day, dependent on resident needs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate responsible staff to provide personal hygiene care to residents' dependant on facility staff, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of dependent resident cares to	2 920		

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2 920	Continued From page 10 ensure their personal hygiene needs are met consistently. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		10/19/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21390	Continued From page 11 This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines to prevent the spread of Covid-19, when during a Covid-19 outbreak, residents and visitors were observed not wearing appropriate personal protective equipment (PPE), specifically masks, for 9 of 41 resident (R2, R5, R8, R10, R14, R22, R24, R25, R35) not in transmission based precautions (TBP). In addition, the facility failed to offer hand-hygiene prior to meals for 4 of 4 residents (R2, R6, R8, R37). Lastly, the facility failed to ensure staff wore wear proper PPE specifically eye protection, when entering the room for 1 of 6 residents (R29) on TPB. This had the potential to affect all 47 residents who resided in the facility. Findings include: Upon survey entrance, on 9/18/23 at 11:30 a.m., observed signs to front doorway entrance indicating masks recommended due to positive Covid-19 as of 9/15/23. Staff noted wearing face masks at front desk, several unknown residents across from front desk in day room without face masks During an observation and interview on 9/18/23 at 4:02 p.m., noted hand sanitizer had not been immediately available outside resident rooms who were in TBP for Covid-19. The director of nursing (DON) stated the facility had made a conscious decision about that and staff were to use the hand sanitizer dispensers on the walls. The DON stated this was to prevent visitors from taking the	21390	Corrected	

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21390	Continued From page 12 bottles of hand sanitizer and was a safety measure for residents with dementia. In a hallway of 13 resident rooms, on OW (Old Wing), only 5 hand sanitizer dispensers were mounted on the wall and available to staff. There were no hand sanitizer dispensers in resident room. During an observation and interview on 9/18/23 at 5:19 p.m., observed a male visitor enter the facility without a mask. Nursing assistant (NA)-E stated visitors did not need to wear a mask. The visitor got further into the building and the DON informed him he needed a mask. The visitor returned to the vestibule of the main entrance and donned a mask. R10's facesheet printed on 9/21/23, included diagnoses of end stage renal disease, diabetes, and dementia. R10's significant change Minimum Data Set (MDS) assessment dated 7/14/23, indicated R10 was cognitively intact; could be understood and could understand others. R10's current care plan with last care plan review date of 8/16/23, did not include precautions for Covid-19, nor if R10 had been assessed for the ability to wear a mask. During an observation on 9/19/23 at 8:55 a.m., R10 was observed with no mask, waiting in a wheelchair next to the nurses station for transportation to dialysis. During an interview on 9/19/23 at 9:02 a.m., R10 had been outside waiting for transportation. R10 stated he had been aware there were residents in the facility who had Covid-19 but no one had informed him he should wear a mask. R10 stated	21390		

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21390	Continued From page 13 he would wear a mask if asked to. During an observation and interview on 9/19/23 at 9:35 a.m., (NA)-F stated she had not been cleaning her hands immediately when exiting the rooms of residents in TBP for Covid-19. NA-F admitted there had been no hand sanitizer directly outside the room for staff to utilize. NA-F stated staff had to walk to the hand sanitizer dispensers mounted intermittently on the corridor walls, which were approximately 10-12 feet from resident rooms. R24's facesheet printed on 9/21/23, included diagnoses of dementia, asthma, and chronic kidney disease. R24's significant change MDS assessment dated 7/29/23, indicated moderately impaired cognition; could be understood and could understand others. R24's current care plan with last care plan review date of 8/16/23, did not include precautions for Covid-19, nor if R24 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 11:00 a.m., activity aide (AA)-A escorted unmasked R24 from his room on the old wing through the facility to the activity room on the new wing. AA-A was aware the facility was in Covid-19 outbreak, adding "I was told it was their decision if they wanted to wear them [mask]." AA-A stated she did not ask or encourage R24 to wear a mask and thought he could make a decision to wear a mask if asked. R2's facesheet printed on 9/21/23, included diagnosis of Parkinson's disease.	21390		

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21390	Continued From page 14 R2's significant change MDS assessment dated 6/15/23, indicated R2 had moderately impaired cognition; could be understood and could understand others. R2's current care plan with last care plan review date of 5/17/23, did not include precautions for Covid-19, nor if R2 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 11:30 a.m., trained medication aide (TMA)-A was observed escorting R2 via wheelchair from his room to the dining room without a mask. TMA-A stated she was aware of the Covid-19 outbreak, and stated residents did not need to wear masks outside of their room; they could if they wanted to. On 9/20/23 at 11:20 a.m., NA-D entered R2's room and assisted R2 from his recliner to stand. R2 used a walker and NA-D walked behind R2 in the hallway to the dining room R2 entered the dining room and was assisted by NA-D and seated in his wheelchair at the dining table. R2 was not offered a mask or offered to wash hands prior to exiting his room. On 9/20/23 at 11:25 a.m., NA-D confirmed the facility was in outbreak status and stated residents were not required to wear masks, but should wear a mask. NA-D confirmed R2 was not offered a mask. On 9/20/23 at 11:33 a.m., R2 was seated in a wheelchair in the dining room. R2 stated he was not offered to wash his hands prior to the meal and stated he would wash his hands when offered. R2 stated was not offered a mask would not wear a mask if not required.	21390		

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21390	Continued From page 15 On 9/20/23 at 12:57 p.m., NA-D confirmed R2 was not offered to wash hand prior to dining and residents were expected to have hand hygiene prior to meals. R5's facesheet printed on 9/21/23, included diagnosis of cerebral vascular disease (a condition that affects blood flow to the brain). R5's annual MDS assessment dated 6/19/23, indicated moderately impaired cognition, could be understood, and could understand others. R5's current care plan with last care plan review date of 4/12/23, did not include precautions for Covid-19, nor if R5 had been assessed for the ability to wear a mask. During an observation and interview on 9/19/23 at 12:12 p.m., R5 was observed self-propelling in her wheelchair from the dining room to her room without a mask. In her room, R5 stated she was unaware anyone in the facility had Covid-19, and stated staff had not asked or encouraged her to wear a mask. R5 stated if they would have, she would wear a mask. R29's quarterly MDS assessment dated 6/12/23, indicated R29 was severely cognitively impaired, no rejection of care, required one person physical assist with dressing and personal hygiene, diagnoses included heart failure, Non-Alzheimer's Dementia, and localized edema (swelling). R29's progress note dated 9/16/23 at 9:30 a.m., indicated R29 was moved to room 116 r/t (related to) cold symptoms and direct exposure to someone that tested positive for COVID 19. On 9/19/23 at 7:47 a.m., NA-B donned a gown,	21390		

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21390	Continued From page 16 gloves, and N-95 mask and entered R29's room, without eye protection. The wall outside of R29's room two signs were posted one sign indicated contact precautions and the other sign indicated droplet precautions. The signs indicated details for PPE and included eye protection. On 9/19/23 at 8:15 a.m., NA-B stated she assumed R29 was on contact precautions and would not need to wear eye protection. No garbage was observed outside R29's room to discard dirty PPE. On 9/19/23 at 8:22 a.m., the DON confirmed R29 was on droplet precautions and confirmed staff had not worn proper PPE when protective eye wear was not worn. R14's quarterly MDS assessment dated 7/18/23, indicated no rejection of care, independent with bed mobility, transfer, locomotion and required one person physical assist with dressing and personal hygiene; diagnoses included hypertension (high blood pressure) and Alzheimer's disease. On 9/19/23 at 11:30 a.m., R14 was observed in the hallway and walked to the dining room, R14 stated he had not been asked or educated by staff to wear a mask. R14 stated would wear a mask if offered a mask. R6's quarterly MDS assessment dated 9/5/23, indicated two person physical assist with bed mobility, toilet use, and one person physical assist with personal hygiene; diagnoses included non-Alzheimer's dementia, and hemiplegia (paralysis of one side of body). On 9/20/23 at 11:34 a.m., R6 was in the dining	21390		

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21390	Continued From page 17 room and was eating her meal, and stated she was not offered to wash hands and would if offered. On 9/19/23 at at 8:42 a.m., during an interview with the DON and administrator stated the residents in the facility who were in TBP precautions at the facility were in droplet precautions, and expected staff to wear proper PPE that included gown, glove, N95 mask, face shield and/or goggles. The administrator and DON stated staff were expected to discard the N95 mask when the room was exited and change into a new clean mask. The administrator and DON confirmed a garbage was not outside of residents' room who were on droplet precautions to discard the mask. R22's face sheet printed on 9/19/23, included diagnoses of hemiplegia/hemiparesis (paralysis of one side of body), tobacco use, heart failure (HF), oxygen dependence, cerebral infarction (stroke), and type 2 diabetes mellitus (DM)-abnormal blood sugars). R22's annual MDS assessment dated 7/19/23, indicated R22 had intact cognition, could be understood, and could understand others. R22's current care plan, printed on 9/19/23, did not include precautions for Covid-19, nor if R22 had been assessed for the ability to wear a mask. During an observation and interview on 9/18/23 at 12:32 p.m., R22 indicated he came out of room for meals, occasionally to participate in activities, and to go outside to smoke cigarettes. R22 stated he was not exhibiting any signs or symptoms (s/s) of Covid-19 at time, was aware of other residents on unit positive for Covid-19. R22	21390		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00037	A. BUILDING: _____ B. WING _____	C 09/21/2023

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

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21390	Continued From page 18 indicated had not been offered face mask when out of room in common areas, would wear face mask if had to, but preferred not to, but had not been offered face mask per staff. R25's face sheet, printed on 9/20/23 included diagnoses of heart failure (HF), kidney disease, chronic obstructive pulmonary disease (COPD)-lung disease), and history of Covid-19 10/20. R25's quarterly MDS assessment, dated 8/31/23, indicated R25 was cognitively intact, could be understood and could understand others. R25's current care plan, printed on 9/20/23, did not include precautions for Covid-19, nor if R25 had been assessed for the ability to wear a mask. During observation and interview on 9/18/23 at 1:02 p.m., R25 indicated she came out of room for meals and to participate in activities, stated she was not exhibiting any s/s of Covid-19 at time, was aware of other residents on unit positive for Covid-19, indicated had not been offered face mask when out of room in common areas, would wear face mask if offered. Later in survey, on 9/19/23, R25 tested positive for Covid-19 and was isolated to room. R37's admission MDS assessment, dated 6/27/23, indicated R37 had intact cognition, could be understood and understands others, and required extensive assist of 1 staff for personal hygiene cares. MDS assessment included diagnoses of HF, renal insufficiency, arthritis (joint inflammation), and anxiety. During an observation and interview on 9/20/23 at 7:34 a.m., R37 was observed sitting at a dining	21390		

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	00037	A. BUILDING: _____ B. WING _____	C 09/21/2023

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MAPLETON COMMUNITY HOME	301 TROENDLE STREET SW MAPLETON, MN 56065

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21390	Continued From page 19 table, no hand sanitizer/wipes present to any dining tables in dining room. R37 indicated dining staff do not offer hand sanitizer/wipes before meals, nursing staff occasionally encouraged residents to wash hands prior to meals, typically only after toileting cares would nursing staff encourage/assist with handwashing. R37 stated would hand sanitize if offered per staff. R8's quarterly MDS assessment, dated 8/8/23, indicated R8 had moderately impaired cognition, could be understood and understands others, and was dependent upon staff for personal hygiene cares. MDS assessment included diagnoses of dementia, seizures, anxiety, bipolar disorder (mental disorder), and schizophrenia (mental disorder). While observed and interviewed on 9/20/23 at 11:25 a.m., NA-F was noted to push R8 in wheelchair from 200-unit activity room to dining room. NA-F set R8 at dining table, NA-F placed a clothing protector on R8, NA-F walked away from R8 at table. The table R8 was sitting at had no hand sanitizer/wipes available, R8 stated would hand sanitize if offered per staff. During an interview on 9/20/23 at 11:27 a.m., NA-F indicated had brought R8 directly from 200-unit activity room to dining table. NA-F confirmed did not offer R8 hand hygiene prior to meal, stated typically only offers/assists residents with hand hygiene after toileting cares. NA-F indicated dining tables used to have hand sanitizer/wipes available for resident hand hygiene prior to meals, no longer available and unsure why, stated hand sanitizer/wipes should be reimplemented. While interviewed, on 9/20/23 at 12:01 p.m., the	21390		

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21390	Continued From page 20 DON indicated it was her expectation for staff to offer/assist residents with hand hygiene needs, especially after toileting and prior to meals. The DON indicated hand hygiene in dining rooms was one of current performance improvement project (PIP) and quality assurance performance improvement (QUAPI) plans, stated trying to find safest product to use for resident hand hygiene prior to implementing, was continuing to work on plan. When interviewed on 9/21/23 at 10:10 a.m., the DON confirmed providing education and masking of residents during an outbreak was expected of staff. The facility Infection Prevention and Control Manual- Interim policy for Suspected or Confirmed Coronavirus (Covid-19) undated, indicated policy of this facility to minimize exposures to respiratory pathogens, promptly identify residents or healthcare personnel with signs or symptoms of Covid-19 and implement interventions based upon Federal/State/Local recommendations to prevent and/or mitigate the spread of Covid-19; consisted of hand hygiene using alcohol based hand sanitizer before and after all patient contact, contact with infectious material and before and after removal of PPE including gloves- ensure ABHR is accessible in all resident-care areas including inside and outside resident rooms. The facility Infection Prevention and Control Manual- Standard Precautions- Hand Hygiene policy dated 2019, indicated appropriate hand hygiene is essential in preventing transmission of infectious agents. Purpose: to cleanse hands to prevent the spread of potentially deadly infections, to provide a clean	21390		

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21390	Continued From page 21 and healthy environment for residents/staff/visitors, to reduce the risk to the healthcare provider of colonization or infections acquired from a resident. Hand hygiene (HH) (e.g., hand washing and/or alcohol based hand rub (ABHR)) should be completed when hands are visibly soiled, after caring for a resident with known or suspected infections during an outbreak, before eating, and after using the restroom. The facility educational sign per CDC recommendations, Use of Personal Protective Equipment (PPE) when Caring for Patients with Confirmed or Suspected Covid-19 dated 6/3/20, indicated before caring for patients with confirmed or suspected Covid-19, healthcare personnel (HCP) must: receive comprehensive training on when and what PPE is necessary, how to don and doff PPE, limitations of PPE, proper care, maintenance, and disposal of PPE; must demonstrate competency in performing appropriate infection control practices and procedures; doffing method: Remove gloves, remove gown and dispose in trash receptacle; HCP may now exit patient room, perform hand hygiene, remove face shield or goggles, remove and discard respirator- do not touch the front of respirator, perform hand hygiene, put on new mask. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee could re-educate staff on appropriate Infection Control practices for Standard and Transmission Based Precautions (TBP) to ensure proper use of personal protective equipment (PPE), acceptable donning/doffing areas for PPE, appropriate resident/staff testing locations, residents offered masks while in common areas, resident hand	21390		

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21390	Continued From page 22 hygiene assistance provided during dining in order to mitigate COVID-19 transmission during outbreak. The DON or designee could perform periodic audits to ensure staff adherence, results of those audits could be taken to the Quality Assurance and Performance Improvement (QAPI) committeeto determine compliance and need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21390		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 16, 2023

Administrator
Mapleton Community Home
301 Troendle Street Sw
Mapleton, MN 56065

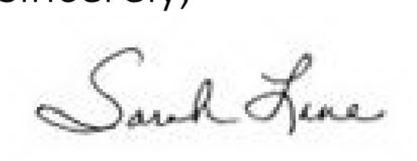
RE: CCN: 245362
Cycle Start Date: September 21, 2023

Dear Administrator:

On November 2, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

November 16, 2023

Administrator
Mapleton Community Home
301 Troendle Street Sw
Mapleton, MN 56065

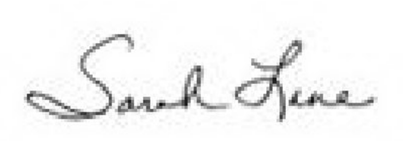
Re: Reinspection Results
Event ID: VZ1612

Dear Administrator:

On November 2, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on September 21, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
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