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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W6GV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00396

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245570**

2. STATE VENDOR OR MEDICAID NO. (L2) **235842500**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **09/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **54** (L18)

13.Total Certified Beds **54** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date : Kathryn Serie, Unit Supervisor 10/26/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 11/2/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **08/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245570

October 26, 2017

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

Dear Mr. Swanson:

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

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

Effective September 26, 2017 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 26, 2017

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

RE: Project Number S5570027

Dear Mr. Swanson:

On August 30, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on August 17, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On September 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on October 24, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 17, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of September 26, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 17, 2017, effective September 26, 2017 and therefore remedies outlined in our letter to you dated August 30, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: W6GV

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(L4) **400 SEVENTH STREET**
(L5) **FULDA, MN** (L6) **56131**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **08/17/2017** (L34)

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

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

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

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

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

* Code: **B** (L12)

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18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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17. SURVEYOR SIGNATURE Date : 09/18/2017 (L19)
Nicole Osterloh, HFE NE IL

18. STATE SURVEY AGENCY APPROVAL Date: 09/22/2017 (L20)
Kamala Fiske-Downing, Health Program Representative

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

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

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25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
August 30, 2017

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

RE: Project Number S5570027

Dear Mr. Swanson:

On August 17, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by September 26, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by November 17, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by February 17, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	08/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On August 14, 15, 16 and 17th, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 309		9/26/17

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

Electronically Signed | 09/05/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	08/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 1 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R60) who received hospice services. Findings include: R60 was admitted to hospice services on 8/11/17, following an exacerbation of shortness of breath (SOB) and blood oxygen saturation levels recorded as 70% (normal saturation levels-94-99% on room air). The admission Minimum Data Set (MDS) assessment dated 7/4/17, identified a Brief Interview of Mental Status (BIMS) of 15, indicating intact cognition. The activities of daily living (ADLs) section identified that R60 required extensive assistance with bed	F 309	Action Plan: The Hospice Provider was contacted and the Hospice Plan of Care for Resident R60 was received and communicated to staff on 8/15. All other hospice resident charts were reviewed to see that they had current plans of care. Measures: A hospice admission protocol and checklist will be developed and used whenever a resident is admitted to hospice, to assure they have provided and we have obtained all necessary information. Staff will be trained on the	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	08/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 2 mobility, dressing and toileting. Review of R60's most recent undated facility care plan did not identify any hospice/palliative care interventions and/or services. No hospice care plan/communication or documentation regarding provision of hospice services was provided on the date of admission to hospice on 8/11/17. The facility care plan indicated R60 had diagnoses of lung nodules highly suspicious for cancer and included interventions as noted: at risk for SOB prefers to have head of bed (HOB) elevated at night and requests to use oxygen (O 2) at night, medications as ordered and adjust for provision of ADLs to compensate for changing abilities. When interviewed on 8/15/17, at 1:05 p.m. licensed practical nurse (LPN)-A stated that R60 was admitted to hospice on Friday 8/11/17. She explained due to a sudden decline in status, a quick/emergency admission occurred after the physician was updated. When given the option for emergency services vs. hospice, R60 and the family requested an immediate hospice admission (8/11/17). The blue hospice provider binder was reviewed with LPN-A and no information/documentation was available related to hospice services for R60 since admission. During a subsequent interview on 8/15/17, at 1:47 p.m. LPN-A indicated she would have expected communication/documentation to be available in the blue hospice binder. LPN-A verified the facility had not yet received any hospice documentation for R60 and further stated her primary concern was lack of comfort orders from the hospice nurse. When interviewed on 8/15/17, at 1:49 p.m. the	F 309	process. Monitoring: The Care Coordinator for the resident will audit hospice charts upon admission to hospice to assure documentation has been obtained. Director of Nursing is responsible and will report to QA on compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	08/17/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3	F 309		

director of nursing (DON) verified the hospice binder lacked any information from hospice. The only document the DON had available from the admitting hospice nurse was an admission note. No further documentation and/or communication had occurred between the hospice nurse and the facility staff since the time of admission. After requesting further information, the DON followed up with the case manager and subsequent communication with the hospice provider. On 8/15/17, at 2:10 p.m. the facility staff received a copy of the hospice plan of care which identified the service plan, medications and comfort measures.

The hospice plan of care received via fax on 8/15/17, at 2:10 p.m. identified the following information: On 8/11/17, R60 was sitting in his chair alert and oriented with a respiratory rate of 44 (normal range 12-20 breaths/minute) using accessory muscles and unable to complete a sentence without stopping to catch his breath. Oxygen was in place at 3 liters (L) via nasal cannula. R60 completed a nebulizer treatment (breathing treatment to assist with opening airways), and his respiratory rate remained in the 40's, lung sounds were diminished with poor air exchange. In addition, R60's lower extremities had 3+ pitting edema (swelling), 1+ sacral (sacrum-base of spine) edema, mottling (patchy appearance-indicating changes in blood flow) to feet/heels, his skin was cool and pale/ashen in color with bluish hue around his lips. R60's Karnofsky (the lower the score, the worse the survival for most serious illness) score was at 40%. (Range 100%=health-0% death).

The faxed hospice plan of care included the following interventions with an initiation date of

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	245570	A. BUILDING _____ B. WING _____	08/17/2017

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F 309	Continued From page 4 8/12/17: (1) Educate/implement nutrition and hydration PRN; (2) Educate/implement bowel regime PRN; (3.) Educate/Implement on dyspnea management PRN; (4) Educate/Implement on fall prevention and safety PRN; (5) Educate/implement on pain management PRN; and (6) Educate/Implement on skin breakdown PRN. Interventions which had an indicted start date of 8/14/17, included: (1) Health Care Directive Form; (2) assess caregiver limitations; (3) assessment of social and emotional factors with visits starting 8/14/17; and (4) counseling for long-range planning and decision making. Neither the hospice plan of care which included services, education, comfort medications and services to be provided was communicated nor provided for staff review until after 8/15/17, at 2:10 p.m. The hospice RN-A (who was not the admitting nurse) was interviewed on 8/16/17, at 2:40 p.m. and explained the admission process. After the verbal order is authorized from the primary physician and the hospice nurse conducts the initial assessment, this information is shared with facility staff. RN-A indicated she was uncertain the reason the process had not been followed when R60 was admitted last Friday. Hospice RN-A concurred that communication had not occurred in verbal and/or written documentation as expected per protocol. A policy was requested from the facility related to hospice admission, hospice communication and/or timeframe's for provision of hospice documentation.	F 309		
F 456	483.90(d)(2)(e) ESSENTIAL EQUIPMENT, SAFE	F 456		9/26/17

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F 456 SS=C	Continued From page 5 OPERATING CONDITION (d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. (e) Resident Rooms Resident rooms must be designed and equipped for adequate nursing care, comfort, and privacy of residents. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to replace the stained ceiling tiles in 4 of 4 double occupancy resident rooms (Rooms-211, 212, 213, 214) where 7 residents resided (R35, R7, R45, R32, R4, R30, R30, R61) and repair the bathroom tile in 1 of 1 resident (R62) bathroom (Rm 102). Findings include: During observation on 8/14/17, at 5:42 p.m. there were 12 ceiling tiles with brown colored water spots/stains noted in room 213. One of the tiles had a notable dark black colored substance. When interviewed at this time, R35 stated the roof at the end of her wing had a leak the previous year which had been fixed; however, the ceiling tiles had never been replaced. During the walk-through and interview on 8/15/17, at 1:37 p.m. with maintenance staff (M)- A it was confirmed the roof leaked last summer and staff had never gotten around to replacing the ceiling tiles. M-A indicated being unaware of the large amount of staining on the identified ceiling tiles. It was noted that three other resident rooms (R45, R32, R4, R30, R30, R61) had stained ceiling tiles	F 456	Action Plan: Stained ceiling tile were replaced during survey. The plumbing holes were covered during survey. Measures: The Preventative Maintenance program will be revised to include a routine visual check of ceilings and walls in the facility. Maintenance staff will be instructed in the new routines. Monitoring: The Administrator is responsible and will report to the QA committee on Preventative Maintenance.	

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F 456	Continued From page 6 from the leaking roof. A total of 29 ceiling tiles located in rooms 211, 212, 213 and 214 were stained with water spots and/or a black colored substance. It was noted that R62's bathroom (room 102) had a 2 inch hole in the wall tile behind the stool and a large gaping 8-inch hole behind the plumbing pipe leading from the wall to the stool. M-A explained the toilet stool had been replaced 3-4 years ago and the tile had never been fixed. M-A agreed it would be difficult to clean the area around the plumbing fixture. When interviewed on 8/15/17, at 1:45 p.m. the administrator indicated there was no preventative maintenance policy/procedure that he was aware. He agreed the ceiling tiles needed replacing and indicated it should have occurred after the roof was fixed. He stated he was unaware of the bathroom tile holes in room 102; and agreed this should have been repaired after the toilet installation.	F 456		

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	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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MAPLE LAWN SENIOR CARE	**400 SEVENTH STREET** **FULDA, MN 56131**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Building 01 of Maple Lawn Nursing Home was found not to be 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) Standard 101 Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145 Facsimile: 651-215-0525, or	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		09/05/2017

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

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K 000	Continued From page 1	K 000		

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

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

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

2. The actual, or proposed, completion date.

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

Maple Lawn Nursing Home was constructed as follows:
The original building was constructed in 1964, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 1st Addition was constructed in 1991, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(000) construction;
The 2nd Addition was constructed in 2001, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction;
The 3rd Addition was constructed in 2004, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction.
The 4th Addition was constructed in 2004, is a activities room, a new building entrance and an

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	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/16/2017**

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MAPLE LAWN SENIOR CARE	**400 SEVENTH STREET** **FULDA, MN 56131**

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K 000	Continued From page 2 elevator, with no patient sleeping or treatment areas and is fully sprinklered. 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 has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 54 beds and had a census of 52 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 918 SS=E	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual	K 918		9/26/17

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K 918	Continued From page 3 transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This STANDARD is not met as evidenced by: Based on documentation review and interview, the Facility failed to provide complete written records of generator maintenance and testing. This deficient practice could affect 52 of 52 residents. Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918	The weekly checks were resumed by the Maintenance Assistant during survey. Maintenance was instructed in the process. The PM log for the emergency generator will be randomly audited by the Administrator to assure compliance with requirements.	

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K 918	Continued From page 4 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked and readily identifiable. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) FINDINGS INCLUDE: On facility tour between 12:00 PM and 4:00 PM on 08/16/2017, during documentation review, it was revealed that documentation could not be provided to show that the emergency generator had received a weekly inspection from 7/11/17 to 08/16/17. This deficient practice was verified by the Facility Maintenance Director.	K 918		

Electronically delivered
August 30, 2017

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

Re: State Nursing Home Licensing Orders - Project Number S5570027

Dear Mr. Swanson:

The above facility was surveyed on August 14, 2017 through August 17, 2017 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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 contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00396	A. BUILDING: _____ B. WING _____	08/17/2017

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

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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: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On August 14, 15, 16 and 17th, 2017, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302		9/7/17

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	00396	A. BUILDING: _____ B. WING _____	08/17/2017

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

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2 302	Continued From page 3 Based on record review and interview the facility failed to provide to consumers a description of the Alzheimer's/Dementia training program provided to their staff/employees. This has the potential to affect any residents with dementia residing in the facility and/or interested. consumers. Findings include: On 8/16/17, at 1:26 p.m. during interview with the quality coordinator it was verified there was no form of notification provided to the consumers and/or resident's regarding the Alzheimer's/dementia training program provided to facilty staff/employees. Both the director of nursing (DON) and administration were interviewed on 8/16/17, at 2:55 p.m. regarding provision of information to the community, residents and/or families regarding Alzheimer's/Dementia training was not provided by the facility. Both the DON and administrator verified this was not occurring. During a subsequent interview with the administrator on 8/16/17, at 3:23 p.m. it was verified the required information had not been provided. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the Alzheimer's training is provided in written or electronic form, to residents and families or other persons who request it, describing the training program and the related training it provides, including the categories of employees trained, the frequency of training, and the basic topics covered. The	2 302	Corrected	

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2 302	Continued From page 4 administrator, director of nursing, or designee could develop a system to educate staff and develop a monitoring system to ensure compliance as directed by the written plan of care. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R60) who received hospice services. Findings include:	2 830	Corrected	9/7/17

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2 830	Continued From page 5 R60 was admitted to hospice services on 8/11/17, following an exacerbation of shortness of breath (SOB) and blood oxygen saturation levels recorded as 70% (normal saturation levels-94-99% on room air). The admission Minimum Data Set (MDS) assessment dated 7/4/17, identified a Brief Interview of Mental Status (BIMS) of 15, indicating intact cognition. The activities of daily living (ADLs) section identified that R60 required extensive assistance with bed mobility, dressing and toileting. Review of R60's most recent undated facility care plan did not identify any hospice/palliative care interventions and/or services. No hospice care plan/communication or documentation regarding provision of hospice services was provided on the date of admission to hospice on 8/11/17. The facility care plan indicated R60 had diagnoses of lung nodules highly suspicious for cancer and included interventions as noted: at risk for SOB prefers to have head of bed (HOB) elevated at night and requests to use oxygen (O 2) at night, medications as ordered and adjust for provision of ADLs to compensate for changing abilities. When interviewed on 8/15/17, at 1:05 p.m. licensed practical nurse (LPN)-A stated that R60 was admitted to hospice on Friday 8/11/17, five days earlier. She explained due to a sudden decline in status, a quick/emergency admission occurred after the physician was updated. When given the option for emergency services vs. hospice, R60 and the family requested an immediate hospice admission (8/11/17). The blue hospice provider binder was reviewed with LPN-A and no information/documentation was available for R60. During a subsequent interview on 8/15/17, at 1:47	2 830		

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2 830	Continued From page 6 p.m. LPN-A indicated she would have expected communication/documentation to be available in the blue hospice binder. LPN-A verified the facility had not yet received any hospice documentation for R60 and further stated her primary concern was lack of comfort orders from the hospice nurse since admission. When interviewed on 8/15/17, at 1:49 p.m. the director of nursing (DON) verified the hospice binder lacked any information from hospice. The only document the DON had available from the admitting hospice nurse was an admission note. No further documentation and/or communication had occurred between the hospice nurse and the facility staff since the time of admission. After requesting further information, the DON followed up with the case manager and subsequent communication with the hospice provider. On 8/15/17, at 2:10 p.m. the facility staff received a copy of the hospice plan of care which identified the service plan, medications and comfort measures. The hospice plan of care received via fax on 8/15/17, at 2:10 p.m. identified the following: On 8/11/17, R60 was sitting in his chair alert and oriented with a respiratory rate of 44 (normal range 12-20 breaths/minute) using accessory muscles and unable to complete a sentence without stopping to catch his breath. Oxygen was in place at 3 liters (L) via nasal cannula. R60 completed a nebulizer treatment (breathing treatment to assist with opening airways), and his respiratory rate remained in the 40's, lung sounds were diminished with poor air exchange. In addition, R60's lower extremities had 3+ pitting edema (swelling), 1+ sacral (sacrum-base of spine) edema, mottling (patchy appearance-indicating changes in blood flow) to	2 830		

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2 830	Continued From page 7 feet/heels, his skin was cool and pale/ashen in color with bluish hue around his lips. R60's Karnofsky (the lower the score, the worse the survival for most serious illness) score was at 40%. (Range 100%=health-0% death). The hospice plan of care included the following interventions with an initiation date of 8/12/17: (1) Educate/implement nutrition and hydration PRN; (2) Educate/implement bowel regime PRN; (3.) Educate/Implement on dyspnea management PRN; (4) Educate/Implement on fall prevention and safety PRN; (5) Educate/implement on pain management PRN; and (6) Educate/Implement on skin breakdown PRN. Interventions which had an indicted start date of 8/14/17, included: (1) Health Care Directive Form; (2) assess caregiver limitations; (3) assessment of social and emotional factors with visits starting 8/14/17; and (4) counseling for long-range planning and decision making. Neither the hospice plan of care which included services, education, comfort medications and services to be provided was communicated nor provided for staff review until after 8/15/17, at 2:10 p.m. The hospice RN-A (who was not the admitting nurse) was interviewed on 8/16/17, at 2:40 p.m. and explained the admission process. After the verbal order is authorized from the primary physician and the hospice nurse conducts the initial assessment, this information is shared with facility staff. RN-A indicated she was uncertain the reason the process had not been followed when R60 was admitted last Friday. Hospice RN-A concurred that communication had not occurred in verbal and/or written documentation as expected per protocol.	2 830		

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2 830	Continued From page 8 A policy was requested from the facility related to hospice admission, hospice communication and/or timeframe's for provision of hospice documentation. SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could develop policies and procedures to ensure hospice communication/provision of care is provided on the day of admission. The director of nursing or her designee could educate all appropriate staff on these policies and procedures. The director of nursing or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to replace the stained ceiling tiles in 4 of 4 double occupancy resident rooms (Rooms-211, 212, 213, 214) where 7 residents resided (R35, R7, R45, R32, R4, R30, R30, R61) and repair the bathroom tile in 1 of 1 resident (R62) bathroom (Rm 102).	21695	Corrected	9/7/17

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21695	Continued From page 9 Findings include: During observation on 8/14/17, at 5:42 p.m. there were 12 ceiling tiles with brown colored water spots/stains noted in room 213. One of the tiles had a notable dark black colored substance. When interviewed at this time, R35 stated the roof at the end of her wing had a leak the previous year which had been fixed; however, the ceiling tiles had never been replaced. During the walk-through and interview on 8/15/17, at 1:37 p.m. with maintenance staff (M)- A it was confirmed the roof leaked last summer and staff had never gotten around to replacing the ceiling tiles. M-A indicated being unaware of the large amount of staining on the identified ceiling tiles. It was noted that three other resident rooms (R45, R32, R4, R30, R30, R61) had stained ceiling tiles from the leaking roof. A total of 29 ceiling tiles located in rooms 211, 212, 213 and 214 were stained with water spots and/or a black colored substance. It was noted that R62's bathroom (room 102) had a 2 inch hole in the wall tile behind the stool and a large gaping 8-inch hole behind the plumbing pipe leading from the wall to the stool. M-A explained the toilet stool had been replaced 3-4 years ago and the tile had never been fixed. M-A agreed it would be difficult to clean the area around the plumbing fixture. When interviewed on 8/15/17, at 1:45 p.m. the administrator indicated there was no preventative maintenance policy/procedure that he was aware. He agreed the ceiling tiles needed replacing and indicated it should have occurred after the roof was fixed. He stated he was unaware of the	21695		

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21695	Continued From page 10 bathroom tile holes in room 102; and agreed this should have been repaired after the toilet installation. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance is adequately completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		