Electronically delivered

August 4, 2020

Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, MN 56131

RE: CCN: 245570
Cycle Start Date: August 3, 2020

Dear Administrator:

On August 3, 2020, the Minnesota Department of Health 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
April 23, 2020

Administrator
Maple Lawn Senior Care
400 Seventh Street
Fulda, MN 56131

SUBJECT: SURVEY RESULTS
CCN: 245570
Cycle Start Date: Cycle Start Date: April 2, 2020

Dear Administrator:

SUSPENSION OF SURVEY AND ENFORCEMENT ACTIVITIES

The Centers for Medicare & Medicaid Services (CMS) is committed to taking critical steps to ensure America's health care facilities are prepared to respond to the threat of disease caused by the 2019 Novel Coronavirus (COVID-19). In accordance with Memorandum QSO-20-20-All, CMS is suspending certain Federal and State Survey Agency surveys, and delaying revisit surveys, for all certified provider and supplier types.

During this time, CMS is prioritizing and conducting only the following surveys: focused infection control surveys, investigations of complaints and facility-reported incidents that are triaged at the Immediate Jeopardy (IJ) level, and revisit surveys for unremoved IJ level deficiencies. With the exception of unremoved IJs, CMS will also be exercising enforcement discretion during the suspension period. For additional information on the prioritization of survey activities please visit https://www.cms.gov/files/document/qso-20-20-allpdf.pdf-0.

SURVEY RESULTS

On April 2, 2020, a survey was completed at your facility by the Minnesota Department of Health completed a COVID-19 Focused Survey at Maple Lawn Senior Care to determine if your facility was in compliance with Federal requirements related to the implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance. The findings from this survey are documented on the electronically delivered CMS 2567.

PLAN OF CORRECTION

You must submit an acceptable plan of correction (POC) for the enclosed deficiencies that were cited during the April 2, 2020 survey. Maple Lawn Senior Care may choose to delay submission of a POC until after the survey and enforcement suspensions have been lifted. The provider will have ten days

from the date the suspensions are lifted to submit a POC. An acceptable POC will serve as your allegation of compliance. Upon receipt of an acceptable POC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. Please note that if an onsite revisit is required, the revisit will be delayed until after survey and enforcement suspensions are lifted. The failure to submit an acceptable POC can lead to termination of your Medicare and Medicaid participation.

To be acceptable, a provider's POC 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; and
- The date that each deficiency will be corrected.

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

INFORMAL DISPUTE RESOLUTION

You have one opportunity to dispute the deficiencies cited on the April 2, 2020 survey through Informal Dispute Resolution (IDR) in accordance with 42 CFR § 488.331. To receive an IDR, send (1) your written request, (2) the specific deficiencies being disputed, (3) an explanation of why you are disputing those deficiencies, and (4) supporting documentation by fax or email to:

Nicole Osterloh, Unit Supervisor
Marshall District Office
Health Regulation Division
Licensing and Certification
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230 Cell: 218-340-3083
Fax: 507-537-7194

An IDR may not be used to challenge any aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution.

Maple Lawn Senior Care may choose to delay a request for an IDR until after the survey and enforcement suspensions have been lifted. The provider will have ten days from the date the suspensions are lifted to submit a request for an IDR in accordance with the instructions above.

QUALITY IMPROVEMENT ORGANIZATION (QIO) RESOURCES

The Quality Improvement Organization (QIO) Program is committed to supporting healthcare facilities in the fight to prevent and treat COVID-19 as it spreads throughout the United States. QIO resources regarding COVID-19 and infection control strategies can be found at https://qioprogram.org/. This page will continue to be updated as more information is made available. QIOs will be reaching out to Nursing Homes to provide virtual technical assistance related to infection control. QIOs per state can be found at https://qioprogram.org/locate-your-qio.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

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 _____	04/02/2020

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
E 000	Initial Comments A COVID-19 Focused Infection Control survey was conducted on 4/2/20, at your facility by the Minnesota Department of Health to determine compliance with Emergency Preparedness regulations § 483.73(b)(6). The facility was IN full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Although no plan of correction is requires, it is required that the facilty acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS A COVID-19 Focused Infection Control survey was conducted on 4/2/20 at your facility by the Minnesota Department of Health to determine compliance with §483.80 Infection Control. The facility was NOT in full compliance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Upon receipt of an acceptable electronic POC, a revisit of your facility will be conducted to validate substantial compliance with the regulations has	F 000		

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

Electronically Signed | 07/13/2020

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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F 000	Continued From page 1 been attained in accordance with your verification.	F 000		
F 880 SS=E	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; §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;	F 880		7/31/20

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F 880	Continued From page 2 (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. §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, interview, and document review, the facility failed to cancel all group activities in accordance with Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines. In addition, the facility failed to appropriately disinfect 1 of 1 multi-use resident glucometers during 1 of 1	F 880	F000 □ Initial Comments This plan of correction constitutes our written allegation of compliance for the deficiencies cited.	

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F 880	Continued From page 3 observation. Findings include: Observation on 4/2/20 at 10:10 a.m., of 4 residents (R7, R11. R12, and R13) identified they were seated within 6 feet of each other in the day room participating in an exercise activity directed by an activities aide. Following completion of the activity some of those residents remained in the day room and watched TV. Observation on 4/2/20 at 2:05 p.m., of 9 residents identified they were seated in the dining room beginning to play BINGO. 1 activity staff member was in attendance overseeing the activity who was wearing a source control mask. R8 was seated at a table in the dining room between the dish room and an open kitchen door. R8 was observed coughing. The activity director (AD) asked R8 if she would "be alright". The AD then retrieved a glass of water for her, offered R8 hand sanitizer, and resumed her preparations for the BINGO group activity. 8 other residents attended BINGO with R8: R1, R2, R3, R4, R5, R6, R7, and R9. No residents had worn any source control masks. Interview on 4/2/20 at 2:23 p.m., with registered nurse (RN)-A, the facility infection control preventionist, identified she was aware that the facility should not be having group activities per CMS guidelines. RN-A indicated the facility implemented no communal dining about a week ago. The facility had daily interdisciplinary team (IDT) meetings and they had discussed the continuation of group activities several times. RN-A stated "we are fully aware of the guidance but have chosen to continue with group activities	F 880	Submission of this plan of correction is not an admission that the deficiency exists or that it is cited accurately. This plan of correction is submitted to meet state and federal requirements. F880 – Infection Prevention & Control 1.a. Resident Out-of-Room activities were fully suspended. Absent Federal clarification or definitional guidance on what constitutes a 'group' – the facility practice was changed (at that time) to allow only one resident in the living or dining room at a time. b. The glucometer used for R10 was disinfected properly upon realization of the mistake. 2.a. All Out-of-Room activities for all residents were suspended. b. No other residents were identified to be at risk of inadequate disinfecting wipe drying times as each resident has their own individual glucometer. 3.a. Staff reviewed current guidance on group activities from CMS, professional sources, and the survey team's interpretation. After review and absent clarifying guidance from CMS, it was determined that facility Out-of-Room activities would be suspended until better guidance was provided. All staff will be trained in current communal activities' guidelines with signage and handouts by	

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F 880	Continued From page 4 to keep as much sanity as possible for our residents". Interview on 4/2/20 at 2:33 p.m., with the activity director (AD) identified the facility was continuing scheduled group activities. AD understood CMS guidelines for group activities was to be a "suggestion" from CDC and CMS. The AD identified if there were an active case of COVID-19 in the facility, then they would end group activities."We are just trying to keep it as normal as possible for our residents mental health". Interview on 4/2/20 at 2:50 p.m., with the director on nursing (DON) identified facility staff talked at IDT about what they should be doing in order to continue "as much routine as we can". The DON had communicated with other facilities and found half were still doing group activities. There was no confirmed COVID-19 cases in their county and the medical director was okay with that decision. The DON was aware of the CMS memo that indicated no communal dining or group activities were to be held but the facility chose to continue with group activities. Interview on 4/2/20 at 3:11 p.m., with the administrator (A) identified he felt the facility was in compliance with all CDC and CMS guidelines. The A felt trying to socially distance resdients while in the dining room was no different than having residents sit in their doorways to play bingo. The A confirmed he was aware of the CMS memos. Review of the April 2020, activity calendar revealed daily scheduled group activities.	F 880	July 31, 2020. The Activities Director will continue to monitor to see that group activities follow current guidelines. Activity Director is responsible and will report on compliance to the QAPI committee. b. LPN-A was counseled to only use the back-up cart glucometer in an emergency or if a resident's personal glucometer fails. LPN-A met with the RN-ICP and reviewed procedures and manufacturer's guidance on drying times for PDI disinfectant wipes. All other nursing staff who use Glucometers were re-educated on glucometer disinfection in the week following this survey. These same staff will be re-educated once again in disinfection by July 31, 2020. An instruction card regarding disinfection will also be placed with each glucometer on each med cart. DON or designee will audit the use of disinfecting wipes on glucometers for proper use weekly x/4 and then monthly x/4. DON is responsible and will report on compliance to the QAPI committee.	

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F 880	Continued From page 5 Record review of the above identified residents confirmed each had multiple comorbidities that placed them at increased risk for contraction of COVID-19. Observation, interview, and manufacturer label review on 4/2/20, at 11:55 a.m., with licensed practical nurse (LPN)-A while checking a blood glucose level for R10 identified she used the facility common use (Assure Prism) glucometer to check R10's blood sugar levels. LPN-A identified residents had individual meters stored in their rooms. Rather than utilize R10's own glucometer, she used the facility multi-resident-use glucometer for convenience. After checking R10's blood glucose level, she returned the meter to the medication cart to disinfect and store the glucometer. LPN-A retrieved a PDI Sani-Cloth Bleach (disinfectant) wipe from the cart and wiped the surface which took less than 3 seconds. She then discarded the wipe into the trash. The surface of the meter was dry within 15 seconds. LPN-A reviewed the wipe manufacturer's label and identified the wipe required a 4 minute wet contact time for disinfection. LPN-A acknowledged the surface had not remained wet for the required 4 minute disinfection time. Interview and manufacturer label review on 4/2/20 at 12:10 p.m. with the infection control preventionist (ICP) identified the manufacture's disinfection time required the surface to be wet 4 minutes for appropriate disinfection to be achieved. She agreed LPN-A should have used the resident's own glucometer. Her expectation was if staff needed to use the multi-resident-use	F 880		

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F 880	Continued From page 6 glucometer, they were to follow manufacturer's guidelines for appropriate disinfection. The policy for disinfecting multiple-resident-use items directed staff to follow manufacture's guidelines. Review of the 1/1/19, Blood Glucose Meters: Checking blood sugar identified glucose monitoring devices (glucometers) were to be cleaned with Sani-Cloth Bleach wipes or with similar product weekly. Staff were to follow manufactures contact time for disinfection. There was no mention multiple-use- items were required to be disinfected between each resident' use.	F 880		