Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 22, 2024

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

RE: CCN: 245362
Cycle Start Date: July 10, 2024

Dear Administrator:

On July 10, 2024, 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, Regional Operations 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 October 10, 2024 (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 January 10, 2025 (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
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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 07/10/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 7/8/24 through 7/10/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 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 7/8/24 to 7/10/24, 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: H53625389C (MN104618). 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 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g)	F 641		7/13/24

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

Electronically Signed | 07/30/2024

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 641	Continued From page 1 §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident status was accurately identified in the Minimum Data Set (MDS) assessment for 1 of 1 resident (R40) reviewed for hospice. Findings include: R40's, undated medical diagnoses face sheet identified she had malignant neoplasm of the colon, malignant neoplasm of the tail of the pancreas, and mild intellectual disability. R40's, 6/11/24, ... (name of local hospice agency) Hospice Open Orders identified she was on hospice services. R40's, 6/13/24, significant change Minimum Data Set (MDS) assessment identified R40 was moderately impaired section J, Prognosis: conditions or chronic diseases that may result in a life expectancy of less than 6 months was marked as yes. There was no mention of hospice services under section O. Interview on 7/10/24 at 9:42 a.m., with registered nurse (RN)-B who is the facility MDS coordinator, identified R40 was on hospice. Upon review of the significant change MDS on the PCC (Point Click Care) system online, RN-B confirmed section O was not coded accurately and would ensure to complete a modification of the data assessment.	F 641	PLAN OF CORRECTION: F0641 Accuracy of Assessments How will the corrective action be accomplished for those residents found to have been affected by the deficient practice: The MDS Coordinator completed a Modification of Significant Change on 7/13/24 for Resident R40. How the facility will identify other residents having the potential to be affected by the same deficient practice: All Residents residing in the facility could potentially be affected by this deficiency. The MDS Coordinator, or specified designee, will thoroughly review MDS for accuracy on or prior to MDS completion date, but not sooner than ARD. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur: The MDS Coordinator, or specified designee, will reference the RAI Manual for accuracy of coding in all areas. Any questions related to interpretation of the RAI Manual will be referred to the State RAI Coordinator through phone call or email. The MDS Coordinator, or specified designee, will thoroughly review documentation in the Resident□s clinical chart, reference staff	

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F 641	Continued From page 2 Interview on 7/10/24 at 10:03 a.m., with director of nursing (DON) and administrator both agreed the MDS should have been coded accurately. Review of 3/2019 MDS Accuracy Policy identified the facility would ensure to utilize the RAI Manual for accurate coding. In addition, the facility would investigate and modify coding errors found and submit them to the QIES (Quality Improvement and Evaluation) system.	F 641	interviews/assessments, and seek further guidance from Resident□s provider and/or interdisciplinary staff if any discrepancies or unclear documentation is noted. Should any item coding error be identified, a modification of MDS will be completed promptly, or within 48 hours of identification of error. The MDS Coordinator will complete RAC-CT Certification on or before November 24, 2024. How will the facility monitor its corrective actions to ensure that the deficient practice being corrected and will not recur: The facility will meet during morning report to update MDS Coordinator, or other designee, on changes in condition, updates on current Resident status, or changes to medications, treatments or plan of care. Residents will be reviewed at IDT meetings, as well. All Resident will be reviewed quarterly at QAPI meeting with Medical Director, Pharmacy, Nursing, and Administration staff, as available. The date that each deficiency will be corrected: The MDS Coordinator completed a Modification of Significant Change on 7/13/24 for Resident R40.	
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on	F 645		7/29/24

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F 645	Continued From page 3 or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual-	F 645		

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F 645	Continued From page 4 (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a pre-admission screening and resident review (PASARR) II referral was completed upon a significant change in condition for 1 of 1 resident (R16) reviewed for PASARR. Findings include: R16's, face sheet identified she had an admission date of 3/03/23, with a diagnosis of Parkinson's, dementia, and depression. R16's, 3/3/23, pre-admission screening and resident review (PASRR) identified R16 had Parkinson's and was not considered by the state to have a serious mental illness or intellectual	F 645	F645 IDT met 7/24/24 in specialized IDT meeting to review procedure and reeducation. How will the facility identify other residents having the potential to be affected by the same deficient practice? -The Social Service Director will check diagnosis following residents being seen on Dr. Rounds and with any significant changes in health to determine if any new diagnosis has been added that qualify for	

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F 645	Continued From page 5 disability or related condition. R16's, undated, current Diagnosis Report identified R16 received a new diagnosis of anxiety disorder on 6/06/23 and psychotic disorder with hallucinations on 6/06/23. R16's, 4/09/24, quarterly Minimum Data Set (MDS) assessment identified R16 had a severe cognitive impairment and no behaviors. R16 felt down, was depressed or hopeless 2 to 6 days and had taken antidepressants on a routine basis. R16's, 4/26/24, significant change (MDS) identified R16 had hallucinations, felt down, was depressed or hopeless 7 to 11 days, trouble falling or staying asleep or sleeping too much 12 to 14 days, feeling tired or having little energy 7 to 11 days, and trouble concentrating on things 12 to 14 days. Section A 1510 identified R16 had not been evaluated for Level II PASRR and did not have a serious mental illness or intellectual disability or related condition. R16's medical record lacked any indication that the State Mental Health Agency (SMHA) had been notified since the new onset of R23's mental illnesses for further evaluation and determination of need for specialized services. Interview on 7/10/24 at 9:38 a.m., with social services designee (SSD) stated the facility process was to discuss new admissions and verify completion of Level I screen but was unsure of the process for Level II screening. She agreed a Level II should have been completed for R16.	F 645	the need of a new PASRR. -Medical records have also been educated to notify the Social Service Director of any new diagnosis that may be added to any resident. -Social service director will do quarterly audits of resident diagnosis to ensure no new Mental illness diagnosis have been added. -PASRR Policy was updated on 7/24/24 to include a new process for OBRA II screening. How corrective action will be accomplished for those residents found to have been affected by the deficient practice? -Social Service Director contacted Blue Earth County Human Services on 7/29/24 to request an OBRA 11 to be completed on R16. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not reoccur? -Social Service Director will audit notes each time a resident is seen on rounds by either primary care, psychologist, psychiatry to ensure no new diagnosis is added. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur? -ADON will audit diagnosis report once weekly for 1 month, and 1 time monthly going forward to ensure no mental illness diagnoses are being missed. Mapleton Community Home Preadmission	

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F 645	Continued From page 6 Interview on 7/10/24 at 9:51 a.m., with director of nursing (DON) stated the facility had no process in place to ensure residents with a new qualifying mental illness diagnosis would receive a Level II screening. Interview on 7/10/24 at 10:10 a.m., with administrator stated the facility had no knowledge of when to determine a Level II screening would be required and have not had to complete one before. Review of undated, Mapleton Community Home Preadmission Screening policy identified required preadmission screening for all admissions admitted to a Medical-Assistance certified nursing facility. There was no mention of how the policy would refer any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition to the state mental health or intellectual disability authority for a Level II resident review.	F 645	Screening Policy "State and federal law requires preadmission screening before all admissions to Medical Assistance-certified nursing facilities." Mapleton Community Home requires a PAS (pre-admission screening) to be done through Senior Linkage Line before a resident can be admitted to its nursing facility. If the sending hospital has not completed the PAS then the Social Service Director or another staff member of Mapleton Community Home will complete the screening for the residents prior to admission. If the resident classifies as a PA1 then a level of care determination will be done as needed. PAS is completed to: " Avoid unnecessary facility admissions by identifying people whose needs might be met in the community and connecting them to community-based services. " Screen people for serious mental illness or developmental disabilities based on the requirements in the Omnibus Budget Reconciliation Act (OBRA) of 1987, also referred to as OBRA Level I screening. This screening is completed to identify and refer people to other professionals to evaluate the need for specialized mental health or developmental disability services as required under federal law. These additional activities are referred to as OBRA Level II evaluation activities;	

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F 645	Continued From page 7	F 645	" Determine and document the need for NF services in MMIS for purposes of MA payment of those services; " Identify people who can benefit from transition assistance in order to return to the community after NF admission. OBRAII " Social Service Director is responsible for tracking all Mental Illness and developmental diagnosis upon admission. " Social service director will be notified of any new Mental Illness and developmental diagnosis that are added for any residents. " Social Service Director will be responsible for running a diagnosis report monthly to ensure no new diagnosis are added.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655		7/24/24

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F 655	Continued From page 8 (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to offer/provide a summary of the baseline care plan to the resident and/or resident representative for 1 of 1 resident (R26) reviewed who were newly admitted. Findings include: R26's Admission Record printed on 7/10/24, identified an admission date of 6/17/24, with diagnoses of sepsis (infection of the blood	F 655	F655 How corrective action will be accomplished for those residents found to have been affected by deficient practice. R26□s care plan was updated and a copy provided to R26 on 7/9/2024. How the facility will identify other residents having the potential to be affected by the same deficient practice. All new admissions from June 1st, 2024	

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F 655	Continued From page 9 stream), cerebral infarction (stroke when a cluster of brain cells die when they don't get enough blood), and type 2 diabetes mellitus. R26's admission Minimum Data Set (MDS) assessment dated 6/21/24, identified R26 as having a brief interview for mental status (BIMS) score of 15 indicating the resident was cognitively intact. R26's required substantial to maximum assistance with activities of daily living, did not walk and used a wheelchair. R26 received insulin, antidepressant, antibiotic and antiplatelet agent 5 days. R26's baseline care plan dated 6/17/24, indicated R26 required staff assist of two and mechanical aid for transfers, and was able to eat independently after set up by staff. When interviewed on 7/8/24 at 2:15 p.m., R26 stated she never received a copy of her baseline plan of care and would like to have one so she could share it with her family. During interview on 7/9/24 at 9:11 a.m., R26 indicated she did have a care conference and some things about her care were discussed but was not offered or received a copy of her plan of care and would like to have a copy of it. When interviewed on 7/9/24 at 10:23 a.m., social worker (SW)-A indicated they did have a care conference where the care plan was discussed, but typically residents aren't given a copy unless they request it. SW-S was unsure who is responsible to ensure a copy of the plan of care is given to the resident. When interviewed 4/10/24 at 10:36 a.m., the	F 655	to current, will be reviewed to ensure that their care plans were completed and a copy offered to the resident or designee. A copy will be offered to the resident if one was not offered at their initial care conference. What measures will be put in place or systemic changes to ensure that the deficient practice will not reoccur. Care planning and care conference policy was updated on 7/26/2024. Care Planning and Care Conference Policy Mapleton Community Home will work with each individual resident and their families / designees to develop a plan of care that all are in agreement with. Nursing, dietary, social service and therapeutic recreation staff will conduct interviews with the resident to learn of the resident□s individual choices and preferences which they will use to develop an initial plan of care. At the initial care conference, the resident and their party will work with nursing, dietary, social service and therapeutic recreation staff on their individual plan of care. Each of those staff will bring the initial care plan that was developed from interviews conducted to the initial care conference for a final review and acceptance from them. The plan of care will specify who will provide the care. At the initial care conference, the resident will be offered a copy of the plan of care. A progress note will be made by the social	

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F 655	Continued From page 10 director of nursing (DON) confirmed a copy of the baseline care plan was not being offered to the resident or a family member unless it was requested. When interviewed on 7/9/24 at 1:57 p.m., registered nurse (RN)-B, also identified as assistant director of nursing (ADON) and MDS coordinator, indicated she attended R26's care conference and confirmed the baseline care plan was not offered to R26 at that time. Facility Care Planning and Care Conference policy dated 8/28/17, included: -The facility will work with each individual resident and their families/designees to develop a plan of care that all are in agreement with. -An initial care conference, the resident and their party will work with nursing, dietary, social service and therapeutic recreation staff on their individual plan of care. Each of these staff will bring the initial care plan that was developed from interviews conducted to the initial care conference for a final review and acceptance from the resident and/or family/designee. -The resident has the right to review the plan of care and request/participate in changes to the plan of care.	F 655	service director or designated director in the absence of social service director, and include whether the resident/family of designee accepted a copy or declined. The resident has the right to review the plan of care and request /participate in the changes to the plan of care. The care plan will be reviewed quarterly with the IDT, resident and / or family / designee. Corrections and updates will be made to the plan of care as needed as care plans are an on-going process. A new admission, re-admission from a hospital or a significant change of condition will require the IDT to review and update the care plan as appropriate. The baseline care plan will be developed within 48 hours of admission and/or re-admission. A master grid will be kept by DON / ADON to assess all new admissions and re-admissions to ensure that care plans are completed within a 48-hour time frame and that they are offered to the resident and / or family / designee at the initial care conference. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur. A master grid will be kept by DON / ADON to assess all new admissions and re-admissions to ensure that care plans are completed within a 48-hour time frame and that they are offered to the resident and / or family / designee at the	

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F 655	Continued From page 11	F 655	initial care conference NAME Date of Admit or Re-admit 48-hour Date for care plan Reviewed by Care Conference Date Documentation of care plan offering RN SS TR Dietary IDT met on 7/24/24 to review the updated care plan and care conference policy. The master grid, as listed above, will be followed to ensure that all future residents have completed baseline care plans within 48 hours of admission/readmission and that care plans are offered to residents at care conference with documentation in progress notes to identify if the resident received a copy or declined wanting a copy. A review of the updated policy and ongoing tracking grid will be provided to QAPI team on 10/4/2024 to ensure that the practice has been corrected.	
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers.	F 686		7/29/24

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F 686	Continued From page 12 Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely repositioning for 1 of 1 resident (R28) who was dependent on staff for repositioning and who had a pressure ulcer (PU) on her coccyx. Findings include: R28's facesheet printed on 7/10/24, included diagnoses of pressure ulcer of sacral region and urinary incontinence. R28's annual Minimum Data Set (MDS) assessment dated 4/30/24, indicated R28 was cognitively intact, was dependent or required substantial assistance with most activities of daily living (ADL), including repositioning and toileting. R28 was unable to walk. R28 was at risk for the development of pressure ulcers and had one or more unhealed pressure ulcers. R28 did not have a turning/repositioning program and had no rejection of cares. R28's Care Area Assessment (CAA) for pressure ulcer dated 4/30/24, indicated R28 was at risk for	F 686	F686 How corrective action will be accomplished for those residents found to have been affected by deficient practice. R28 care plan updated on 7/29/24 to include Per wound care - Resident is to lie down in bed for 2-3 hrs. per day. When in w/c reposition every 2hrs (standing in place for 1 min ok). While in bed, turn on side. Will Return Clock placed on R28□s door as per updated pressure ulcer management program policy. Staff caring for resident were updated on Will Return Clock protocol. Staff will move clock ahead to next time repositioning is due after each positioning change is done. How the facility will identify other residents having the potential to be affected by the same deficient practice. A review of resident orders were completed on 7/29/24 by DON/ADON for residents who require wound care and are	

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F 686	Continued From page 13 skin breakdown related to immobility and urinary incontinence. R28 required substantial assistance with repositioning. R28 had a stage four pressure ulcer (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) to coccyx, which was healing at the time of the assessment. R28 was receiving supplements to assist with wound healing/promotion along with utilizing a pressure relieving cushion in the wheelchair and pressure reducing mattress on bed. R28's Mobility CAA dated 4/30/24, indicated R28 required substantial/maximum assistance for all ADLs except eating. R28 was wheelchair bound and required two staff for transfers with use of a mechanical standing lift (also known as an EZ stand - an assist device that moves residents from one surface to another surface). R28 was dependent on staff for toileting, dressing, and managing hygiene. R28's pressure ulcer risk assessment (Braden Score) dated 6/24/24, identified R28 at low risk for the development of a pressure ulcer. R28's care plan with revised date of 8/21/23, indicated a healing stage four pressure ulcer on the coccyx. There were no interventions listed for repositioning or offloading. In addition, the care plan indicated R28 was frequently incontinent of bladder, would be free from skin breakdown, used disposable briefs and was to be checked for incontinence (no time frame was specified). Care plan with revised date of 10/27/23, indicated R28 required total assistance of two staff to use the toilet, using the EZ stand.	F 686	dependent on nursing staff for positioning to determine if orders are present for a turn/reposition schedule. If orders are not present a review w/ PCP will be completed 7/30/24 to determine if a turn/reposition schedule is needed for quality of care. If PCP finds it necessary for care, an order will be obtained with specific repositioning hours (2,3 or 4), placed into TAR and updated in the care plan. What measures will be put in place or systemic changes to ensure that the deficient practice will not reoccur. Pressure Ulcer Management Program updated on 7/26/24 Pressure ulcers will be identified, a plan of treatment implemented and be monitored weekly. An identified pressure ulcer will be staged (SDTI through stage IV) and documentation made in medical record. Notifications will be made to physician, family and dietary. Referrals will be made to wound care (facility or outpatient) if needed. A plan of treatment for wound care will be made and reviewed with provider for approval of orders. This will include (but not limited to): dressing change, type of pressure reduction surface for bed and wheelchair, repositioning schedule. If a resident has an order for a specific repositioning schedule the resident will receive a will return clock, placed on the resident□s door. Upon completion of repositioning, the nursing staff will turn	

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F 686	Continued From page 14 R28's physician orders dated 5/5/23, indicated R28 was to lie down in bed for two to three hours per day. When R28 is in the wheelchair, reposition every two hours (stand in place for one minute was ok). During a continuous observation on 7/9/24 from 9:40 a.m. to 12:30 p.m., (2 hours 50 minutes) R28 was not repositioned in the wheelchair, offloaded, or toileted. During the observation period from 9:40 a.m. to 11:24 a.m., R28 was seating in her wheelchair in her room, watching TV. At 11:34 a.m., R28 was taken via wheelchair to the dining room for lunch. At 12:30 p.m., R28 remained in her wheelchair at the dining room table. During interview on 7/9/24 at 1:24 p.m., nursing assistant (NA)-B stated she was assigned to care for R28 that day and was aware R28 had a pressure ulcer on the coccyx. NA-B stated R28 should be off her bottom every couple hours and stated she had repositioned R28 that morning, however, was not able to say what time she had repositioned R28. During interview on 7/9/24 at 1:45 p.m., licensed practical nurse (LPN)-A stated she didn't think R28 had been laid down that morning and stated R28 should be repositioned or offloaded every two hours. During an observation on 7/10/23 at 7:20 a.m., observed LPN-A complete a dressing change to the PU on R28's coccyx. The wound was approximately the size of a nickel, pink and no drainage. LPN-A stated it was much improved and healing well.	F 686	clock to the next time that repositioning is due so that all parties working with the resident are aware of the turning schedule. The resident care plan will be updated. Nursing staff (RN, LPN, CNA) will be updated on the plan of care. Weekly documentation will be completed by LPN or RN and placed in the medical record to document the following: Location of wound Size of wound (LxWxD) Drainage including color and odor Wound bed characteristics Peri wound characteristics Pain The selected wound care provider care will continue to follow the resident and wound until healed. When healed a review of interventions will be completed with facility and provider to determine optimal interventions for the resident to maintain highest level of skin integrity. Staff education provided on 7/29/24 for policy update. Policy provided to nursing assistants, LPN and RN□s for review with signature requirement and return to DON. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur. An audit will be completed by DON/ADON to observe one resident weekly through 2024 then quarterly beginning in January of 2025 to ensure that residents on a turn/reposition schedule are repositioned in the time frame specified by PCP. Audit Tool □ Turn and Reposition	

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F 686	Continued From page 15 During interview on 7/10/24 at 10:09 a.m., the director of nursing (DON) stated R28 was to be repositioned every two to three hours and offloaded every two hours. The DON stated staff would offer toileting or use the EZ stand to offload pressure. The DON was informed of the continuous observation on 7/9/24, from 9:40 a.m. to 12:30 p.m., (2 hours 50 minutes) where R28 had not been repositioned or offloaded. The DON looked in the EHR (electronic health record) and stated when R28 was in the wheelchair she should be repositioned every two hours or could stand in place for one minute to offload. The DON was not aware R28 had not been repositioned and stated she expected staff to follow the physician orders for repositioning and offloading. Facility Pressure Ulcer Prevention Program policy revised date 5/24/11, indicated residents admitted with pressure ulcers would receive necessary treatment and services to promote healing. Pressure ulcer (stage 2-4 and unstageable): follow wound nurse recommendations.	F 686	Resident Name: _____ _____ Date: _____ Turn/reposition schedule: _____ _____ Time completed: _____ _____ Clock changed to: _____ _____ Nursing staff returned at: _____ _____ Any reducation required to nursing staff: _____ A review of ongoing audit findings will be discussed at August 12th LPN/RN meeting and again at August 13th nursing assistant meeting. QAPI will be updated on audit findings and policy changes at 10/4/2024 meeting.	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		8/1/24

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F 812	Continued From page 16 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dietary staff followed appropriate infection control practices when handling cups during food service in the dining room. This had potential to affect all 47 residents who resided in the facility. Findings include: During an observation on 7/9/24 at 12:00 p.m., when filling cups with juice for residents seated at tables, dietary aide (DA)-A was observed holding the small, clear plastic tumblers by the rim of the cup with bare hands, and when setting the cup on the table. During an observation on 7/9/24 at 12:05 p.m., when filling beverages for residents, observed DA-B pour milk and orange juice into two small, clear plastic tumblers. With bare hands, DA-B set the cups on the table by holding the rim. During an observation on 7/9/24, at 12:07 p.m., when filling beverages for residents, observed DA-B pour coffee into a navy-blue thermal coffee	F 812	F812 Food safety requirements Corrective action for all of the residents found to have been affected by deficient practice will be continuing education with current staff and new hires will be trained on the process and procedure. Corrected during survey, verbal education was given to staff. An in-service will be held 07/31/24 and 08/01/24 to go over education, policy and procedure for dining service delivery. A visual board has been posted in the kitchen and dietary manager or designee have started doing dining service audits. Audits of dining service for breakfast/lunch/supper will be done three times a week for four weeks this started 07/23/24. Audits will then go to twice a week for the following four weeks and then move to once a week quarterly (once a week for twelve weeks). Dietary Manager will also address this in the next QAPI meeting on 10/04/24, all staff meeting before year end, and on-going as	

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F 812	Continued From page 17 mug and set it on a residents table by holding the rim of the mug. During an observation on 7/9/24 at 12:11 p.m., observed DA-A pour juice for a resident and set the cup on the table by holding the rim. During an interview on 7/9/24 at 12:26 p.m., dietary manager (DM)-C stated dietary staff received training at orientation on the proper way to hold cups when filling and serving. DM-C was informed of observations and stated staff should not hold cups by the rim due to potential contamination by their hands. During an interview on 7/9/24 at 12:27 p.m., both DA-A and DA-B stated they had training on the proper way to hold a resident's drinking cup when filling and serving. When informed of observations, both acknowledged they held cups by the rim and were aware they should not be due to potential infection control concerns. An orientation packet for DA-A indicated he signed an undated policy titled Dish & Utensil Handling on 10/12/23, which indicated: fingers would not be placed in or at the lip of contact surfaces of cups, glasses, and/or flatware. The same policy was signed by DA-B on 6/19/23.	F 812	needed.	
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	F 880		7/30/24

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F 880	Continued From page 18 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; (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	F 880		

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F 880	Continued From page 19 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 record review the facility failed to use appropriate infection prevention and control practices for 1 of 2 residents (R28) who was dependent on staff for pressure ulcer wound care. In addition, the facility to ensure a mechanical transfer lift was cleaned after resident use for 2 of 2 residents (R7 and R14) observed for infection control practices and proper infection prevention practices was observed when sorting soiled laundry. Findings include: R28's facesheet printed on 7/10/24, included diagnoses of pressure ulcer of the sacral region and urinary incontinence.	F 880	F880 Wound Care: How corrective action will be accomplished for those residents found to have been affected by deficient practice. Purple Sanitizer wipes placed in closest of R28 for use of disinfectant to surface prior to wound care. 1:1 reeducation completed with LPN on the procedure of having a clean surface for completing wound care. How the facility will identify other residents having the potential to be affected by the same deficient practice. All residents receiving wound care from LPN/RN will have a wound care bucket with wound care instructions, wound care policy, wound care supplies, hand sanitizer and purple top disinfectant wipes. All wound	

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F 880	Continued From page 20 R28's annual Minimum Data Set (MDS) assessment dated 4/30/24, indicated R28 is cognitively intact, could understand and be understood. R28 required substantial assistance with most activities of daily living (ADL), including wound care. R28 was at risk for developing pressure injuries, had a pressure ulcer over a bony prominence, had one or more unhealed pressure injuries, indicated pressure ulcer care, and had no rejection of care. R28's Pressure Injury Care Area Assessment (CAA) dated 4/30/24, indicated R28 was at risk for skin breakdown related to immobility and urinary incontinence. R28 had a stage four pressure ulcer to coccyx, currently healing. R28 required assistance from staff for managing wound care. R28's Mobility CAA dated 4/30/24, indicated R28 required substantial/maximum assistance for all ADLs except eating. R28 was dependent on staff for toileting, dressing, and managing hygiene. R28's care plan with revised date of 8/21/23, indicated actual impairment to skin integrity related to healing stage four pressure injury on coccyx. R28's physician orders included the following: 1. 7/5/24: Cleanse wound with normal saline or wound cleanser, pat dry. Apply skin prep to peri wound skin and allow to dry. Sprinkle collagen powder (supports granulation tissue formation and debridement of wounds) into open wound or use collagen dressing packed gently into wound bed, apply thin layer of Triad Paste (helps promote skin healing) to help hold in powder and protect peri wound skin from maceration, cover	F 880	care buckets will be completed and placed in resident rooms on 7/30/24. What measures will be put in place or systemic changes to ensure that the deficient practice will not reoccur. ADDED: All current LPN's and RN's provided a copy of the updated policy for wound care which includes in steps 1 and 8 to disinfect the surface that will be used/and was used for wound care supplies (overbed table or side table). Reviewed at LPN/RN meeting on 8/12/24. All new hired LPN and RN's will receive a copy of the wound care policy and procedure during their orientation. Wound care procedure updated on 7/26/24. Wound care procedure form: Resident Name: Copy of wound orders in supply bucket: YES / NO Purple top wipes and hand sanitizer to be kept on top shelf of closet with wound care supply bucket. 1. Disinfect the surface that will be used for wound care supplies (overbed table or side table) 2. Gather and set up supplies 3. Wash hands and put on gloves 4. Remove old dressings and discard 5. Wash hands or sanitize and put on new gloves 6. Complete measurement and description weekly and document in medical record 7. Complete wound care as directed a. Wash wound b. Pat dry c. Apply protection to peri-wound (if ordered)	

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	245362	A. BUILDING _____ B. WING _____	C 07/10/2024

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 21 with bordered foam adhesive dressing. Change every other day and as needed for healing stage 4 pressure ulcer. 2. 7/6/24: Triad Hydrophilic Wound Dress External Paste Wound Dressings, (helps maintain optimal wound healing), apply to coccyx/sacrum topically one time a day every other day for wound care and apply to coccyx/sacrum topically every 12 hours as needed for wound care. During observation on 7/10/24 at 7:16 a.m., licensed practical nurse (LPN)-A used R28's overbed table as a work surface as she opened dressing change supplies, setting the supplies on top of the packages they came in. LPN-A did not clean or disinfect, nor use a barrier between the table and the supplies. Further, LPN-A did not remove R28's personal items, including muffins in a Ziploc bag and water bottle off the overbed table before using it at a work surface for dressing change supplies. During observation on 7/10/24 at 7:40 a.m., the overbed table was not cleaned or disinfected prior to setting R28's breakfast tray on it after it being used as a work surface for a dressing change as evidenced by multiple water rings on the surface. During interview on 7/10/24 at 9:51 a.m., LPN-A stated the supplies she set out were placed on top of the opened packages, not directly on the overbed table. After further thought, LPN-A stated the table should have been cleaned before and after wound care. During interview on 7/10/24 at 10:13 a.m., the DON stated she expected staff to move everything off the overbed table prior to starting wound care and expected the overbed bedside	F 880	d. Apply treatment to wound opening e. Cover and secure 8. Upon completion, disinfect surface that wound care supplies were placed on (overbed table) A copy of the updated procedure given to all LPN and RN□s on 7/30/24 for review and signature page returned to DON. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur. Random audit of wound care to one resident weekly in 2024 and then quarterly beginning January 2025 by DON or ADON to ensure all steps are followed. Res receiving wound care: _____ Nurse under observation: _____ All steps (1-8) followed: _____ Re-education provided if needed: _____ A review of procedure and ongoing audit findings will be discussed at August 12th LPN/RN meeting. A review of procedures and 7ongoing audit findings will be discussed at QAPI on October 4th. Mechanical Lifts: How corrective action will be accomplished for those residents found to have been affected by deficient practice. 1:1 reeducation completed on 7/26/24 with nursing assistant who did not complete disinfection of mechanical lift. How the facility will identify other residents having the potential to be affected by the	

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F 880	Continued From page 22 table to be cleaned before and after wound care. Facility Dressing Changes policy updated on 6/13/11, indicated, all dressings must be handled in a safe and sanitary manner. Mechanical Lift Disinfecting R7's quarterly Minimum Data Set (MDS) assessment dated 6/20/24, indicated R7 was cognitively intact, dependent on staff for toileting, required substantial/maximal assistance with transfers, used a wheelchair for mobility, and had diagnoses of hemiplegia (muscle weakness or paralysis on one side of the body) and reduced mobility. R7's care plan updated 4/19/24, indicated R7 was to transfer with a mechanical lift with toileting sling in and out of bed and a mechanical standing lift with two staff members for all other transfers. R14's face sheet printed on 7/10/24, indicated R14 had diagnoses of unspecified dementia (loss of cognitive functioning) and the need for assistance with personal cares. R14's quarterly MDS assessment dated 6/6/24, indicated R14 had severely impaired cognition, was dependent on staff for all transfers, and had diagnoses of dementia and Parkinson's disease (a disorder that affects movement). R14's care plan updated 4/15/24, indicated R14 required the assist of two staff with a full body mechanical lift for all transfers. On 7/9/24 at 8:58 a.m., nursing assistant (NA)-A removed a mechanical standing lift from R7's room and placed the mechanical lift near a wall in	F 880	same deficient practice. All residents are at risk of being affected by deficient practice if mechanical lifts are not disinfected. What measures will be put in place or systemic changes to ensure that the deficient practice will not reoccur. Updated policy for mechanical lift cleaning given to all nursing staff (nursing assistants, LPN and RN) on 7/30/24 requiring signature after review and returned to DON. Mechanical Lift Cleaning Procedure Purpose: To ensure that all Hoyer and EZ Stands are cleaned for use with all residents. Procedure: All mechanical lifts will have a blue bag that contains gloves and a container of purple disinfectant wipes. After use of lift with a resident the handles and prongs will be wiped down following a two-minute contact time for disinfection. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not reoccur. Four audits will be completed weekly by DON/ADON DON / ADON will observe staff remove mechanical lifts from resident rooms to ensure that disinfection takes place. Wing: _____ Lift Hoyer EZ Stand # :_____ Room removed from: _____	

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F 880	Continued From page 23 the hallway. NA-A was observed to walk down the hallway and no cleaning of the mechanical lift was observed. NA-A confirmed he should have disinfected the mechanical lift immediately after use and verified he did not disinfect the mechanical lift after use with R7. On 7/9/24 at 9:09 a.m., NA-B removed a mechanical lift from R14's room and placed it in room 22. NA-B was observed to walk to a different hallway and no cleaning of the mechanical lift was observed. NA-B confirmed she did not clean the mechanical lift after use or while it was in room 22 for storage. On 7/9/24 at 10:20 a.m., licensed practical nurse (LPN)-A verified mechanical lifts should be cleaned immediately after each use with disinfectant wipes to prevent spread of infection. LPN-A further confirmed education was provided to staff regarding disinfecting mechanical lifts after each use at the time of hire and at staff meetings. On 7/9/24 at 2:07 p.m., with director of nursing (DON), also known as the infection preventionist, the DON stated it was the expectation staff were to clean mechanical lifts immediately after each use and between uses to prevent spread of infection. The DON stated mechanical lifts are shared among multiple residents. Facility policy titled Mechanical Lift Cleaning Procedure dated 7/10/24, indicated after use of a lift with a resident the handles and prongs will be wiped down following a two-minute contact time for disinfection. Laundry	F 880	Gloves and wipes in blue holders: YES / NO Did staff disinfect lift: YES/NO Staff: _____ Was re-education needed: _____ A review of policy/procedure and ongoing audit findings will take place at nursing meetings Aug 12th (RN/LPN) and August 13th (nursing assistants). QAPI will be updated and audit findings reviewed on Oct 4th. ADDED: All current CNA's, LPN's and RN's provided copy of mechanical lift cleaning policy for re-education and returned to DON after review and singed. Reviewed at LPN/RN Meeting on 8/12/24 and reviewed with CNA's on 8/13/24 to ensure that re-education was completed. New nursing staff will be provided during their orientation proper procedure for mechanical lift cleaning to ensure new staff are following the proper procedures. F880 Laundry The soiled linen room has been cleared out making room to bring soiled linen directly into that room to be stored and sorted. Gowns and gloves are stored in that room and will be worn anytime when handling any soiled linens. After linens have been transferred to the washers, the gown will be removed and put in the	

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F 880	Continued From page 24 During observation and interview on 7/10/24 at 8:15 a.m., housekeeping (H)-A was observed in the laundry room where dirty and soiled laundry requiring laundering and clean laundry were both present. H-A stated soiled laundry comes into the laundry room through a central door and passes directly in front of the washing machines. H-A further stated soiled laundry was sorted in the same room near the washing machines and soaking of soiled laundry was completed in a double sink in the same room. H-A was observed dumping soiled laundry from a clear plastic bag with gloves on but without a gown. H-A stated she does not wear a gown while sorting soiled laundry. H-A verified this could cause contamination to clean laundry when removing from washing machines, dryers, and when folding. H-A stated she was not trained to wear a gown and was not facility practice to wear a gown when sorting dirty linens. On 7/10/24 at 8:22 a.m., environmental services (EVS)-A director confirmed soiled laundry and clean laundry were processed in the same room and verified laundry staff do not wear gowns to sort soiled laundry. EVS-A stated this could cause contamination to clean laundry. On 7/10/24 at 8:45 a.m., the DON, also known as the infection preventionist, confirmed laundry staff should be wearing a gown when sorting dirty laundry and soiled laundry should be sorted in a separate room to prevent the spread of infection. Facility Infection Prevention and Control Manual section titled Handling Soiled Linen dated 2019, directed staff to wear gown/apron if gross soiling of uniform is likely.	F 880	washer to be washed. The empty cart will be returned to the soiled linen room. The soiled linen room and laundry room will be cleaned and disinfected daily. Clear signage will be placed on the doors indicating where soiled linen is to be placed. This was completed on or before 7/12/2024. Auditing will be done weekly for four weeks then monthly for four weeks and then go to quarterly after that to ensure compliance with infection control. All current laundry staff have been provided with the new updated laundry policy and been re¿ educated on the policy. For any new hires, the policy will be given to them, and the procedures will be explained during training. The new policy will also be presented at our QAPI meeting on 10/4/2024. A message has been sent out to all staff indicating that no soiled linen is to go directly into the laundry room. All soiled linen has to be left in the soiled linen room. Statement Of Purpose: Laundry The facility is to always have available a quantity of linen essential for proper care and comfort of patients. Linens are to be handled, stored, processed, and transported in such a manner as to	

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F 880	Continued From page 25	F 880	prevent the spread of infection. Separate Entrances for Clean And Soiled Linen: A. Separate entrances are provided for the soiled and clean laundry areas. B. Soiled linen shall always be taken into the soiled linen room through the soiled linen entrance to be sorted before taking to the washing machines. C. At no time shall soiled linen come in contact with clean linen. Cleaning The Area: A. The laundry room should be cleaned and disinfected daily. B. Always clean the clean laundry area before cleaning the soiled laundry area. Soiled Linen: A. All soiled linen will be placed in a plastic bag before being placed in the soiled linen room. B. Gloves and a gown shall be worn when handling soiled linen. Washing And Storing Instructions: A. The water temperature will be at or above 160 degrees. B. Linen will be washed for 30 - 60 minutes, depending on load size. C. All linen must be thoroughly dry before folding and storing. D. Blankets and bedspreads shall be laundered after each patient use. E. Blankets and bedspreads will be washed on a regular schedule for long term residents. F. Separate laundry carts will be used	

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F 880	Continued From page 26	F 880	for soiled and clean linen. G. Linen shall be covered when being transported. Isolation Linen: A. Linen from an infected patient shall be bagged in a red bag. B. Gloves and a gown shall be worn when handling contaminated linen.	

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	245362	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/10/2024**

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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 07/10/2024. 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. Building 01 of Mapleton Community Home was constructed as follows: The original building was constructed in 1965, is one-story, has a partial basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st Addition was constructed in 1977, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 2nd Addition was constructed in 1983, is one-story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 3rd Addition was constructed in 1995, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th Addition was constructed in 1997, is one-story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The 2011 nursing home addition, which included a link to an assisted living facility. The link	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.

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K 000	Continued From page 1 incorporates a barber/beauty shop, storage rooms and staff office space. Building 02 is one-story in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II (111) construction. 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 48 at the time of the survey.	K 000		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
August 30, 2024

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

RE: CCN: 245362
Cycle Start Date: July 10, 2024

Dear Administrator:

On August 26, 2024, 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.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us