DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 13, 2021

Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

RE: CCN: 245362
Cycle Start Date: June 10, 2021

Dear Administrator:

On August 31, 2021, we notified you a remedy was imposed. On October 4, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of September 14, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective September 10, 2021 be discontinued as of September 14, 2021. (42 CFR 488.417 (b))

However, as we notified you in our letter of July 1, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from September 10, 2021.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered

August 31, 2021

Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

RE: CCN: 245362
Cycle Start Date: June 10, 2021

Dear Administrator:

On July 1, 2021, we informed you that we may impose enforcement remedies.

On August 12, 2021, the Minnesota Department of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective September 10, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective September 10, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective September 10, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by September 10, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Mapleton Community Home will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from September 10, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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.

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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their 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 SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 10, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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 08/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 8/10/21 through 8/12/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5362031C (MN75491), with a deficiency cited at F689. The following complaint was found to be UNSUBSTANTIATED: H5362032C (MN75422) 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 that substantial compliance with the regulations has been attained.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		9/14/21

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

Electronically Signed | 09/10/2021

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F 689	Continued From page 1 by: Based on observation, interview and document review the facility failed to implement interventions developed to reduce elopements risks for 1 of 3 residents (R1) reviewed for elopements Findings include: R1's undated admission record Face Sheet indicated R1 was admitted to the facility on 7/29/21, with diagnoses of dementia, Alzheimer's disease, Parkinson's disease, and urinary tract infection (UTI). R1's Base Line Care Plan completed 7/29/21, by licensed practical nurse (LPN)-A, identified R1's Cognition Assessment as confused and was identified as an elopement risk. Behavior Concerns included confusion, wandering and elopement risk; documented Alarms and Restraints were identified as WanderGuard (device placed on person or persons' mobility device which alarms when person passes through exit threshold to alert staff of potential safety concern) ; and Physician Orders indicated to see current treatment administration record (TAR). R1's Safety Risk Evaluation dated 7/29/21, identified LPN-A documented R1 tried to elope from the facility twice since admission to the facility, R1 was noted to appear confused and looking for his truck and tractor and wandering into other resident rooms. R1's Elopement Risk Assessment Form completed on 7/29/21, by registered nurse (RN)-A, identified the summary of the	F 689	Elopement Policy Upon admission to Mapleton Community Home all residents will be screened for elopement risk with our Elopement Risk Assessment Form. After completion of the Elopement Risk Assessment Form if the resident triggers the need to have a WanderGuard placed the WanderGuard will be applied immediately by the nurse on duty. Wandergaurds are kept in the A DON office in designated bin. RN/LPN are able to apply Wadergaurds and have key entry access to ADON office. The nurse completing the Wandergaurd application will place an order in the TAR for the NOC shift to check Wandergaurd battery daily. A progress note indicating site of Wanderguard placement will be made in resident electronic record. As part of the auditing process on the next business day after the resident admits to the facility the nurse will bring the completed Elopement Risk Assessment Form and base line care plan to the Interdisciplinary Team (IDT) Meeting for review. The IDT will review the gathered	

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F 689	Continued From page 2 assessment question(s), "is the resident at risk for elopement" and "is the care plan updated" were not completed. The facility Admission Checklist dated 7/29/21, identified the Elopement Risk Assessment Form as completed. R1's Progress Note(s) identified the following: - 7/29/21, at 7:35 p.m. identified R1 as very confused and wandering into other resident rooms; made multiple comments about needing to leave to find his pickup and tractor; and attempted unsuccessfully to exit the facility twice through emergency exit doors. - 7/31/21, at 3:56 p.m. R1 sustained a fall from his wheelchair and stated he was just looking for his truck. - 7/31/21, at 10:00 p.m. indicated R1 was impulsive and forgetful during the shift. R1 had the capability to propel himself down the halls and entered a resident room with two female residents. R1 was described as confused and the female residents went to find a nurse for assistance. The responding nurse indicated R1 displayed confusion, asking what time he had to be at the funeral and what his wife should wear. - 8/1/21, at 1:12 p.m. indicated R1 was wandering the halls most of the shift, propelling himself in his wheelchair. R1 made attempts to enter other resident rooms but was easily redirected. R1 stated he should be working here and is looking for his wife. - 8/3/21, at 6:15 p.m. (late entry) identified an unidentified nurse in the office adjacent to north exit heard the door release being depressed and	F 689	information and verify accuracy of the information gathered. The Elopement Risk Assessment will be reviewed quarterly at Care Conferences with the resident and family and also by the Charge Nurse with any significant change. The audit of this process will be completed during the IDT meeting by DON/ADON at this time. DON/ADON will educate nursing staff for noncompliance after the initial audit. Audits will be reviewed at our QAPI meeting held in October. R1 returned from hospital on 8/9/21. Elopement Risk Assessment was completed and Wandergaurd applied. Care Plan and TAR updated on 8/9/21. Elopement Risk Assessment Audit Resident Name: Nurse Completing Assessment: Resident Admission Date: Was Form Completed In Entirety: Date Elopement Risk Assessment Completed: Was Resident In Need of Wandergaurd: Was Wandergaurd applied if needed: Were all of the above steps completed? If not was re-education provided?	

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F 689	Continued From page 3 witnessed R1 push open the door and begin to wheel himself into the vestibule. R1 was assisted back into the building. The nurse informed the unidentified charge nurse and unidentified nursing assistant registered (NA) R1 was exit seeking. The maintenance director (MD) was contacted by the nurse and asked if the north door could be locked. MD replied R1 needed a WanderGuard. The nurse obtained a WanderGuard device but could not locate R1. The nurse announced over the walkie for staff to cease current tasks and assist in locating R1. As staff proceeded to look for R1, it was reported there were people at the main front door. The people at the front door reported there was a gentleman outside and wondered if he is a resident. Staff proceeded to the north exit door where neighbors, from across the street, were assisting R1 in his wheelchair back to the north door. The neighbors stated they witnessed R1 wheel to the end of the sidewalk of the north entrance, over the curb, and tipped out of the wheelchair. R1 was brought inside the facility and a WanderGuard was applied. R1's medical record lacked evidence R1's WanderGuard was placed prior to eloping from the facility on 8/3/21. During an interview on 8/10/21, at 11:23 a.m. the director of nursing (DON) stated the facility utilized WanderGuard's to prevent residents from eloping. The Base Line Care Plan and Elopement Risk Assessment were required to be completed upon resident admission. The elopement risk was determined by the Base Line Care Plan which indicated R1 required a WanderGuard, but it was not placed. The elopement risk was screened on admission and should have been placed on R1 at	F 689	Date education provided: Education provided by: RN/LPN will be provided education on Elopement Risk Assessment and baseline care plan by 9/14/21.	

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F 689	Continued From page 4	F 689		

that time; however,the facility did not place it until yesterday 8/9/21. R1 was in the hospital for UTI issues and was not sure what happened as they thought they had a good process in place for admissions.

During interview on 8/10/21, at 11:57 a.m. RN-A stated R1 was an elopement risk and she must have forgotten to answer the questions on the elopement risk questionnaire of, "is the resident at risk for elopement" and "is the care plan updated." RN-A stated she only completed the Elopement Risk Assessment Form on 7/29/21, and did not look at the Base Line Care Plan.

During interview on 8/10/21, at 12:45 p.m. LPN-B stated LPN's could complete the Baseline Care Plan, but a registered nurse had to complete all the rest of the assessments. Once the Base Line Care plan was completed it was placed in a 3-ring binder at the nurse's station. The 3-ring binder was available for all staff so they know what cares should be completed for the resident. Once the Comprehensive Care Plan was completed, the Base Line Care Plan was placed in the resident's paper chart, and staff access the Comprehensive Care Plan in PCC.

During interview on 8/10/21, at 1:04 p.m. R1 stated if he wanted to go outside, he can just go. He does not need anyone to go with him. R1 could not recall that he went outside and fell out of his wheelchair.

During interview on 8/10/21, at 1:38 p.m. LPN-A started the beginning of the admission process but had to hand it off due to short staffing. LPN-A indicated reading the hospital summary for R1 it described R1 was confused and indicted he was

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F 689	Continued From page 5	F 689		

at risk for elopement. The completed Base Line Care Plan was put in a binder in the nurse's station for everyone to see. Further, R1 should have had a WanderGuard placed on admission, but the evening shift was busy and short staffed, and no upper management was in the facility to obtain a WanderGuard, so it was passed off to the unidentified night nurse.

During observation on 8/11/21, 10:02 a.m. seven WanderGuard bracelets with numerous attachment bands were in a small plastic box, just inside the assistant director of nursing (ADON) office.

During an interview on 8/11/21, at 11:16 a.m. ADON stated WanderGuard bracelets are always available in her office and during off hours, the key to her office was in the Medication Storage Room. Further, all staff were previously educated on obtaining the key because of other medical supplies kept in her office.

Facility provided staff records lacked evidence of staff education regarding baseline care plans upon admission, elopement protocols, WanderGuard device locations/access, or re-education on assessment completion.

The facility indicated they did not have an elopement policy.

Electronically delivered
August 31, 2021

Administrator
Mapleton Community Home
301 Troendle Street
Mapleton, MN 56065

Re: State Nursing Home Licensing Orders
Event ID: BG3Y11

Dear Administrator:

The above facility was surveyed on August 10, 2021 through August 12, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
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
	00037	A. BUILDING: _____ B. WING _____	C 08/12/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/10/21 through 8/12/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5362031C (MN75491) with a licensing order issued at MN Rule 4658.0520 Subp. 1 The following complaint was found to be UNSUBSTANTIATED: H5362032C (MN75422). 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 surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to	2 000		

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2 000	Continued From page 2 the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to implement interventions developed to reduce elopements risks for 1 of 3 residents (R1) reviewed for elopements Findings include:	2 830	Elopement Policy Upon admission to Mapleton Community Home all residents will be screened for elopement risk with our Elopement Risk Assessment Form. After completion of the Elopement Risk	9/14/21

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2 830	Continued From page 3 R1's undated admission record Face Sheet indicated R1 was admitted to the facility on 7/29/21, with diagnoses of dementia, Alzheimer's disease, Parkinson's disease, and urinary tract infection (UTI). R1's Base Line Care Plan completed 7/29/21, by licensed practical nurse (LPN)-A, identified R1's Cognition Assessment as confused and was identified as an elopement risk. Behavior Concerns included confusion, wandering and elopement risk; documented Alarms and Restraints were identified as WanderGuard (device placed on person or persons' mobility device which alarms when person passes through exit threshold to alert staff of potential safety concern) ; and Physician Orders indicated to see current treatment administration record (TAR). R1's Safety Risk Evaluation dated 7/29/21, identified LPN-A documented R1 tried to elope from the facility twice since admission to the facility, R1 was noted to appear confused and looking for his truck and tractor and wandering into other resident rooms. R1's Elopement Risk Assessment Form completed on 7/29/21, by registered nurse (RN)-A, identified the summary of the assessment question(s), "is the resident at risk for elopement" and "is the care plan updated" were not completed. The facility Admission Checklist dated 7/29/21, identified the Elopement Risk Assessment Form as completed. R1's Progress Note(s) identified the following: - 7/29/21, at 7:35 p.m. identified R1 as very confused and wandering into other resident	2 830	Assessment Form if the resident triggers the need to have a WanderGuard placed the WanderGuard will be applied immediately by the nurse on duty. Wandergaurds are kept in the A DON office in designated bin. RN/LPN are able to apply Wadergaurds and have key entry access to ADON office. The nurse completing the Wandergaurd application will place an order in the TAR for the NOC shift to check Wandergaurd battery daily. A progress note indicating site of Wanderguard placement will be made in resident electronic record. On the next business day after the resident admits to the facility the nurse will bring the completed Elopement Risk Assessment Form and base line care plan to the Interdisciplinary Team (IDT) Meeting for review. The IDT will review the gathered information and verify accuracy of the information gathered. The Elopement Risk Assessment will be reviewed quarterly at Care Conferences with the resident and family and also by the Charge Nurse	

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2 830	Continued From page 4 rooms; made multiple comments about needing to leave to find his pickup and tractor; and attempted unsuccessfully to exit the facility twice through emergency exit doors. - 7/31/21, at 3:56 p.m. R1 sustained a fall from his wheelchair and stated he was just looking for his truck. - 7/31/21, at 10:00 p.m. indicated R1 was impulsive and forgetful during the shift. R1 had the capability to propel himself down the halls and entered a resident room with two female residents. R1 was described as confused and the female residents went to find a nurse for assistance. The responding nurse indicated R1 displayed confusion, asking what time he had to be at the funeral and what his wife should wear. - 8/1/21, at 1:12 p.m. indicated R1 was wandering the halls most of the shift, propelling himself in his wheelchair. R1 made attempts to enter other resident rooms but was easily redirected. R1 stated he should be working here and is looking for his wife. - 8/3/21, at 6:15 p.m. (late entry) identified an unidentified nurse in the office adjacent to north exit heard the door release being depressed and witnessed R1 push open the door and begin to wheel himself into the vestibule. R1 was assisted back into the building. The nurse informed the unidentified charge nurse and unidentified nursing assistant registered (NA) R1 was exit seeking. The maintenance director (MD) was contacted by the nurse and asked if the north door could be locked. MD replied R1 needed a WanderGuard. The nurse obtained a WanderGuard device but could not locate R1. The nurse announced over the walkie for staff to	2 830	with any significant change. An audit of this process will be completed during the IDT meeting by DON/ADON at this time. DON/ADON will educate nursing staff for noncompliance and will be reviewed at QAPI meeting held in October. R1 returned from hospital on 8/9/21. Elopement Risk Assessment was completed and Wandergaurd applied. Care Plan and TAR updated on 8/9/21. Elopement Risk Assessment Audit Resident Name: Nurse Completing Assessment: Resident Admission Date: Was Form Completed In Entirety: Date Elopement Risk Assessment Completed: Was Resident In Need of Wandergaurd: Was Wandergaurd applied if needed: Were all of the above steps completed? If not was re-education provided? Date education provided: Education provided by: RN/LPN will be provided education on Elopement Risk Assessment and baseline care plan by 9/14/21.	

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2 830	Continued From page 5	2 830		

cease current tasks and assist in locating R1. As staff proceeded to look for R1, it was reported there were people at the main front door. The people at the front door reported there was a gentleman outside and wondered if he is a resident. Staff proceeded to the north exit door where neighbors, from across the street, were assisting R1 in his wheelchair back to the north door. The neighbors stated they witnessed R1 wheel to the end of the sidewalk of the north entrance, over the curb, and tipped out of the wheelchair. R1 was brought inside the facility and a WanderGuard was applied.

R1's medical record lacked evidence R1's WanderGuard was placed prior to eloping from the facility on 8/3/21.

During an interview on 8/10/21, at 11:23 a.m. the director of nursing (DON) stated the facility utilized WanderGuard's to prevent residents from eloping. The Base Line Care Plan and Elopement Risk Assessment were required to be completed upon resident admission. The elopement risk was determined by the Base Line Care Plan which indicated R1 required a WanderGuard, but it was not placed. The elopement risk was screened on admission and should have been placed on R1 at that time; however,the facility did not place it until yesterday 8/9/21. R1 was in the hospital for UTI issues and was not sure what happened as they thought they had a good process in place for admissions.

During interview on 8/10/21, at 11:57 a.m. RN-A stated R1 was an elopement risk and she must have forgotten to answer the questions on the elopement risk questionnaire of, "is the resident at risk for elopement" and "is the care plan updated." RN-A stated she only completed the

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2 830	Continued From page 6 Elopement Risk Assessment Form on 7/29/21, and did not look at the Base Line Care Plan. During interview on 8/10/21, at 12:45 p.m. LPN-B stated LPN's could complete the Baseline Care Plan, but a registered nurse had to complete all the rest of the assessments. Once the Base Line Care plan was completed it was placed in a 3-ring binder at the nurse's station. The 3-ring binder was available for all staff so they know what cares should be completed for the resident. Once the Comprehensive Care Plan was completed, the Base Line Care Plan was placed in the resident's paper chart, and staff access the Comprehensive Care Plan in PCC. During interview on 8/10/21, at 1:04 p.m. R1 stated if he wanted to go outside, he can just go. He does not need anyone to go with him. R1 could not recall that he went outside and fell out of his wheelchair. During interview on 8/10/21, at 1:38 p.m. LPN-A started the beginning of the admission process but had to hand it off due to short staffing. LPN-A indicated reading the hospital summary for R1 it described R1 was confused and indicted he was at risk for elopement. The completed Base Line Care Plan was put in a binder in the nurse's station for everyone to see. Further, R1 should have had a WanderGuard placed on admission, but the evening shift was busy and short staffed, and no upper management was in the facility to obtain a WanderGuard, so it was passed off to the unidentified night nurse. During observation on 8/11/21, 10:02 a.m. seven WanderGuard bracelets with numerous attachment bands were in a small plastic box, just inside the assistant director of nursing	2 830		

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2 830	Continued From page 7 (ADON) office. During an interview on 8/11/21, at 11:16 a.m. ADON stated WanderGuard bracelets are always available in her office and during off hours, the key to her office was in the Medication Storage Room. Further, all staff were previously educated on obtaining the key because of other medical supplies kept in her office. Facility provided staff records lacked evidence of staff education regarding baseline care plans upon admission, elopement protocols, WanderGuard device locations/access, or re-education on assessment completion. The facility indicated they did not have an elopement policy. SUGGESTED METHOD OF CORRECTION: The DON, or designee, could review and revise/ enforce applicable policies and procedures pertaining to elopement risk assessments and care plans; then educate staff and on ensuring timely completion of such assessments; then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		