Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 5, 2024

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

RE: CCN: 245570
Cycle Start Date: February 14, 2024

Dear Administrator:

On February 14, 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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 May 14, 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 August 14, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

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March 5, 2024

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

Re: State Nursing Home Licensing Orders
Event ID: GBP111

Dear Administrator:

The above facility was surveyed on February 12, 2024 through February 14, 2024 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:

Nicole Osterloh, RN, Unit Supervisor
Marshall District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 102
Marshall, Minnesota 56258-2504
Email: nicole.osterloh@state.mn.us
Office: 507-476-4230
Mobile: (507) 251-6264 Mobile: (605) 881-6192

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245570	A. BUILDING _____ B. WING _____	C 02/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/12/24 through 2/14/24, 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 2/12/24 through 2/14/24, 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: H55709501C (MN00092900), H55709500C (MN00092542) and H55709498C (MN00098120). The following complaints were reviewed: H55709497C (MN00100162) and H55709499C (MN00091291) with deficiencies cited at F585, F609, and F657. 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.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2024

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 000	Continued From page 1 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 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the	F 585		4/1/24

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F 585	Continued From page 2 facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system; (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions	F 585		

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F 585	Continued From page 3 include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their grievance procedures and ensure they were addressed in a timely manner for 1 of 1 resident (R5). Findings include: Review of 2/19/23, facility report to the state agency (SA), identified R5 requested assistance from staff in her bathroom for a change of clothes. The staff member did not assist R5 and had left R5's room. A second employee arrived in R5's room to assist her with a clothing change. R5 went to the activities director (AD) with her concerns and the AD filed a grievance report on behalf of R5.	F 585	Policy for grievances was reviewed and updated to reflect grievance log processes. Grievance log will contain all written grievances, as well as OHFC reports. All grievances will be addressed in a timely manner. Social Services is the designated Grievance Officer, who will be responsible to ensure grievance log is updated and followed up with appropriately. Social Services Designess was educated on grievances, timeframes, logging, investigation, and follow-up by Administrator. Administraot will ensure SSD completes approriately. Audit will be conducted to ensure incidents are placed	

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F 585	Continued From page 4 Interview on 2/13/24 at 4:44 p.m., with social services designee (SSD) stated she did not receive any formal grievances or complaints last year from residents and had no documentation to provide upon request. Interview on 2/14/24 at 8:54 a.m., with activities director (AD) related to the above incident identified R5 had visited her the following Monday to discuss her concerns of an employee who cared for her the night before. The AD confirmed she filed a grievance with SSD and the SSD stated to her she would take care of it. Record review of Resident Grievance/Complaint Log the last three years identified R5 had no grievances filed. There was no documentation of grievances from November of 2022 through the date of the survey. Review of the undated Filing Grievances/Complaints Policy identified the appointed designee would receive grievances conduct an investigation and resolution within 5 business days and would notify findings to the Administrator.	F 585	on the log as they occur. Audit will be done weekly x4, monthly x3, then brought to QAPI at least quarterly for 1 year to ensure compliance.	
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property,	F 609		4/1/24

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F 609	Continued From page 5 are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report immediately but not later than 2 hours, allegations of potential abuse to the State Agency for 1 of 1 residents (R4). Findings include: Review of 1/21/24 at 10:40 p.m.., report to the State Agency (SA) report identified earlier on 1/21/24 at approximately 12:01 a.m., nursing assistant (NA-E) informed licensed practical nurse (LPN-C) she refused to scratch R4's genital area as R6 requested. LPN-C found R4 crying in his room and R4 stated he asked NA-E to wash his genital area and NA-E refused. R4's 1/23/24 Significant Change Minimum Data	F 609	To obtain and ensure continued compliance, education given to all staff for reporting timeframes on allegations on abuse, neglect, exploitation, or mistreatment, including injuries with unknown source and misappropriation of resident property. Training includes immediate, but not less than 2-hour requirements versus 24-hour requirements in relation to serious or non-serious bodily injury or abuse. All staff will be required to understand how to file a report independently, should they receive an allegation that meets immediate, but not less than 2 hours to report. A floor nurse login has been created through OHFC Reporting Site to allow all floor	

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F 609	Continued From page 6 Set (MDS) identified R4 had diagnosis of Aphasia, dementia, hemiplegia/hemiparesis, anxiety and depression. R4 was cognitively intact and required maximum assist for toileting and transfers. R4 took antidepressants daily. Interview on 2/14/24 at 8:35 a.m., with director of nursing (DON) stated she was made aware of the incident the next day and NA-E did not work at the facility after the incident. Interview on 2/14/24 at 4:44 p.m., with NA-E stated she worked on 1/21/24 on the night shift when R4 asked her to clean him. After cleaning him, she stated R4 asked her to scratch his genitals and she refused. R4 said to NA-E if she refused he would get the nurse. NA-E stated she left the room and informed LPN-C of the situation. NA-E stated she worked later that day on the evening shift on 1/21/24 and was approached by the DON who stated that R4 was "afraid of me" and I would not work the rest of my shift. Interview on 2/14/24 at 5:11 p.m., with LPN-C stated R4 had his call light on and found R4 in his room crying. LPN-C stated she cleaned and applied cream to R4's genital area. LPN-C stated R4 said he was upset at NA-E. LPN-C stated to R4 she would handle the situation. LPN-C stated she did not inform the DON of the incident until later that same day and assumed the DON would be notified by other staff who worked that night. Interview on 2/14/24 at 5:28 p.m., with R4 identified he felt NA-E "mistreated" him. R4 refused to answer any other questions and made no mention of the incident noted above. Interview on 2/14/24 at 6:13 p.m., with	F 609	nurses the ability to report in compliance with the required timeframes, should the current users be unavailable to report within such timeframes. Additionally, MDS Coordinator and DON will include threshold requirements for reporting timeframes, information on Incident Reporting in “Quick Guide” binders that are located on each medication cart, nurses station, and CNA stations. DON and Administrator are responsible to ensure compliance with timely reporting for allegations of abuse, neglect, exploitation, maltreatment. DON will complete an audit on compliance of timely reporting daily x 10 days, weekly x 4 weeks, then monthly x 3 months. Audits will be brought to Administrator and QAPI for review and continued surveillance	

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F 609	Continued From page 7 administrator (ADM) stated her expectations would be for staff to contact her of allegations of potential abuse of residents in the facility. Review of September 2023, Abuse Prohibition and Prevention policy indicated the facility will ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do no involve abuse and do not result in serious bodily injury, to the director of nursing, administrator of the facility and to officials including the state agency.	F 609		
F 744 SS=D	Treatment/Service for Dementia CFR(s): 483.40(b)(3) §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comprehensively assess and develop individualized intervention for dementia and behaviors of dementia for 2 of 2 residents (R17 and R33). Findings include: R33's 12/21/23, quarterly Minimum Data Set (MDS) assessment identified R33 had severe cognitive deficits. He had difficulty focusing his	F 744	Effected resident's care plans were comprehensively assessed, reviewed, and updated to ensure proper focus, goals, and interventions were in place for dementia diagnosis', as well as behaviors due to dementia. By 4/1/2024, all current resident's care plans will be audited, reviewed, and revised as needed to establish protection. To ensure compliance in the future, during resident's annual/comprehensive MDS assessment,	4/1/24

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F 744	Continued From page 8 attention, had disorganized thinking, and altered level of consciousness that fluctuated. R33 had physical and verbal behaviors towards others and had refused cares 1 to 3 days during the assessment period. R33's 2/14/24, diagnosis list identified Alzheimer's disease, vascular dementia severe with agitation, major depressive disorder, restlessness and agitation, emotional lability, history of stroke, and palliative care. R33's 9/21/23, cognitive loss/dementia Care Area Assessment (CAA) identified R33 had an actual problem related to dementia and not being able to understand, answer questions or process information. R33's ability to make himself understood had declined and he displayed disorientation, confusion, and forgetfulness. R33 had behavioral symptoms that had triggered however, no details were identified on the worksheet of the behaviors or contributing factors. The CAA worksheet identified that cognitive loss/dementia would be addressed on the care plan to slow or minimize decline, minimize risks, and avoid complications. Staff would need to anticipate R33's needs and adhere to his wishes when appropriate. R33's behavior symptoms CAA identified R33 had an actual problem as he acted out following a family visit. He had reached out and grabbed and tried to stand and walk away. R33 yelled at staff, and this was identified to occasionally occur. R33 displayed physical behaviors towards others such as kicking, hitting, scratching, grabbing, and pushing. He had verbal behaviors towards others such as cursing, threatening, and yelling. The assessment identified R33 had a long history of mental health problems and behavioral	F 744	an audit will be conducted to establish proper review of care plans for all appropriate areas of care. Upon admission of a resident, such audit will also be completed within the first 15 days, as comprehensive care plans are completed by day 14. DON and MDS Coordinator are responsible to conduct the above audits x 12 months and retain audits for at least 1 year. Completed audits will be brought to QAPI at least quarterly x 4 quarters.	

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F 744	Continued From page 9	F 744		

disturbances, he had sensory impairments such as vision and hearing that could exacerbate his behavior. R33 had a diagnosis of Alzheimer's disease. Behavioral symptoms would be addressed on the care plan to slow or minimize decline, minimize risk, and avoid complications. Staff would need to keep R33 safe from injury and re-approach later when he was agitated.

Interview on 2/13/24 at 11:56 a.m., with nursing assistant (NA)-A identified R33 would fight a lot during cares. Normally staff did not get him up before 10:00 a.m., with his dementia as that worked best for him. She reported if staff got him up before he woke up on his own, he would have a lot more behaviors. R33 would strike out at staff, and he liked to bite. Staff really must be careful when putting his dentures in as he tries to bite you. She reported we always use 2 staff when completing his cares in the morning. She stated R33 typically had more behavior in the morning.

Interview on 2/13/24 at 2:12 p.m., with NA-B identified that staff needed to approach R33 slowly and make sure they explained exactly what they were going to do before they started as that seemed to help prevent some of his behaviors. R33 really did not like anything cold touching him and she reported that she typically warmed the wipes by placing in warm running water before using them on him.

Interview on 2/14/24 at 7:42 a.m., with NA-C identified if Nascar was on that was a must that staff set him up to watch, as he really liked watching Nascar he was a big fan. She reported it worked best to let him sleep and wake up on his own otherwise he had more behaviors. She

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F 744	Continued From page 10 stated if she went by his room and his eyes were open that meant he was ready to get up. If he was sleeping and staff knocked on his door and said his name and woke him up, he would have more behaviors. R33 was combative if staff did not go slow and really explain what they were trying to help him with, but once he was up for the day, he was pretty good. R33's care plan printed on 2/14/24, identified he had a fall related to poor comprehension and a diagnosis of dementia with behavioral disturbance. He was unaware of his safety needs. He would climb out of bed, stand, or go to the floor to fix things. He had a silent alarm and staff were to keep the bed in the lowest position with a fall mat next to bed when he was in bed. He was identified to have a care deficit related to Alzheimer's disease and was dependent on staff for bed mobility and transfers. R33 had behaviors consistent with Alzheimer's disease of resisting care non-combative, staff were to determine behavior cycle and event that triggered behavioral problems however, there was no triggers identified. Staff were to stop if R33 became resistant and document attempts and R33's response. Staff were to orientate to immediate surroundings and point out simple landmarks in the facility. R33 had a wander guard on his wrist. The care plan lacked identification of R33's behaviors of being combative. The care plan lacked identification that being woken up was a trigger for behaviors, or that using cold wet wipes was a trigger with no identified interventions to prevent those behaviors. The care plan had no mention that R33 really enjoyed watching Nascar and that he was a fan although staff were aware those interventions helped to calm his behaviors.	F 744		

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F 744	Continued From page 11 Interview on 2/14/24 at 1:30 p.m., with registered nurse (RN)-A who reported she was the MDS nurse she was responsible to review the care plan and ensure the care plan reflected the resident and their needs. She identified that social service designee (SSD) was responsible for the dementia and behavior portion of the care plan, and she had been struggling a little with care planning. She further reported that she had been working with SSD on some training of writing care plans, and how the MDS triggered certain areas and those should be addressed on the care plan. RN-A stated if there was a triggered CAA for dementia and/or behaviors related to dementia she would expect to see that addressed on the care plan. The care plan was a working document and should be update any time the resident had a change. She reported that getting direct care staff input was part of her assessment process and she put out a form for each shift for the staff to document on what works, doesn't work and a place for comments for her to review and follow up on if needed. She was unsure if SSD interviewed direct care staff for insight but felt that was best practice as the front-line staff know the residents best. After review of R33's care plan she agreed that the care plan lacked individualization and addressed R33's dementia and behaviors related to his dementia. Interview on 2/14/24 at 2:02 p.m., with director of nursing (DON) identified that overall, the nursing department ended up covering everything but, she would expect each department to follow up and do more related to resident care plans and visit with the staff to help individualize them. The SSD had had been given tools to assist her with care planning and SSD has even watch YouTube	F 744		

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F 744	Continued From page 12 videos on how to care plan. Her expectation was that if dementia was triggered on the MDS that it would be addressed on the care plan. R17's 12/8/23, Significant Change Minimum Data Set Assessment (MDS) identified R17's cognition was severely impaired, she had diagnosis of dementia, non-traumatic brain injury, anxiety, and bi-polar disorder. R17 had behaviors of rejection of care 1-3 days during the assessment period. R17's 12/8/23 Care Area Assessment (CAA) identified triggering conditions of Alzheimer's disease or other dementia and displayed characteristics of confusion, disorientation, and forgetfulness. R17's CAA identified that cognitive loss/dementia would be addressed on her care plan with an overall objective to slow or minimize decline, avoid complications, and minimize risks. Interview on 2/13/24 at 4:00 p.m., with nursing assistant (NA)-F identified when R17 is "having a bad day" they sit with her and visit, if she is upset or not talking or refusing care it helps to lotion her legs or visit with her about her family. She collects teacups and enjoys when we talk with her about that or talk with her about her grandson who is a doctor. NA-F identified that R17 sometimes had hallucinations of a small girl in her room, when that happens NA-F consoles her by telling her she is safe and that she is not alone. R17's current care plan printed on 2/13/24, lacked any indication of the interventions mentioned above, nor did it identify any other meaningful interventions for R17's diagnosis of dementia.	F 744		

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F 744	Continued From page 13 Review of 10/26/23, Dementia- Clinical Protocol policy identified that the interdisciplinary team would evaluate residents with cognitive impairments and help identify symptoms. For residents with dementia the facility would develop an individualized care plan to maximize function and quality of life. The care plan would be reviewed for the effectiveness of interventions and revised as needed with the progression of dementia.	F 744		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in	F 755		2/26/24

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F 755	Continued From page 14 sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for monitoring the plastic lock on the emergency kit (E-kit) that contained controlled substances for 1 of 1 E-kits to detect potential diversion at each change of shift. Findings include: Review of the facility's ER KIT item list of what was located in the E-kit identified it contained the controlled medications of lorazepam 0.5 milligrams (mg) 6 tablets and morphine 20 mg/milliliter (ml) oral solution quantity, 15 milliliters. Observation and interview on 2/14/24 at 10:04 a.m., with licensed practical nurse (LPN)-A of the facility medication room. Locked in a cupboard was the facility E-kit with a red plastic lock with the number 882383. LPN-A revealed if the facility removed an item from the E-kit they had to fill out a form and fax it to the pharmacy. The staff would then place a green plastic lock on the E-kit those were located inside the E-kit. The pharmacy would then send a new E-kit and the facility would send the E-kit that had an item removed from it back to the pharmacy. LPN-A confirmed that the E-kit contained controlled medication. LPN-A revealed that the facility did not monitor the E-kit plastic lock number at all. LPN-A confirmed that	F 755	A tracking form has been developed and implemented on 02/26/2024 to enhance the security of emergency medication kit and reduce the risk of drug diversion. The overnight nurse and one day shift nurse will verify and record the E-Kit tag on a daily basis. Audits will be conducted daily x 1 week, weekly x 4 weeks, and monthly x 3 months. Further auditing of the E-Kit tracking form, as well as medication cart counts, will be completed on a random basis and as needed to ensure and maintain compliance. DON is responsible to ensure E-Kit tracking form is audited and remains compliant. Audits will be presented to the QAPI meeting until completed and compliance is secured.	

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F 755	Continued From page 15 during the shift narcotic count that the E-kit was not checked to ensure the plastic lock number was correct and had not been compromised. Interview on 2/14/24 at 10:26 a.m., with the director of nursing (DON) identified she was unaware that the facility should have been monitoring the E-kit plastic lock but agreed it made sense since the E-kit contained controlled medications. She stated, "I just didn't think of that". She agreed by not monitoring the plastic lock on the E-kit there was potential for diversion. She agreed that if someone had removed the controlled medication from the E-kit it was likely that no one would notice until the E-kit had been returned to the pharmacy to be restocked for removal of another medication. She reported she would be implementing a tracking system immediately. Review of 9/19/23, Controlled Substances policy identified the facility would ensure a safe and secure storage system and mechanisms to minimize diversion or loss. Controlled substances that are stored in the locked medication room for emergency or on hand supply would be stored in a locked cupboard. The pharmacy would supply the container that the medication would be stored in with a numbered locking toggle system. At the end of each shift all controlled substances would be counted with the on coming nurse and nurse going off duty. There was no mention of monitoring the lock on the E-kit that contained controlled medications. Review of October 2023, Emergency Pharmacy Service and Emergency Kits identified the pharmacist would inventory the emergency kit every 30 days for expiration dates and ensure	F 755		

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F 755	Continued From page 16 completeness. For controlled substances if a medication was removed from the emergency kit the nurse would reorder, obtain a handwritten prescription for physician and document the replacement of the controlled substance by the date and number of doses received. Accountability for controlled substances identified a inventory system would be used, with a separate sheet for each individual medication in the kit. Each dose used and replacement dose would be entered on the inventory sheet, with the amount remaining identified. The charge nurse going off duty and the charge nurse coming on duty would verify the inventory of controlled substance at each change of shift.	F 755		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but	F 867		2/23/24

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F 867	Continued From page 17 not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to	F 867		

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F 867	Continued From page 18 ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s)	F 867		

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F 867	Continued From page 19 functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure data submitted to the QAPI committee was analyzed and documented to ensure areas identified had oversight for their perspective outcomes brought forth. This had the potential to affect all 41 residents. Findings include: Review of quarterly QAPI meetings from January 2023 through December 2023, identified the facility departments were submitting data to be reviewed by the committee. 2 Examples of failure to analyze and document that process identified in: 1. Quarter 2 April, may, and June of 2023, identified data brought forth that included pressure ulcers, falls, catheter use, and infections. The QAPI minutes failed to identify an analysis of that data to determine the need for improvement, a root cause, a measurable goal, or an action plan for improvement. 2. Quarter 3 July, August, and September 2023, identified data brought forth that included prevalence of falls, pressure ulcers, skin, infections, medication errors. The QAPI minutes	F 867	QAPI plan and meeting structure was reviewed by Administrator & DON and necessary changes were made to implement and align with the requirements and eliminate potential effect on all current residents. A restructuring of the QAPI meeting has been implemented beginning February 23rd, 2024. Revised QAPI structure includes; • Sign-In Sheet with signatures and titles, along with those who were invited and attended, • Formal agenda template including identified necessary focuses, data and research, targets and goals, and system for monitoring. • A tracking system that allows QAPI team to identify, implement, and track high-risk problems that are identified (adverse events, medication errors, falls, etc.). • Progressive log for facility QIIP's and PIP's that details goals, action plans, due dates, and responsible parties. • Tracking of reviews for facility	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 20 lacked any indication that an analysis of the data had been completed to identify problem areas, a root cause, a measurable goal, or action plan for improvement. Interview on 2/14/24 at 10:38 a.m., with the administrator identified she would expect the QAPI minutes to include a thorough analysis of the data, problem areas to be identified, a root cause analysis, a measurable goal, and an action plan for improvement. She agreed that the facility QAPI was missing those components and identified that they were currently working to restructure their QAPI committee program. Review of the facilities 2024, Quality Assurance & Performance Improvement Plan identified the QAPI committee would identify problems and opportunities for improvement, systematically analyze underlying causes of systemic problems and adverse events and develop corrective action or performance improvement activities.	F 867	assessment, QAPI plan, Emergency Preparedness, Infection Control Program/Surveillance to ensure proper timeframes are met and maintained. Additionally, a formal checklist was created to ensure successful implementation of new structure. Checklist ensures that each meeting is tracked on the agenda and followed up with formal minutes that denotes action plans/goals, due dates, and details of data reviewed and analyzed for improvement opportunities. This checklist will be used as a form of tracking linked to this plan of correction. Each month, or at least quarterly, when QAPI meetings are held, the checklist will be given to the Administrator to ensure fulfillment of requirements. Director of Nursing is responsible for ensuring Administrator receives the proper checklist and data for auditing purposes. This ensures that all meetings will be formally and adequately tracked and maintained for retention of records. The administrator will audit the restructuring of QAPI meetings monthly x 4. Correction has been implemented since the monthly QAPI meeting on February 23rd, 2024.	
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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:	F 881		4/1/24

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	245570	A. BUILDING _____ B. WING _____	C 02/14/2024

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F 881	Continued From page 21 §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop and implement a comprehensive antibiotic stewardship program, with established monitoring, to help reduce unnecessary antibiotic use, reduce potential drug resistance, and help prevent the spread of infectious diseases for 5 of 12 residents (R1, R5, R17, R28, and R33) reviewed. Findings include: Review of the facility infection surveillance tracking log identified residents who had been identified as having an infection and being administered an antibiotic. The surveillance logs lacked any documentation that an antibiotic time out had been completed or the date that the infection had been resolved. 1.) R1 was identified as having a urinary tract infection (UTI), she was prescribed an antibiotic cefdinir oral capsule that started on 5/31/23. The surveillance log lacked indication that a 72 hour time out had been completed or when the infection had resolved. 2.) R5 was identified to have had a UTI, she was prescribed an antibiotic Cipro 500 mg on 8/15/23. The surveillance log lacked indication that a 72-hour time out had been completed or when the infection had resolved. 3.) R17 was identified to have had a UTI, she was prescribed an antibiotic Macrobid 100 mg twice daily for 5 days on 8/30/23. She was also identified to have a UTI and started another	F 881	Residents that are currently on antibiotics were surveillance and ensured no adverse effects or resistance were noted, as well as followed up with resident's primary care provider to ensure effective treatment. DON will initiate and maintain a calendar/log that indicates when the resident started on an antibiotic, what type of infection is being treated, duration of treatment, as well as 72-hour "time-outs". 72 hours after a resident is placed on an antibiotic, nursing staff will complete a time-out that evaluates potential resistance, reactions, or unnecessary use that is followed up with by resident's physician. Time outs will take place during IDT and presented by Infection Preventionist, or DON. This review will ensure symptoms are reviewed and appropriateness of antibiotic for treated infection. Nursing staff will continue monitoring each shift for side effects or adverse reactions throughout the entire duration of antibiotic use. Infection Preventionist and DON are responsible for completing overall surveillance and follow-up of antibiotic use and evaluation to reduce improper use or adverse reactions. Audits will be conducted to ensure antibiotic use is being well maintained and time-outs are being completed and reviewed by	

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F 881	Continued From page 22 antibiotic cefdinir 300 mg daily for 7 days, the surveillance log lacked any indication the facility had completed a time out or if either infection had resolved. 4.) R28 was identified as having an upper respiratory infection (URI) and starting an antibiotic on 6/24/23. The surveillance log lacked indication that a 72-hour time out had been completed or when the infection had resolved. 5.) R33 was identified as having an unknown infection, he started an antibiotic amoxicillin 875-125 mg on 5/16/23. The surveillance log lacked indication of what the infection was, did not identify if a time out had been completed, and did not indicate when or if the infection had resolved. Interview on 2/14/24 at 1:34 p.m., with the director of nursing (DON) identified that the surveillance tracking log provided was a program used in the facilities electronic medical record system Point Click Care (PCC) that automatically pulled data when a new order for an antibiotic was entered. The DON stated, "I can't say that I have evaluated or analyzed the data". She identified that the facility has an individual infection resident report that includes all the information such as resolve date and monitoring of symptoms, she reports she has not been completing these reports and states "we just don't have enough hours". She reports she is not reviewing the information to see if there is a correlation to indicate a cause of infections or spread of infections but states "I do look at shift report daily". The DON identified that she has not completed an antibiotic time out since she took the infection preventionist position several months ago.	F 881	resident's physician. Audits to be conducted daily x 10 days, weekly x 4 weeks, monthly x 3 months. Audits and overall antibiotic stewardship will be reviewed during QAPI meetings.	

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F 881	Continued From page 23 Review of the 1/31/2023, facility Antibiotic Stewardship Policy identified all clinical infections treated with antibiotics would undergo a review by the infection preventionist, or designee. The policy identified that the facility would complete an antibiotic time out 72 hours after the first dose is administered and report to the physician. The infection preventionist will review antibiotic utilization and identify specific situation that are not consistent with the appropriate use of antibiotics and notify the physician.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F 883		4/1/24

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F 883	Continued From page 24 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R1, R5, and R28) were offered and/or administered vaccination for pneumonia upon admission or when eligible. This had the potential to affect all 41 residents. Findings include:	F 883	Policies for immunizations were reviewed and updated, as necessary. All current residents reviewed for vaccination status on Influenza and Pneumococcal to determine up-to-date status. Those who are not up-to-date will be notified, residents representatives will be given written and/or verbal education regarding the benefits and potential side effects of	

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F 883	Continued From page 25 Review of the current Centers for Disease Control (CDC) pneumococcal vaccine guidelines located at https://www.cdc.gov/vaccines/vpd/pneumo/hcp/pneumo-vaccine-timing.html, identified for: 1) 2) Adults 65 years of age or older, e) Received PCV-13 at Any Age AND PPSV-23 AFTER Age 65 Years aa) Use shared clinical decision-making to decide whether to administer PCV20. If so, the dose of PCV-20 should be administered at least 5 years after the last pneumococcal vaccine. Review of 5 sampled residents for vaccinations identified: 1) R1 was 94 years old and was admitted to the facility in April of 2022. R2 was administered the PPSV-23 on 9/15/13, and the PCV-13 on 7/17/15. R1 should have been offered and/or provided the PCV-20 at least 5 years after the last pneumococcal vaccine per CDC guidelines. 2) R5 was 90 years old and was admitted to the facility in July of 2018. R5 was administered the PPSV-23 on 6/20/13, and the PCV-13 on 10/2/15. R5 should have been offered and/or provided the PCV-20 at least 5 years after the last pneumococcal vaccine per CDC guidelines. 3) R28 was 90 years old and was admitted to the facility in December of 2021. R28 was administered the PCV-13 on 10/26/15, and the PPSV-23 on 11/20/18. R28 should have been offered and/or provided the PCV-20 at least 5 years after the last pneumococcal vaccine per CDC guidelines. Review of the September 2022, facility Pneumococcal Vaccine Policy identified pneumococcal vaccines or re-vaccinations would be made in accordance with current CDC	F 883	the immunization. To ensure compliance, upon admission, each resident will undergo an immunization review for vaccination status and offered immediate education to resident or representative, which includes type of immunization, benefits and possible side effects, and schedule to maintain up-to-date status. All education and conversations around immunizations will be held within resident's medical record, including whether a resident did or did not receive the offered immunization due to medical contraindication or refusal. Infection Preventionist and DON are responsible for ensuring each resident is offered, educated, and have availability to receive influenza and pneumococcal immunizations per CDC Guidelines. Audit to track vaccination status of residents will be conducted weekly x 4 weeks, monthly x 3 months. Audit and immunizations will be brought to QAPI and reviewed for continued compliance.	

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F 883	Continued From page 26 recommendations.	F 883		

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	245570	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/13/2024**

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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 02/13/2024. At the time of this survey, Maple Lawn Senior Care was found not 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, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/06/2024

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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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. This one-story with partial basement facility was built in 1964, with building additions constructed in 1991 and 2001. All are fully sprinklered. The 1991 addition was determined to be of Type II (000) construction. The 1964 and 2001 buildings were determined to be of Type II (111) construction. BLDG 02 was constructed in 2004, as an addition to the existing nursing home. It is one-story, has a partial basement and is fully sprinklered, and	K 000		

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K 000	Continued From page 2 was determined to be of Type II (111) construction. It consists of a new activities room, new entrance and an elevator/elevator lobbies. There are no patient sleeping or treatment areas in Building 02. These Buildings are being surveyed as one building as allowed in the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. The facility has a capacity of 46 beds and had a census of 41 at the time of the survey.	K 000		
K 920 SS=E	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a	K 920		3/30/24

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K 920	Continued From page 3 structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to install power strips for patient-care-related electrical equipment (PCREE)that meet UL 1363A or UL 60601-1 per NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.2.3.6 and 10.2.4. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 02/13/2024 at 10:00AM, it was revealed by observation that there was medical equipment plugged into non patient-care-related electrical equipment (PCREE) power strips that meet UL 1363A or UL 60601-1 standards. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	Patient rooms were audited for compliance. Resident rooms who were non-compliant with K920 had power strips removed from use. Power strips will be ordered to ensure patient-care-related electrical equipment meets UL 60601-1 standards per NFPA 99. Education to be provided to all staff to ensure compliance and safety of power cords and extension cord use. Maintenance Director is responsible for follow-up and auditing of electrical equipment usage. Maintenance Director will monitor resident vicinities to ensure proper use of power strips and medical equipment monthly x 3. Electrical Equipment will be added and reviewed by QAPI for at least 2 quarters to ensure compliance. Power strips to be placed in proper use by 3/30/2024 assuming shipping and freight arrives in adequate timeframe.	

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	00396	A. BUILDING: _____ B. WING _____	C 02/14/2024

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/12/24 through 2/14/24, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55709497C (MN100162) and H55709499C (MN91291) with licensing orders issued at 1880 and 1980. H55709498C (MN98120) , H55709500C (MN92542), H55709501C (MN92900) were also reviewed with NO licensing orders issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be	2 000		

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	00396	A. BUILDING: _____ B. WING _____	C 02/14/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 2 corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
21600	MN Rule 4658.1335 Subp. 2 Stock Medications; Emergency Supply Subp. 2. Emergency medication supply. A nursing home may have an emergency medication supply which must be approved by the QAA committee. The contents, maintenance, and use of the emergency medication supply must comply with part 6800.6700. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a system for monitoring the plastic lock on the emergency kit (E-kit) that contained controlled substances for 1 of 1 E-kits to detect potential diversion at each change of shift. Findings include: Review of the facility's ER KIT item list of what was located in the E-kit identified it contained the controlled medications of lorazepam 0.5	21600	A tracking form has been developed and implemented on 02/26/2024 to enhance the security of emergency medication kit and reduce the risk of drug diversion. The overnight nurse and one day shift nurse will verify and record the E-Kit tag on a daily basis. Audits will be conducted daily x 1 week, weekly x 4 weeks, and monthly x 3 months. Further auditing of the E-Kit tracking form, as well as medication cart counts, will be completed on a random	2/26/24

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21600	Continued From page 3 milligrams (mg) 6 tablets and morphine 20 mg/milliliter (ml) oral solution quantity, 15 milliliters. Observation and interview on 2/14/24 at 10:04 a.m., with licensed practical nurse (LPN)-A of the facility medication room. Locked in a cupboard was the facility E-kit with a red plastic lock with the number 882383. LPN-A revealed if the facility removed an item from the E-kit they had to fill out a form and fax it to the pharmacy. The staff would then place a green plastic lock on the E-kit those were located inside the E-kit. The pharmacy would then send a new E-kit and the facility would send the E-kit that had an item removed from it back to the pharmacy. LPN-A confirmed that the E-kit contained controlled medication. LPN-A revealed that the facility did not monitor the E-kit plastic lock number at all. LPN-A confirmed that during the shift narcotic count that the E-kit was not checked to ensure the plastic lock number was correct and had not been compromised. Interview on 2/14/24 at 10:26 a.m., with the director of nursing (DON) identified she was unaware that the facility should have been monitoring the E-kit plastic lock but agreed it made sense since the E-kit contained controlled medications. She stated, "I just didn't think of that". She agreed by not monitoring the plastic lock on the E-kit there was potential for diversion. She agreed that if someone had removed the controlled medication from the E-kit it was likely that no one would notice until the E-kit had been returned to the pharmacy to be restocked for removal of another medication. She reported she would be implementing a tracking system immediately. Review of 9/19/23, Controlled Substances policy	21600	basis and as needed to ensure and maintain compliance. DON is responsible to ensure E-Kit tracking form is audited and remains compliant. Audits will be presented to the QAPI meeting until completed and compliance is secured.	

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21600	Continued From page 4 identified the facility would ensure a safe and secure storage system and mechanisms to minimize diversion or loss. Controlled substances that are stored in the locked medication room for emergency or on hand supply would be stored in a locked cupboard. The pharmacy would supply the container that the medication would be stored in with a numbered locking toggle system. At the end of each shift all controlled substances would be counted with the on coming nurse and nurse going off duty. There was no mention of monitoring the lock on the E-kit that contained controlled medications. Review of October 2023, Emergency Pharmacy Service and Emergency Kits identified the pharmacist would inventory the emergency kit every 30 days for expiration dates and ensure completeness. For controlled substances if a medication was removed from the emergency kit the nurse would reorder, obtain a handwritten prescription for physician and document the replacement of the controlled substance by the date and number of doses received. Accountability for controlled substances identified a inventory system would be used, with a separate sheet for each individual medication in the kit. Each dose used and replacement dose would be entered on the inventory sheet, with the amount remaining identified. The charge nurse going off duty and the charge nurse coming on duty would verify the inventory of controlled substance at each change of shift. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist should review, revise, or create policies and procedures for proper security and reconciliation of medications in the emergency kit. Nursing and/or medication aide	21600		

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21600	Continued From page 5 staff should be educated to those changes. The DON or designee, and pharmacist, should routinely audit all medications and storage to ensure compliance. The results of those audits should be taken to QAPI ongoing to determine compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21600		
21880	MN St. Statute 144.651 Subd. 20 Patients & Residents of HC Fac.Bill of Rights Subd. 20. Grievances. Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place. Every acute care inpatient facility, every residential program as defined in section 253C.01, every nonacute care facility, and every facility employing more than two people that provides outpatient mental health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient	21880		3/13/24

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21880	Continued From page 6 or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs as defined in section 253C.01 which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their grievance procedures and ensure they were addressed in a timely manner for 1 of 1 resident (R5). Findings include: Review of 2/19/23, facility report to the state agency (SA), identified R5 requested assistance from staff in her bathroom for a change of clothes. The staff member did not assist R5 and had left R5's room. A second employee arrived in R5's room to assist her with a clothing change. R5 went to the activities director (AD) with her concerns and the AD filed a grievance report on behalf of R5. Interview on 2/13/24 at 4:44 p.m., with social services designee (SSD) stated she did not receive any formal grievances or complaints last year from residents and had no documentation to	21880	Corrected.	

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21880	Continued From page 7 provide upon request. Interview on 2/14/24 at 8:54 a.m., with activities director (AD) related to the above incident identified R5 had visited her the following Monday to discuss her concerns of an employee who cared for her the night before. The AD confirmed she filed a grievance with SSD and the SSD stated to her she would take care of it. Record review of Resident Grievance/Complaint Log the last three years identified R5 had no grievances filed. There was no documentation of grievances from November of 2022 through the date of the survey. Review of the undated Filing Grievances/Complaints Policy identified the appointed designee would receive grievances conduct an investigation and resolution within 5 business days and would notify findings to the Administrator. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to greivances to ensure grievances are acted upon and the resident given a resolution to the identified grievance. The director of nursing, social worker, or designee should develop a system to educate staff and develop a monitoring system such as measurable audits to ensure grievacnes are acted upon and the resolution notification is made to the resident and/or family. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one	21880		

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21880	Continued From page 8 (21) days.	21880		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this	21980		4/1/24

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21980	Continued From page 9 subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to report immediately but not later than 2 hours, allegations of potential abuse to the State Agency for 1 of 1 residents (R4). Findings include: Review of 1/21/24 at 10:40 p.m.., report to the State Agency (SA) report identified earlier on 1/21/24 at approximately 12:01 a.m., nursing assistant (NA-E) informed licensed practical nurse (LPN-C) she refused to scratch R4's genital area as R6 requested. LPN-C found R4 crying in his room and R4 stated he asked NA-E to wash his genital area and NA-E refused. R4's 1/23/24 Significant Change Minimum Data Set (MDS) identified R4 had diagnosis of Aphasia, dementia, hemiplegia/hemiparesis, anxiety and depression. R4 was cognitively intact and required maximum assist for toileting and transfers. R4 took antidepressants daily.	21980	To obtain and ensure continued compliance, education given to all staff for reporting timeframes on allegations on abuse, neglect, exploitation, or mistreatment, including injuries with unknown source and misappropriation of resident property. Training includes immediate, but not less than 2-hour requirements versus 24-hour requirements in relation to serious or non-serious bodily injury or abuse. All staff will be required to understand how to file a report independently, should they receive an allegation that meets immediate, but not less than 2 hours to report. A floor nurse login has been created through OHFC Reporting Site to allow all floor nurses the ability to report in compliance with the required timeframes, should the current users be unavailable to report within such timeframes. Additionally, MDS Coordinator and DON will include threshold requirements for reporting	

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21980	Continued From page 10 Interview on 2/14/24 at 8:35 a.m., with director of nursing (DON) stated she was made aware of the incident the next day and NA-E did not work at the facility after the incident. Interview on 2/14/24 at 4:44 p.m., with NA-E stated she worked on 1/21/24 on the night shift when R4 asked her to clean him. After cleaning him, she stated R4 asked her to scratch his genitals and she refused. R4 said to NA-E if she refused he would get the nurse. NA-E stated she left the room and informed LPN-C of the situation. NA-E stated she worked later that day on the evening shift on 1/21/24 and was approached by the DON who stated that R4 was "afraid of me" and I would not work the rest of my shift. Interview on 2/14/24 at 5:11 p.m., with LPN-C stated R4 had his call light on and found R4 in his room crying. LPN-C stated she cleaned and applied cream to R4's genital area. LPN-C stated R4 said he was upset at NA-E. LPN-C stated to R4 she would handle the situation. LPN-C stated she did not inform the DON of the incident until later that same day and assumed the DON would be notified by other staff who worked that night. Interview on 2/14/24 at 5:28 p.m., with R4 identified he felt NA-E "mistreated" him. R4 refused to answer any other questions and made no mention of the incident noted above. Interview on 2/14/24 at 6:13 p.m., with administrator (ADM) stated her expectations would be for staff to contact her of allegations of potential abuse of residents in the facility. Review of September 2023, Abuse Prohibition and Prevention policy indicated the facility will ensure that all alleged violations involving abuse,	21980	timeframes, information on Incident Reporting in “Quick Guide” binders that are located on each medication cart, nurses station, and CNA stations. DON and Administrator are responsible to ensure compliance with timely reporting for allegations of abuse, neglect, exploitation, maltreatment. DON will complete an audit on compliance of timely reporting daily x 10 days, weekly x 4 weeks, then monthly x 3 months. Audits will be brought to Administrator and QAPI for review and continued surveillance.	

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21980	Continued From page 11 neglect, exploitation or mistreatment of resident property, are reported immediately, but not later than two hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or no later than 24 hours if the events that cause the allegation do no involve abuse and do not result in serious bodily injury, to the director of nursing, administrator of the facility and to officials including the state agency. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise policies or procedures to ensure timely reporting of all allegations of abuse or neglect are within appropriate timeframes for reporting. The facility should re-educate staff to policies and procedures, and audit all complaints of alleged abuse or neglect in a measurable and specific way. The results of those audits should be taken to the Quality Assurance Performance Improvement (QAPI) committee to determine the need for further monitoring or compliance. Those audits should be ongoing and random after compliance is determined by QAPI to ensure compliance is being maintained. TIME PERIOD FOR CORRECTION: 21 DAYS	21980		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 12, 2024

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

Re: Reinspection Results
Event ID: GBP112

Dear Administrator:

On April 11, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 14, 2024. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
April 12, 2024

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

RE: CCN: 245570
Cycle Start Date: February 14, 2024

Dear Administrator:

On April 11, 2024, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112
Email: Kamala.Fiske-Downing@state.mn.us