STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245362	A. Building B. Wing	08/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mapleton Community Home	301 Troendle Street SW Mapleton, MN 56065

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide timely repositioning and toileting for 1 of 3 residents (R5) reviewed for pressure ulcer care and who was dependent on staff for repositioning, toileting, and who had a PU on her sacrum. Findings include:R5's face sheet received on 8/20/25, included diagnoses of a stage 4 pressure ulcer (PU) to sacral region, and obesity.R5's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated severe cognitive impairment. R5 had clear speech, was usually understood and could usually understand. R5 was dependent upon staff for all activities of daily living (ADLs) and had no rejection of care. R5 was always incontinent of bowel and bladder. R5 was at risk for pressure ulcers and had one stage 4 PU present on admission in May 2022. R5's significant change MDS care area assessment (CAA) dated 9/23/24, indicated R5 was at risk for skin breakdown related to decreased mobility, inability to change or shift positions, urinary and bowel incontinence, previous pressure ulcer, and poor nutrition. R5 was repositioned every one-two hours. Resident had a pressure relieving mattress on her bed and pressure reducing cushion in her chair. R5's physician orders included: --3/18/24: Lay down between 12:30 p.m. and 1:00 p.m., and be up by 2:00 p.m., for activity. Husband upset R5 not out of bed and going to activities. -- 7/22/25: Encourage R5 to lay down for at least one hour between meals to help offload (relieve or redistribute pressure from at-risk areas of the body - typically a wound) after meals related to pressure ulcer of sacral region, stage 4. -- 8/8/25: Continue with Broda type wheelchair with built in memory cushions. Encourage R5 to lay down for at least one hour between meals to help offload every shift. -- 8/8/25: T & R (turn and reposition)/offload at least every two hours or more frequently as indicated.R5's care plan with revision date of 8/21/23, indicated R5 had actual impairment to skin integrity related to healing stage 4 pressure injury on her coccyx. Care plan dated 7/29/24, indicated R5 was to lie down in bed for two to three hours per day. When in wheelchair, reposition every two hours - standing in place for one minute. While in bed, turn on side. R5's care plan with revision date of 9/19/24, indicated total assist of two staff to use toilet with mechanical lift. R5's care plan with revision dated of 8/20/25, indicated extensive assist of one staff to reposition and turn in bed. Wound provider notes indicated: --5/16/25: sacral ulceration measure 0.4 cm (centimeters) x 0.6 cm x 0.3 cm. Wound has decreased in size. No odor or drainage. Tissue is friable (delicate and prone to easy tearing or bleeding when touched or manipulated) and 100% granular new connected tissue which forms on the surface of a would during healing). Margins intact and irregular. --6/20/25: sacral ulceration measured 1.4 cm x 1 cm x 0.2 cm. Wound has increased in size. No odor or drainage. Tissue is friable and 100% granular. Margins intact.--8/8/25: Sacral ulceration measured 1.3 cm x 2.3 cm x 0.4 cm. Wound has increased in size. No odor or drainage. Tissue is friable and 100% granular. Margins intact.Wound nurse note dated 8/20/25, indicated: sacrum: 1.0 cm x 1.5 cm x 0.3 cm. Granular base. Pink healthy skin. No pain or discomfort. Drainage noted. During continuous observation on 8/19/25 from 8:20 a.m., to 1:00 p.m., R5 was not checked or changed, nor repositioned: At 8:20 a.m., R5 was observed in her wheelchair in the dining room for breakfast. At 9:10 a.m., R5 was in her room in her wheelchair. The small plastic will return clock on the outside of R5's door indicated 10:30 a.m., the time when R5 should be checked, changed and/or (continued on next page)

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.

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

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	repositioned.At 9:55 a.m., R5 was taken via wheelchair to bible study in the chapel.At 10:36 a.m., R5 was still in the chapel, sitting in her wheelchair in a row with other residents. At 11:23 a.m., R5 was moved from the chapel to the activity room for an activity and to await lunch. R5 remained in her wheelchair. At 11:56 a.m., R5 was moved to the dining room via wheelchair for lunch. At 12:36 p.m., R5 was transported from the dining room to her room via wheelchair. At 12:49 p.m., R5 remained in her wheelchair in her room. During an observation and interview on 8/19/25 at 1:00 p.m., nursing assistant (NA)-B and NA-C entered R5's and assisted R5 to lay down in bed via mechanical lift. Once R5's adult diaper was removed, NA-B stated it was pretty wet. The absorbent part of the adult diaper was significantly expanded. R5 was turned onto her right side. R5 had a large and fleshy buttock, and the lower half was pinkish/red in color with many skin creases. A new adult diaper was applied and R5 was repositioned onto her left side with a bolster pillow behind her back. NA-B stated R5's buttock was red from sitting so long, adding R5 also had a lot of wrinkles in her skin from sitting. NA-B stated the last time R5's adult diaper had been changed, or she had been repositioned was about 8:00 a.m. that morning. NA-B stated R5 needed special care because of the wound on her bottom and stated she R5 should be offloaded every two hours. NA-B stated it was hard to do every two hours because of the activities R5 attended. During an interview on 8/20/25 at 11:31 a.m., the director of nursing (DON) stated she went through camera footage and observed staff had not changed or repositioned R5 for more than four hours on 8/19/25. DON had interviewed licensed practical nurse (LPN)-A who had been on duty to determine if NAs reported any behaviors indicating R5 refused to lay down. There were no behaviors or refusals. DON stated R5's family wanted her at activities, but R5 should still be checked and changed and offloaded every two hours. DON stated on 8/19/25, staff had an opportunity to take R5 back to her room after chapel to change her, or before or during music-in-motion activity and offload before lunch. DON stated she had been working hard with staff to ensure R5 was offloaded and had implemented the will return clock outside of R5's room as a tactic to help remind staff to reposition and/or change R5's adult diaper. During an observation on 8/20/25 at 12:40 p.m., with DON, looked at R5's PU. DON pulled back the border adhesive dressing. DON described PU was circular shaped and the approximate diameter of a D-size battery. No drainage observed. Tissue around PU was skin colored. DON stated the PU waxed and waned in size. DON stated a wound provider assessed the wound monthly and an employed wound nurse assessed it weekly. This was verified with document review. Facility Pressure Ulcer Prevention Program policy, undated, indicated a resident admitted with a pressure ulcer would receive treatment and services to promote healing, pretention infection and prevent new pressure ulcers from developing. Facility Pressure Ulcer Management Program, undated, indicated if a resident had an order for a specific repositioning schedule, the resident would receive a will return clock, placed on the resident's door. Upon completion of repositioning, the nursing staff would turn the clock to the next time that repositioning is due so that all parties working with the resident would be aware of the turning schedule.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure safe and appropriate water temperatures were maintained below 120 degrees Fahrenheit (F) to prevent potential scalding for 2 of 2 residents (R37, R28) observed for accidents and hazards. Findings include:R37's facesheet received on 8/20/25, included diagnosis of Parkinson's disease. R37's quarterly Minimum Data Set (MDS) assessment dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R37 was independent with personal hygiene, toileting and toileting hygiene. R37 used a wheelchair and walker for mobility. R37's care plan with revised date of 12/23/23, indicated R37 needed extensive assist with toileting. R37's care plan with revised date 10/27/23, indicated R37 needed extensive assist of one for personal hygiene.During an observation and interview on 8/18/25 at 2:07 p.m., in R37's room, noted water at the bathroom faucet seemed excessively hot to the touch. R37 agreed and stated he didn't want to tell anyone because others (residents) complained it wasn't hot enough. R37 stated he used the bathroom independently. R28's facesheet received on 8/20/25, included chronic kidney disease.R28's annual MDS dated [DATE], indicated intact cognition, clear speech, was understood and could understand. R28's used a walker and wheelchair for mobility and was independent with personal hygiene, toileting and toileting hygiene. R28's care plan with revised date of 11/15/23, indicated independence with personal hygiene and care plan with revised date of 10/3/23, indicated independence with toileting.During an observation and interview on 8/18/25 at 3:30 p.m., in R28's room, noted water at the bathroom faucet seemed excessively hot to the touch. R28 stated the water got pretty hot but she had not burned herself. During an observation and interview on 8/19/25 at 8:29 a.m., with director of environmental services (DES)-A, he measured the water temperature at R37's bathroom faucet with a mug and a digital thermometer with probe. The temperature reached 121.8 degrees Fahrenheit (F). DES-A stated he tried to keep the temperature between 115 and 118-degrees F and was aware the water temperature in resident bathrooms should not exceed 120 degrees F due to potential for scalding a resident. DES-A stated all bathroom faucet water temperatures in this hallway would be the same, as the water was coming from the same location. DES-A stated he did not regularly check water temperatures - only when he noticed water seemed too hot or staff reported the water was hot and did not document water temperatures. DES-A stated most residents complained about water being too cold. DES-A stated he would turn the water temperature down. During an observation and interview on 8/19/25 at 9:16 a.m., DES-A measured the water temperature at R28's bathroom faucet at 121.3 degrees F. R28 stated she used her bathroom independently. During an interview on 8/20/25 at 7:44 a.m., trained medication aide (TMA)-A stated both R37 and R28 used their bathrooms independently. During an interview on 8/20/25 at 7:45 a.m., DES-A stated now the water temperature in R37 and R28's hallways was 115 degrees F. and stated he had started working on a process to monitor and record the temperatures going forward. Facility policy on monitoring water temperatures in resident bathrooms was requested and not received.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review the facility failed to ensure personal protective equipment (PPE) was utilized for 1 of 3 residents (R21) reviewed for pressure ulcers.Findings include:R21's admission Minimum Data Set (MDS) dated [DATE], indicated sever cognitive impairment, one stage two pressure ulcer present on admission, four stage two pressure ulcers present on admission, and diagnoses included open wound left food, open wound left lower leg, open wound left buttock.R21's care plan revised 6/12/25, indicated actual impairment to skin integrity r/t (related to) decreased mobility, poor nutrition, current wounds; complete wound care as ordered.On 8/19/25 at 11:05 a.m., no signage was posted to indicate R21 was on enhanced barrier precautions (EBP), and registered nurse (RN)-A and nursing assistant (NA)-A were present in R21's room. RN-A and NA-A were observed with gloves on hands, however, were not wearing gowns. RN-A and NA-A were observed to roll R21 from side to side while in bed, and RN-A was observed to complete wound care on R21. R21 was observed with open wound on buttocks area, RN-A was observed and completed wound care and applied a dressing to R21's buttocks. NA-A completed R21's brief change. RN-A and NA-A removed gloves and disinfected hands prior to exiting R21's room.On 8/19/25 at 11:44 a.m., NA-A stated she had asked the director of nursing (DON) if gowns were required and was educated by the DON R21's wound did not meet requirements that required gown or additional PPE beyond gloves.On 8/19/25 at 11:47 a.m., RN-B stated R21 had chronic wounds that were opened and would expect R21 was placed on EBP with the wounds.On 8/19/25 at 11:50 a.m., RN-A stated R21 was not on EBP that required a gown to be worn during the dressing change.On 8/19/25 at 11:53 a.m., the director of nursing (DON), who also served as the facility's infection preventionist, stated the facility's EBP policy applies to residents with catheters, central lines, wound vacuums, or wounds with depth/tunneling. DON acknowledged misinterpreting EBP guidelines, and confirmed R21 had chronic pressure wounds and should have been on EBP. DON stated she would immediately place PPE and signage outside R21's room.Facility policy titled Infection Prevention and Control Manual Transmission-Based Precautions dated 2024, indicated:Enhanced Barrier Precautions (EBP) Policy.It is the policy of this facility that Enhanced barrier precautions in addition to standard and contact precautions will be implemented during high risk care activities from caring for residents that have increased risk for acquiring a multi-drug resistant organism (MDRO), such as a resident with wounds and dwelling medical devices or residents with infection or colonization's with an MDROEnhanced barrier precautions refer to an infection control intervention designed to reduce transmission of multi drug resistant organisms that employs targeted gown and gloves used during high contact resident care activitiesProtective equipment is required for all staff providing high contact resident activities to include: gown and gloves: with transferring, providing hygiene , changing liens, changing briefs, wound care: any skin opening requiring a dressing.