DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 14CU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00520

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245276**

2.STATE VENDOR OR MEDICAID NO.
(L2) **010343800**

3. NAME AND ADDRESS OF FACILITY
(L3) **MAPLEWOOD CARE CENTER**
(L4) **1900 SHERREN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55109**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/08/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **130** (L18)

13.Total Certified Beds **130** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II 02/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/20/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/14/2017
(L33)

Posted 03/21/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245276
March 20, 2017

Ms. Sara Sterling, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Dear Ms. Sterling:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective January 31, 2017 the above facility is certified for or recommended for:

130 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 130 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 17, 2017

Ms. Sara Sterling, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: Project Number S5276027

Dear Ms. Sterling:

On January 10, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 30, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 30, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 31, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 30, 2016, effective January 31, 2017 and therefore remedies outlined in our letter to you dated January 10, 2017, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245276	A. Building B. Wing	2/8/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.21(b)(3)(ii) LSC	Correction Completed 01/31/2017	ID Prefix F0309 Reg. # 483.24, 483.25(k)(l) LSC	Correction Completed 01/31/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 03/17/2017	SIGNATURE OF SURVEYOR 30922	DATE 02/08/2017
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
12/30/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 14CU

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(L2) **010343800**

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(L3) **MAPLEWOOD CARE CENTER**
(L4) **1900 SHERREN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55109**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/30/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

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13.Total Certified Beds 130 (L17)

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A. In Compliance With
Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program
Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: (L12)

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	130			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE Date :
Mary Heim, HFE NE II 01/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 02/13/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
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3. Both of the Above :
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05/01/1985
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 02/14/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 10, 2017

Ms. Sara Sterling, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: Project Number S5276027

Dear Ms. Sterling:

On December 30, 2016, a standard 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 30, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5276090 that was found to be unsubstantiated.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be

contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by February 8, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a 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:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC 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. 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, 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. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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 March 30, 2017 (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). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 30, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 12/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5276090 was completed and found not to be substantiated.	F 000		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, the facility failed to ensure the care plan was followed for 1 of 3 residents reviewed for personal hygiene and skin conditions, R138. Findings include:	F 282	F000. The Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be	1/31/17

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

Electronically Signed | 01/19/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 12/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(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 282	Continued From page 1 The care plan, last revised 12/29/16, directed staff "Check and Change Program: Resident is unable to take self to the toilet, has cognitive limitations and does not identify need to use toilet on a regular basis. Staff to check resident on arising, before and after meals, and before going to bed. Staff to assist with change of brief as needed. Peri care am [morning] and hs [bed time] and after each incontinent episode." ; "Confined to chair, will need assistance for toileting." ; "Diuretics (urgency, frequency) taken, potential for urinary frequency or urgency, offer toilet frequently through out the day." ; "Encourage fluid intake." ; History of UTI. Observe for changes in character of urine, frequency, co of [complaints of] abdominal discomfort, changes in cognition and behavior, elevated T." ; "Large brief." ; and "Unable to tell need to urge to void/defecate." During observations on 12/29/16 from 8:00 a.m. to 12:14 p.m. revealed R138 was not offered check and change services between breakfast and lunch. At 8:00 a.m., R138 was sleeping in wheelchair at the dining room table. After lunch, at 12:08 p.m., R138 was slumped forward in the chair with eyes closed. At 12:14 p.m., R138 was wheeled by NA-A to R138's room. A nursing assistant, (NA)-C, along with NA-A, offered R138 to use the toilet or get incontinence brief changed in bed. R138 chose the bed. NA-A and NA-C use a transfer belt and R138 was transferred from wheelchair to sitting and then laying in bed. NA-A and NA-C assisted R138 to roll back and forth and removed R138's pants and incontinence brief. There was an odor of sweat as R138's brief was removed. R138 had slightly pink and red areas in creases underneath the belly. NA-C wiped front perineal area and applied barrier cream to the crease. R138's bottom area was	F 282	construed as an admission against interest of the facility, its Administrator or any employee, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance within ten days of the receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance with this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admissions by the facility. F282. It is the policy of Maplewood Care Center to ensure each resident□s care plan is followed. Resident #138 identified in this statement of deficiency has been clinically reassessed for toileting needs and a skin assessment was conducted on 12/29/16. No changes were made at this time. All staff responsible for care for resident has been educated on resident□s care plan in regards to toileting plan and skin integrity reporting. The Director of Nursing and/or Nurse Manager has implemented corrective actions for other residents potentially	

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	245276	A. BUILDING _____ B. WING _____	C 12/30/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

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F 282	Continued From page 2 noted to be red as well. NA-C noted R138's skin becomes red with incontinence and it would appear and then resolve. NA-C reported she will return in half an hour to apply cream to R138's bottom as R138 had fallen asleep. When asked about the last time R138 was checked, NA-A reported R138 had a shower this morning. When asked if R138 sat in the wheelchair without being checked since then, NA-A reported she thought she took R138 to the toilet at 10:00 a.m., however at 2:37 p.m. NA-C reported she did not assist with toileting R138 at 10:00 a.m., so was unsure if R138 used the toilet at that time. On 12/30/16 at 9:19 a.m. the nurse manager, (RN)-B reported there was no particular time frame for checking and changing R138's brief before and after meals, but reported she would expect staff to check R138's brief and change it, if needed, between breakfast and lunch.	F 282	affected by this practice including: care plan review in regards to toileting needs and bowel and bladder incontinence; and weekly skin checks by January 19, 2017. No other residents have had skin issues related to toileting plans. The Director of Nursing and/or Designee will implement measures to ensure that this practice does not recur, including: weekly IDT skin/wound rounds, quarterly care plan review for all residents, weekly care plan reviews for residents with skin integrity concerns; policy review of the following policies and procedures Prevention and Treatment of Skin Breakdown, Incontinence Care, Care Plan. The Medical Director will review current policies. Nursing staff were trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by January 31, 2017. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Auditing of nursing assistants following toileting plans for R138 and randomized other residents weekly for one month, then monthly for two months. Upon completion of audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the audits. Failure to adhere to educated protocols	

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F 282	Continued From page 3	F 282	will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for three months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing will be responsible for maintaining compliance. The facility alleges that it will be in substantial compliance with the standard indicated by January 31, 2017.	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such	F 309		1/31/17

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F 309	Continued From page 4 services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on document review, interview and observation, the facility failed to ensure 1 of 3 residents reviewed for skin conditions and personal hygiene, R138, was provided with necessary services. Findings include: R138's admission minimum data set [MDS], dated 9/14/16 revealed R138 was frequently incontinent of urine. R138's quarterly MDS, dated 12/14/16, revealed R138 was always incontinent of urine and required extensive assistance from two or more staff for bed mobility, transfers, toileting and personal hygiene. R138's quarterly MDS indicated severe cognitive impairment. R138's urinary incontinence care area assessment, dated 9/14/16, revealed "Resident is incontinent of urine and stool related to: Cognitive impairment, Diuretic use, History of constipation, History of UTI [urinary tract infection], functional incontinence, Memory loss, psychoactive drug use. Mobility restrictions making resident unable to take self to the toilet, does not identify the need to use the toilet on a regular basis." On 12/27/16 at 7:23 p.m., a family member of R138, (F)-A, reported concerns related to R138 getting the assistance R138 needed with toileting. F-A reported R138 sometimes had to wait a long time to use the bathroom. F-A noted sometimes R138 or R138's clothes had an unpleasant odor.	F 309	F309. It is the policy of Maplewood Care Center to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Resident #138 identified in this statement of deficiency has been clinically reassessed for toileting needs and a skin assessment was conducted on 12/29/16. No changes were made at this time. All staff responsible for care for resident has been educated on resident□s care plan in regards to toileting plan and skin integrity reporting. The Director of Nursing and/or Nurse Manager has implemented corrective actions for other residents potentially affected by this practice including: care plan review in regards to toileting needs and bowel and bladder incontinence; and weekly skin checks by January 19, 2017. No other residents have had skin issues related to toileting plans. The Director of Nursing and/or Designee will implement measures to ensure that this practice does not recur, including: weekly IDT skin/wound rounds, quarterly care plan review for all residents, weekly	

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F 309	Continued From page 5 The care plan, last revised 12/29/16, directed staff "Check and Change Program: Resident is unable to take self to the toilet, has cognitive limitations and does not identify need to use toilet on a regular basis. Staff to check resident on arising, before and after meals, and before going to bed. Staff to assist with change of brief as needed. Peri care am [morning] and hs [bed time] and after each incontinent episode." ; "Confined to chair, will need assistance for toileting." ; "Diuretics (urgency, frequency) taken, potential for urinary frequency or urgency, offer toilet frequently through out the day." ; "Encourage fluid intake." ; History of UTI. Observe for changes in character of urine, frequency, co of [complaints of] abdominal discomfort, changes in cognition and behavior, elevated T." ; "Large brief." ; and "Unable to tell need to urge to void/defecate." During observations on 12/29/16 from 8:00 a.m. to 12:14 p.m. revealed R138 was not offered check and change services between breakfast and lunch. At 8:00 a.m., R138 was sleeping in wheelchair at the dining room table. A plate of food was brought to R138. R138 ate and drank breakfast without assistance. At 8:22 a.m., the plate was cleared from the table by the director of nursing (DON). R138 sat at the table without a plate of food, nodding head and falling asleep until pills were brought to R138 at 8:48 a.m. by the floor nurse (RN)-A. R138 remained at the table until moved to the nearby lounge at 9:04 a.m. At 9:26 a.m. a nursing assistant (NA)-A wheeled R138 to the memory care unit, where the scale was located. At 9:28 a.m., R138 was wheeled by NA-A back to the lounge. At 9:28 a.m., R138 participated in an exercise group with	F 309	care plan reviews for residents with skin integrity concerns; policy review of the following policies and procedures Prevention and Treatment of Skin Breakdown, Incontinence Care, Care Plan. The Medical Director will review current policies. Nursing staff were trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by January 31, 2017. The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Auditing of nursing assistants following toileting plans for R138 and randomized other residents weekly for one month, then monthly for two months. Upon completion of audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the audits. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for three months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan. Facility Director of Nursing will be responsible for maintaining compliance.	

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F 309	Continued From page 6 foam noodles and a ball. At 9:50 a.m.,the activity was over. R138 remained in the lounge, nodding off, sleeping and watching the television. At 10:50 a.m. NA-A greeted R138 and told R138 it was almost lunch time. R138 looked up at NA-A and smiled. At 11:04 a.m., NA-A wheeled R138 back to the dining room table. At 11:22 a.m. the dietician brought R138 a plate of food to R138. At 11:33 a.m. a nursing assistant, (NA)-B assisted R138 with eating lunch. At 11:51 a.m. NA-B brought R138 back to the lounge. At 12:08 p.m., R138 was slumped forward in the chair with eyes closed. At 12:14 p.m., R138 was wheeled by NA-A to R138's room. A nursing assistant, (NA)-C, along with NA-A, offered R138 to use the toilet or get incontinence brief changed in bed. R138 chose the bed. NA-A and NA-C use a transfer belt and R138 was transferred from wheelchair to sitting and then laying in bed. NA-A and NA-C assisted R138 to roll back and forth and removed R138's pants and incontinence brief. There was an odor of sweat as R138's brief was removed. R138 had slightly pink and red areas in creases underneath the belly. NA-C wiped front perineal area and applied barrier cream to the crease. R138's bottom area was noted to be red as well. NA-C noted R138's skin becomes red with incontinence and it would appear and then resolve. NA-C reported she will return in half an hour to apply cream to R138's bottom as R138 had fallen asleep. NA-C and NA-A reapplied a new incontinence brief and readjusted R138's pants. R138 napped in bed. When asked about the last time R138 was checked, NA-A reported R138 had a shower this morning. When asked if R138 sat in the wheelchair without being checked since then, NA-A thought R138 was taken to the toilet at 10:00 a.m., however at 2:37 p.m. NA-C reported	F 309	The facility alleges that it will be in substantial compliance with the standard indicated by January 31, 2017.	

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F 309	Continued From page 7 she did not assist with toileting R138 at 10:00 a.m., so was unsure if R138 used the toilet at that time. On 12/30/16 at 9:19 a.m. the nurse manager, (RN)-B reported there was no particular time frame for checking and changing R138's brief before and after meals, but reported she would expect staff to check R138's brief and change it, if needed, between breakfast and lunch.	F 309		

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	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**12/28/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maplewood Care Center was found to be 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. This 3-story building was constructed in 1964 and was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 149 beds and had a census of 103 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.