DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
December 20, 2023

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 26, 2023

Dear Administrator:

On December 14, 2023, the Minnesota Departments of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 20, 2023

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: Reinspection Results
Event ID: 3BQY12

Dear Administrator:

On December 14, 2023 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 October 26, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2023

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 26, 2023

Dear Administrator:

On October 26, 2023, 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 isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 January 26, 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 April 26, 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,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 10/26/2023

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
E 000	Initial Comments On 10/23/23 through 10/26/23 a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) 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 10/23/23 through 10/26/23, 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: H52766551C (MN89305) and H52766652C (MN97957). The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3)	F 655		12/7/23

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

Electronically Signed | 11/16/2023

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 655	Continued From page 1 §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions.	F 655		

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F 655	Continued From page 2 (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a baseline care plan was reviewed and provided timely to ensure knowledge of care and promote person-centered care planning for 1 of 2 residents (R24) reviewed for care planning. Findings include: R24's face sheet undated, indicated R24 admitted to the facility 9/11/23, was readmitted to the hospital on 9/23/23, and readmitted to the facility on 10/11/23 R24's admission cognition assessment dated 9/17/23, indicated R24 was cognitively intact. R24's diagnoses list dated 9/11/23, indicated R24's diagnoses included spinal stenosis cervical region, diabetes mellitus, occlusion and stenosis of left carotid artery, and cerebral infarction (disrupted blood flow to the brain) R24's baseline care plan initiated 9/12/23, included pain, psychotropic medications, respiratory diagnosis, and skin with no interventions listed. During interview on 10/26/23 at 12:20 p.m., R24's significant other (SO) indicated he had not received any information regarding R24's plan of care or what the expectations for R24 were. SO	F 655	This plan of correction is prepared and executed because it is required by the provisions of the State and Federal regulations and not because the facility agrees with the allegations and citations listed in the statement of deficiencies. Maplewood Care Center maintains the alleged deficiencies do not individually or collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. Affected Resident(s): R24 had a 48-hour baseline care plan developed. Potential Affected Resident(s): All residents who have been admitted in the last 3 months were audited to see that their 48-hour baseline care plan is in place. Those missing their plan we given a copy of their baseline care plan and medication list. Measures/Systematic Changes: Policy and Procedure: 48-Hour Care Plan Summary and Baseline Care Plan was	

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F 655	Continued From page 3 denied R24 having a care conference or being invited to a care conference, or being provided anything verbally or in writing regarding R24's cares. During interview on 10/26/23 at 1:36 p.m., social service director stated an initial care conference should be held by day 21. She verified a 48 hour care plan was not given to R24 and the process needs improvement. The facility policy: 48 Hour Care Plan Summary & Baseline Care Plan dated 5/18/2023, indicated, "The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- be developed within 48 hours of a resident' s admission. Once the 48 hour summary and care plan is complete both must be printed out, reviewed with and a signed copy given to the resident or resident representative prior to completion of the comprehensive care plan. "	F 655	reviewed and remains current. Education was provided to the interdisplinary Team. Monitoring: Audits for baseline care plan on new admitted residents will be done weekly. Frequency will be weekly. Chart audits will be completed for up to 5 residents for 2 weeks; Up to 2 residents for 2 weeks and then 1 resident weekly for 4 weeks. The Director of Social Services/designee will be responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.	F 657		12/7/23

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F 657	Continued From page 4 (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan for 1 of 1 resident (R54) reviewed for ongoing medication refusals. Findings include: R54's quarterly Minimum Data Set (MDS) dated 8/11/23, indicated R54 had cognitive impairment and rejection of care which occurred one to three days in a seven day period. R54's face sheet printed 10/23/23, indicated diagnosis of major depressive disorder recurrent (a mood disorder that causes a persistent feeling of sadness and loss of interest) generalized anxiety disorder (GAD; the feeling of being extremely worried or nervous more frequently about things, even when there is little or no reason to worry about them), dissociative and	F 657	Affected Resident(s): R 54 was affected by F657 had their care plan reviewed and updated. Resident was offered a care conference. Potential Affected Resident(s): All residents who were admitted in the last 3 months have had their care plans reviewed, updated and were offered a care conference. Measures/Systematic Changes: Policy/Procedure: Comprehensive Care Plan was reviewed and remains current. Education to be provided to the Interdisplinary Team Monitoring: Audits of weekly care planning for timing and revision to be done weekly.	

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F 657	Continued From page 5 conversion disorder (mental health conditions that can occur together. Dissociative disorders cause a person to become disconnected from important aspects of their lives. Conversion disorder causes physical symptoms that mimic neurological conditions), and personal history of transient ischemic attack (a stroke that lasts only a few minutes. It occurs when the blood supply to part of the brain is briefly interrupted). R54's care plan undated, lacked documentation of ongoing medication refusals with goals and intervention to address R54's daily refusals of medications since transferred to the second floor in 7/2023. R54's physician orders as of 10/25/23, included the following medications: -Fluoxetine Hydrochloride (hcl) capsule 30 milligram (mg) by mouth (PO) one time a day related to major depressive disorder. -Lisinopril 20 mg tablet PO one time a day related to essential hypertension. -Remeron tablet give 15 mg PO at bedtime related to major depressive disorder. -Carvedilol tablet give 25 mg po two times a day related to essential hypertension. R54's medication administration record (MAR) for 10/2023, indicated R54 refused all her medications daily for at least 25 days up to the time of review on 10/26/23, and was coded a "3" on the MAR, which indicated refusals. R54's progress notes included the following: -8/10/23 at 9:05 a.m., shook head no when morning meds offerred. Refused breakfast to her room. -8/14/23 at 11:05 a.m., resident refused all	F 657	Frequency will be weekly. Up to five residents for two weeks; 2X per week for two weeks and then weekly for 4 weeks. The Director of Social Services/designee shall be responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 657	Continued From page 6 morning medication; she stated she will take them when the doctor says she can leave second floor. -10/2/23 at 7:17 p.m., resident is resistive to taking her meds -10/6/23 at 9:28 a.m., resident refused to take her scheduled medication. After review of R54's numerous progress notes, lacked documentation of R54's ongoing daily refusals of medications with no interventions. During an interview on 10/25/23 at 11:26 a.m., nurse manager registered nurse (RN)-C verified R54 did not have a care plan with goals and interventions regarding R54's ongoing daily refusals of medications and verified R54's ongoing daily refusals of medications should have been care planned. During an interview on 10/26/23 at 1:00 p.m., MDS coordinator (MDSC) stated there should be a careplan if R54 had ongoing medication refusals since R54 was coded for rejection of care. MDSC verified R54 did not have a care plan in place to verify the ongoing medication refusals. During an interview on 10/26/23 at 1:30 p.m., director of nursing (DON) stated R54 should have a care plan in place for her ongoing refusals of medications with goals and interventions, and verified R54 did not currently have one. DON further clarified the care plan could be done as a target behaviour with approaches and would be beneficial if R54 had one. The facility policy updated 10/2022, indicated it is the policy of Volunteers of America to provide a temporary care plan within 48 hours of admission	F 657		

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F 657	Continued From page 7 (Admission Individual Care Plan) and a complete person centered and comprehensive care plan by the resident's 21st day of admission. The care plan will ensure the resident the appropriate care required to maintain or attain the resident's highest level of practicable function possible consistent with resident rights. This comprehensive care plan will have problem/strength statements, measureable goal statements, treatment preferences and interventions. The care plan will be written in a culturally competent manner recognizing the patient's diverse values, beliefs, and behaviors, including tailoring delivery to meet patient's social, cultural, and linguistic needs.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor skin conditions for 1 of 1 resident (R238) who had facial bruising upon admission. The facility also failed to ensure physician's orders were accurately transcribed for 1 of 1 resident (R13)reviewed who required follow-up care after skin excisions.	F 684	Affected Resident(s): R238 has discharged. R13 care plans were reviewed to ensure all physician orders, treatment(s) and cares are accurately transcribed. Potential Affected Resident(s): All other residents with skin concerns	12/7/23

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F 684	Continued From page 8 Findings include: R238's admission Minimum Data Set (MDS) dated 10/16/23, indicated intact cognition and diagnoses of displaced fracture of the second cervical vertebra, osteoporosis with current pathological fracture, chronic pain syndrome, and syncope (fainting) and collapse. It further indicated R238 required moderate assistance with activities of daily living (ADL), dependent on staff for transfers and mobility and had a fall with fracture prior to admission. R238's admission/readmission (day 1) assessment dated 10/10/23, indicated R238 had facial bruising under her right eye. R238's nursing weekly skin checks dated 10/15/23 and 10/22/23 lacked documentation of the bruise under her right eye. During observation/interview on 10/23/23 at 8: 11 a.m., R238 was lying in bed wearing a cervical collar and had a bruise underneath her right eye. R238 stated she received the bruise as a result of a fall at home before she was admitted. During an observation on 10/25/23 at 9:21 a.m., R238 was sitting in her wheelchair in her room, watching television. She had her cervical collar on had a bruise underneath her right eye. During an interview on 10/26/23 at 9:21 a.m., registered nurse (RN)-B stated when a resident was admitted with a bruise or a new bruise was discovered, the nurses were responsible for filling out a risk management and documenting it. Then going forward, the nurse would be responsible for documenting the bruise on the weekly skin	F 684	and/or treatments will be audited to ensure treatment and care is being provided. Measures/Systematic Changes: Physician's Order and Body Audit Policy/Procedure was reviewed and remains current. Education to be provided to the licensed nurses. Monitoring: Audits of weekly skin checks for residents will continue to be done weekly and results reported at clinical meeting. Frequency will be weekly. Three residents per week x 2 weeks; then, two residents per week x 2 weeks; then, one resident per week x 4 weeks. Director of Nursing/designee will be responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 684	Continued From page 9 assessments and monitoring it until it was resolved. During an interview on 10/26/23 at 9:31 a.m., licensed practical nurse (LPN)-A verified R238 had a bruise under her right eye and R238 had been admitted with the bruise. LPN-A further stated when a resident was admitted with bruising/a bruise, the nurses were responsible for documenting it and including it in the admission assessment. Then going forward, the nurses would be responsible for documenting the bruise on the weekly skin assessments and following it through until the bruise was gone. During an interview on 10/26/23 at 10:04 a.m., the assistant director of nursing (ADON) verified R238's weekly skin checks dated 10/15/23 and 10/22/23 lacked documentation of the bruise under her right eye. ADON stated when a resident was admitted with a bruise(s) the nurses were expected to complete a thorough skin check and capture everything on the day one assessment. The ADON further stated she expected the nurses to be specific about the size of the bruise and where it was located. The bruise(s) should also be captured on every weekly skin check until they were resolved. During an interview on 10/26/23 at 1:00 p.m., the director of nursing (DON) stated when a resident was admitted with bruises or a bruise was discovered, the nurses were responsible for documenting the bruises and montioring them until they had resolved. A policy for monitoring bruising was not provided. R13's quarterly Minimum Data Set (MDS) dated 8/31/23, included diagnoses of Acute Kidney	F 684		

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F 684	Continued From page 10 Failure, Anemia, and lacked a dermatology diagnosis. R13's Provider orders (Surgery Aftercare date 10/11/23), included surgery aftercare orders. R13's treatment administration record (TAR) (printed 10/26/23) for dates 10/11/23 - 10/25/23, indicates wound care treatment twice daily. The TAR was updated 10/26/23 to record pressure dressing removal on 10/12/23. R13's care plan (last updated 8/24/23), lacked a surgical skin after-care procedure related to skin excisions. During an observation and interview on 10/23/23 at 1:50 p.m., R13 had a large, tan soiled Band-Aid on upper forehead with dried blood under the front edge. No date noted on Band-Aid. R13 stated surgery was performed on [R13]'s head, but did not elaborate further. During an observation on 10/24/23 at 1:21 p.m., R13 had the same large, tan, soiled Band-Aid with dried blood on front edge of adhesive area on the upper forehead. During an observation on 10/25/23 at 9:33 a.m., a different style Band-Aid was on R13's forehead. No date was marked on the Band-Aid, but there was still some dried blood on front and left edges of the Band-Aid. During an interview on 10/25/23 at 9:52 a.m., registered nurse (RN)-A stated surgical wounds are not considered like other wounds, therefore dressings are not initialed and dated when changed. Surgical wounds are assessed weekly	F 684		

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F 684	Continued From page 11 on bath day by the wound care team and are not measured daily. RN-A stated R13 had a shower yesterday and the band aid was changed by RN-A because the wound needs to be kept dry. RN-A indicated R13's wound care was found in the physician order. However, the order was not yet scanned into the electronic medical record (EMR). RN-A stated the need for the surveyor to speak with the wound nurse, who was the assistant director of nursing (ADON) for further explanation. During an interview on 10/25/23 at 10:02 a.m., ADON stated the bandage was to be changed twice daily with Vaseline or Aquaphor ointment applied over the steri-strips. ADON directed RN-A to change the bandage at this time. ADON further stated attend weekly wound rounds with the wound provider, so ADON was known as the "wound nurse." During an interview and observation on 10/25/23 at 10:13 a.m., RN-A again stated R13 had a shower yesterday (10/24/23) and the Band-Aid was replaced at that time. RN-A, using aseptic technique, removed the Band-Aid exposing adhered steri-strips, cleansed the wound with soap and water on 4X4 gauze, dried area with new 4X4 gauze, applied Aquaphor onto the steri-strips and covered the area with three smaller Band-Aids. During an interview on 10/25/23 at 10:32 a.m., R13 stated today was the first time wound care has been done for a while, however couldn't state when the last time the wound care was done but stated it was not done every day. During an interview on 10/25/23 at 10:41 a.m.,	F 684		

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F 684	Continued From page 12 the ADON found the to-be-scanned Surgery Aftercare instructions form from the dermatology clinic which indicated no wound care would be necessary while the steri-strips were still attached. ADON suggested there was confusion with the order because the order also indicated to gently wash area daily with soap and water, then apply ointment and cover with Band-Aid twice daily. ADON stated it appeared the second part of the order should have occurred after the steri-strips have fallen off. ADON acknowledged the order left room for interpretation, and verified the staff should have clarified the order. During an interview on 10/26/23 at 2:10 p.m., the director of nursing (DON) stated it was important to have clear orders to reduce errors. DON also stated when a resident comes back from an outside appointment with orders, the housing unit coordinator should enter the orders, then a RN should review the order. DON further stated if there were any questions with an order the RN was to contact a nurse manager, or contact the on-call clinic manager for further instruction. A policy for transcribing orders was not provided.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and	F 686		12/7/23

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F 686	Continued From page 13 (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure interventions were in place for 1 of 2 residents (R12) at risk for pressure ulcers. Findings include: R12's quarterly Minimum Data Set (MDS) dated 8/11/23, indicated R12 was cognitively impaired, required two person total assistance for most activities of daily living (ADLs) and was at risk for developing pressure ulcers, and had two stage II ulcers (partial thickness lost of dermis presenting as a shallow open ulcer with a red or pink wound bed, without slough. may also present as an intact or open/ruptured serum filled blister) and one stage III pressure ulcer (full thickness tissue loss. subcutaneous fat may be visible, but bone, tendon or muscle is not exposed). R12's diagnosis included end stage renal disease (ESRD), chronic obstructive pulmonary disease (COPD), dementia, obesity, diabetes mellitus with neuropathy, and anemia. R12's care plan printed 10/26/23, indicated R12 had alteration in skin integrity related to mobility deficit, incontinence, chronic pain, bipolar disorder, depression, opioid and psychotropic use. Has itchy skin that may be related to ESRD. Interventions included: will show no	F 686	Affected Resident(s): R12 care plan reviewed to ensure interventions are current and being provided. Potential Affected Resident(s): All high risk residents for pressure ulcers will have interventions audited to ensure intervention is being followed and care provided. Measures/Systematic Changes: Prevention and Treatment of Pressure Ulcers/Pressure Injury Policy/Procedure was reviewed and remains current. Education to be provided to licensed nurses and nursing assistants. Monitoring: Audits of residents at high risk of pressure ulcers will be completed weekly to ensure interventions are being completed correctly. Frequency will be weekly. Three residents per week x 2 weeks; then, two residents per week x 2 weeks; then, one resident per week x 4 weeks. Director of Nursing/designee responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will	

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F 686	Continued From page 14 complications in wounds with ordered wound treatment , I require Prevalon boots to be on my bilateral feet at all times to protect my heels from pressure. I require repositioning every 2 hrs. Pressure reducing device for bed. Pressure reducing device for chair. Weekly skin assessment by Licensed Nurses R12's physician orders dated 9/21/23, indicated : Wound care: Right heel and right ankle- Remove and discard old dressing, clean wound with wound cleaner and dry with clean gauze, cut piece of calcium alginate to fit in wound bed and apply Cover with foam dressing, change daily and prn (as needed) if dirty or soiled or falling off. Prevalon boots (a heel protector boot that has a cushioned bottom that floats the heel off the surface of a mattress, helping reduce pressure) to bilateral heels at all times. During observation on 10/24/23 at 5:27 p.m., R12 was sitting in a broda chair (a wheelchair that provides supportive positioning through a combination of tilt, recline, adjustable legrest angle, wings with shoulder bolsters and height adjustable arms). in the dining room. R12 had grippy socks on, no Prevalon boots. During observation on 10/24/23 an 6:28 p.m., R12 was in the same position in the dining room. During observation on 10/24/23 at 6:42p.m., the director of nursing (DON) and nursing assistant (NA)-B assisted R12 into bed. The DON indicated there was only one Prevalon boot and it was for R12's right foot. During observation on 10/25/23 at 10:55 a.m., R12 was sitting in Broda chair in the hallway with	F 686	recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 686	Continued From page 15 a Prevalon blue boot on the right foot only. During observation on 10/25/23 at 3:20 p.m., R12 was sitting in a broda chair by the nurses office, and did not have any Prevalon boots on. During interview on 10/25/23 at 3:24 p.m., registered nurse (RN) -B indicated R12 had two Prevalon boots, and had just removed them, and showed me both boots. RN-B indicated the dressing change was completed in the morning and both areas were healed . Interview on 10/26/23 at 9:21 a.m., the assistant director of nursing (ADON) indicated R12 has two boots and they are preventative, as R12 has a history of the areas on her ankles opening up, and R12 should wear the Prevalon boots all the time. During observation on 10/26/23 at 11:8 a.m., ADON and the hospice nurse completed the dressing change to R12's right foot. Only one open area was noted. ADON applied both Prevalon boots after the dressing change was complete. A policy was not provided.	F 686		
F 698 SS=D	. Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who	F 698		12/7/23

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F 698	Continued From page 16 require dialysis receive such 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 interview, and document review, the facility failed to ensure the medical record reflected accurate care and monitoring of the dialysis access site for 1 of 1 residents (R23) reviewed for dialysis. Findings include: R23's annual Minimum Data Set (MDS) dated 6/8/23, identified intact cognition, no rejection of care and diagnoses of kidney failure and dialysis dependency. R23 required substantial/maximal assistance with upper body dressing. R23's Care Plan dated 4/21/22, identified a dialysis shunt location (central line) in the right upper chest. Interventions included no blood draws from central line, and in emergency situations if shunt started to bleed, apply ice and pressure, if bleeding does not cease after 15 minutes, call 911, doctor, dialysis and family. The care plan lacked interventions related to a dialysis fistula such as removing a pressure dressing after dialysis session, assessment of bruit and thrill (sounds and vibrations that indicated a fistula worked properly), and to ensure no blood pressures, blood draws or intravenous access occurred to the left upper arm fistula. R23's dialysis Treatment Details report dated 10/18/23, identified the left upper arm fistula was placed on 7/7/22. Additionally, R23 arrived to	F 698	Affected Resident(s): Resident identified as R23 was immediately assessed for any adverse effects. Care was reviewed and updated. Resident was informed of the change in the care plan. Potential Affected Resident(s): All like residents were assessed to assure medical record reflected accurate care and monitoring of the dialysis site. Care plans were reviewed and updated as needed. Measure/Systematic Changes: Policy/Procedure: Hemo Dialysis was reviewed and remains current. Education to be provided to the Interdisciplinary Team on care planning dialysis resident. All licensed nurses will be trained on the policy/procedure. Monitoring: Frequency will be weekly. All residents who receive dialysis will have audits completed up to 5x's per week for 2 weeks, 2x's per week for 2 weeks and then weekly for 4 weeks. Director of Nursing/designee will be responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report	

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F 698	Continued From page 17 dialysis with pressure dressing on access from the previous dialysis session two days ago. R23 was advised to let care center staff know to remove the dressing since R23 lacked the strength to remove the dressing. R23's facility Dialysis Data Collection Pre and Post Appointment form dated 10/23/23, identified the bruit and thrill were assessed but lacked mention of care provided to the pressure dressing. R23's facility Dialysis Data Collection Pre and Post Appointment form dated 10/25/23, identified the bruit and thrill were assessed but lacked mention of care provided to the pressure dressing. R23's Order Summary Report dated 10/26/23, identified a shunt location (central line) in right upper chest. The orders lacked interventions related to a dialysis fistula such as location of fistula, removing a pressure dressing after dialysis session, assessment of bruit and thrill (sounds and vibrations that indicated a fistula worked properly), and to ensure no blood pressures, blood draws or intravenous access occurred to the left arm. During an interview on 10/23/23 at 8:57 a.m., R23 stated he had a dialysis fistula in his left upper arm and no longer had dialysis central line in his right upper chest. During an interview on 10/25/23 at 12:03 p.m., registered nurse (RN)-A stated she would check the resident orders and care plan for dialysis interventions. RN-A stated she worked with R23 routinely and R23 would update nursing on new	F 698	audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 698	Continued From page 18 dialysis orders. RN-A reviewed R23's dialysis orders and care plan and agreed they did not match the current cares provided. RN-A stated she knew to remove the pressure dressing to fistula after the session because R23 had told her in the past. RN-A stated she knew to assess bruit, thrill, and emergency care of a fistula from her past training. RN-A added it could be confusing to a nurse not familiar to the resident which cares were required if the orders and care plan were not up to date. During an interview on 10/26/23 at 10:54 a.m., the dialysis RN (DRN) stated R23 had a upper left arm fistula and not a central line. After the dialysis session a pressure dressing was placed and the facility would need to remove the pressure dressing a couple of hours after the dialysis session. The DRN stated there were a couple of times R23's pressure dressing remained in place until the next dialysis session two days later. The DRN stated if left in place for too long the pressure dressing may damage the resident's access site. The DRN stated additional cares to the upper left arm fistula included no blood pressures, intravenous access or blood draws to the affected arm due to the risk of disrupting the flow to the access site. During an interview on 10/26/23 at 12:35 p.m., RN-B stated she would look on resident orders and care plan for dialysis interventions, if there was a discrepancy the dialysis clinic would be contacted for clarification. During an interview on 10/26/23 at 12:49 p.m., the director of nursing (DON) verified R23's order and care plan had not been updated to reflect current care and monitoring of the left upper arm	F 698		

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F 698	Continued From page 19 fistula. The DON agreed it was important to ensure orders were consistent and the dialysis access was cared for properly because it was R23's lifeline. The facility policy titled Hemodialysis dated 8/2021, identified cares and services for dialysis would be consistent with professional standards of practice and included the comprehensive person-centered care plan, and the residents' goals and preferences, and ongoing communication and collaboration with the dialysis facility regarding dialysis care and services.	F 698		
F 699 SS=D	Trauma Informed Care CFR(s): 483.25(m) §483.25(m) Trauma-informed care The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to assess for and identify potential triggers for 1 of 1 resident (R28) who had a history of trauma. Findings include: R28's annual Minimum Data Set (MDS) dated 10/3/23, identified intact cognition, no rejection of care and diagnoses of depression, bipolar disease and post-traumatic stress disorder (PTSD). R28 had several days in the lookback	F 699	Affected Resident(s): R 28 was affected by F699. His care plan reviewed and updated. Resident was offered a care conference. Potential Affected Resident(s): All like residents with a current PTSD or other trauma related diagnosis were audited to see if they were missing the Trauma Informed Care Assessment. Those missing their assessment had a	12/7/23

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F 699	Continued From page 20 period where he felt little interest or pleasure in doing things or felt down, depressed, or hopeless. R28's Mood/Trauma care plan dated 7/25/18, identified a diagnosis of PTSD. Interventions included to call 911 in an urgent situation, complete a suicide self-harm interview as needed, remove items resident threatens to kill himself with, implement Threats to Self Harm policy and 1:1 checks, refer to psychologist as needed and encourage to express feelings and utilize family. The care plan lacked identification of triggers which had the potential to re-traumatize. R28's Social Services Resident History, Demographics and Goals assessment dated 10/3/23, 7/3/23, and 4/5/23 lacked notation of trauma history or potential triggers. R28's Behavior Monitoring form dated 9/26/23 through 10/25/23, identified no behaviors were observed. During an interview on 10/23/23 at 1:36 p.m., R28 stated had PTSD and was more withdrawn and had difficulty sleeping. R28 stated he talked to a counselor about it and changes were made to his medications. R28 stated no one had talked to him about potential triggers for his PTSD. R28 stated his triggers include loud noises, slamming doors and those occurred at the facility occasionally. During an interview on 10/25/23 at 11:38 a.m., nursing assistant (NA)-A stated he worked with R28 routinely. NA-A stated he had online training on trauma informed care. NA-A stated he was unaware of R28's diagnosis of PTSD or potential triggers.	F 699	new assessment completed by social services. Any trauma that was indicated has been added to their care plan. Measures/Systematic Changes: Trauma Informed Care and Post Traumatic Stress Disorder Policy/Procedure was reviewed and remains current. Education to be provided to the Social Services/Nursing Team. Monitoring: Audits of Residents for risk of PTSD/trauma related diagnosis will be completed weekly to assure it has been addressed on the care plan. Frequency will be weekly. Up to five resident's weekly for two weeks; 2X per week for two weeks and then weekly for 4 weeks. The Director of Social Services/designee shall be responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is to at 90% in compliance.	

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 10/26/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 699	Continued From page 21 During an interview on 10/25/23 at 12:03 p.m., registered nurse (RN)-A stated she worked with R28 routinely and had online training on trauma informed care. RN-A stated R28's behavior was monitored but was not aware of a diagnosis of PTSD or any triggers R28 might have. During an interview on 10/25/23 12:04 p.m., social services (SS)-A stated trauma was assessed and reassessed upon admission, quarterly, annually and with any changes. SS-A reviewed R28's care plan and verified potential triggers for PTSD had not been assessed. R28 stated one trigger for R28 was his lack of family visits. SS-A stated assessment for potential triggers was important to avoid retraumatization. During an interview on 10/26/23 at 11:23 a.m., the director of social services (DSS) stated potential triggers for R28's PTSD had not been assessed and and implemented into the care plan and should have been. The facility policy titled Trauma Informed Care and PTSD dated 9/1/20, identified it was important for staff to be well-informed regarding the recognition of PTSD, appropriate interventions and the facility must identify triggers which could re-traumatize residents with a history of trauma.	F 699		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		12/7/23

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F 757	Continued From page 22 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure antibiotic medications had appropriate monitoring, diagnosis, and indication for use for 1 of 1 resident (R15) reviewed for unnecessary medications. Findings include: R15's quarterly minimum data set (MDS) dated 9/20/23, indicates a brief interview for mental status (BIMS) score of 15, and R15 had an indwelling urinary catheter. R15's hospital progress plan note dated 8/9/23, had the order to continue Bacitracin three times daily to reduce catheter irritation. R15's provider orders (after visit summary) dated	F 757	Affected Resident(s): R15 medical record was reviewed to ensure antibiotic medication had appropriate monitoring, diagnosis, and indication for use, ensuring no unnecessary medication. Potential Affected Resident(s): All other residents with antibiotic orders will have appropriate monitoring, diagnosis and indication for use, ensuring no unnecessary medication. Measures/Systematic Changes: Unnecessary drugs: Pharmacy Medication Regimen Review Policy and Procedure was reviewed and remains current. Education to be provided to licensed	

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F 757	Continued From page 23 8/11/23, included the medications Bacitracin (topical antibiotic ointment) and cefpodoxime (oral antibiotic). R15's order summary report printed 10/26/23, included provider orders since 8/1/23, which did not include an order for Bacitracin. However, the follow-up visit dated 9/5/23, included Bacitracin for catheter care. R15's treatment administration record (TAR) for October 2023, has Bacitracin for catheter care discontinued on 10/26/23, and restarted 10/26/23, with the indication of prophylaxis to prevent urinary tract infection (UTI). No end date noted. R15's care plan printed 10/26/23, has a self-administration of medication plan starting 8/30/23, and antibiotic use dated 8/31/23. R15's medical record lacked evidence of the physician's rationale for continued use of Bacitracin ointment. During an interview on 10/25/23 at 12:36 p.m., R15 stated the nurses provide catheter care and antibiotic administration. During an observation on 10/25/23 at 12:54 p.m., R15's room revealed a cup with packets of Bacitracin at R15's bedside. During an interview on 10/26/23 at 8:19 a.m., registered nurse (RN)-A stated that nurses provide all catheter care and medications associated with catheter care. RN-A also stated R1's Bacitracin was ordered prophylactically after urinary stent removal. RN-A stated R15 was prone to infection, explaining the reason why	F 757	nurses and health unit coordinators. Monitoring: Audits of antibiotics will occur to ensure all antibiotics have appropriate monitoring, diagnosis, and indication for use. Frequency will be weekly. Three residents per week x 2 weeks; then, two residents per week x 2 weeks; then, one resident per week x 4 weeks. Director of Nursing/designee responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 757	Continued From page 24 there was no end date for administration. RN-A removed the cup with Bacitracin packets from R15's room. During an interview on 10/26/23 at 10:28 a.m., the assistant director of nursing (ADON) stated a nursing assessment/infection note was ordered twice daily if a resident was on an antibiotic. ADON also stated the housing unit coordinator (HUC) enters the order for these assessments. ADON stated there should be a stop date on antibiotics, however, prophylactic use was an exception. During an interview on 10/26/23 at 1:34 p.m., the director of nursing (DON) stated antibiotics treating an acute infection need an infection note from a nurse assessment every shift. DON also stated infection notes and end dates are not required for prophylactic antibiotics. DON stated medication orders require a rationale. During an interview on 10/26/23 at 1:48 p.m., the consulting pharmacist (CP) stated there are instances when an antibiotic could be ordered without an end date, including prophylactically. CP also stated a rationale for the antibiotic should be included in the order. During an interview on 10/26/23 at 2:12 p.m., the ADON stated the provider will make the decision on the continued necessity of an antibiotic, and nurses also monitor effectiveness and adverse effects. The facility's antibiotic stewardship protocol dated September 2022 indicates all antibiotics ordered and placed in the electronic health (EHR) record will display on the antibiotic clinical dashboard.	F 757		

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F 757	Continued From page 25 The IP will then start the infection control data collection tool in the EHR that analyzes for the required criteria to merit using an antibiotic. The nurse is to follow-up in the chart 48 hours after the antibiotic is completed or infection cleared. The infection is to be added to the care plan and resolved when the infection is cleared.	F 757		
F 881 SS=D	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: §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 implement protocols to ensure appropriate antibiotic treatment was in place for 1 of 1 resident (R15) with an active infection. Furthermore, the facility failed to ensure monitoring and documentation of prophylactic antibiotic use for 1 of 1 resident (R15) reviewed for antibiotic stewardship. R15's quarterly minimum data set (MDS) dated 9/20/23, indicated a brief interview for mental status (BIMS) score of 15, and R15 has an indwelling urinary catheter. R15's provider orders (after visit summary) dated 8/11/23, included the medications Bacitracin and cefpodoxime (oral antibiotic), and follow-up visit	F 881	Affected Resident(s): R15 medical record was reviewed to ensure antibiotic medication had appropriate monitoring and documentation for use to ensure antibiotic stewardship is being met. Potential Affected Resident(s): All residents receiving antibiotics were reviewed to ensure antibiotic medication had appropriate monitoring and documentation for use to ensure antibiotic stewardship is being met. Measures/Systematic Changes: Policy/Procedure: Antibiotic Stewardship Program was reviewed and remains	12/7/23

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F 881	Continued From page 26 dated 9/5/23, included Bactrim and Bacitracin. R15's medication administration record (MAR) for October 2023, revealed administration of Bactrim twice daily for 10 days, Diflucan (an antifungal), and continuation of Bacitracin three times daily with catheter care. R15's care plan printed 10/26/23, indicated a self-administration of medication plan started 8/30/23, and antibiotic use dated 8/31/23. R15's infection nurses note printed 10/26/23, revealed last assessment completed on 11/10/22, for urinary tract infection (UTI). However, R15 was listed on a spreadsheet for house acquired infections which indicated the antibiotic cefpodoxime with a resolution date of 8/25/23. The facility's clinical dashboard for antibiotic medications printed 10/26/23, revealed a start date of 10/26/23, for R15's Bacitracin. Nystatin, an antifungal was reported on the dashboard as well. However, R15's current administration of Diflucan was not reported. R15's hospital progress plan note dated 8/9/23, had the order to continue Bacitracin three times daily to reduce catheter irritation. During an interview on 10/26/23 at 8:19 a.m.,registered nurse (RN)-A stated R1's Bacitracin was ordered prophylactically after urinary stent removal. RN-A stated R15 was prone to infection, explaining why there was no end date for administration. During an interview on 10/26/23 at 10:28 a.m., the assistant director of nursing (ADON) and	F 881	current Education will be provided to licensed nurses. Monitoring: Audits of residents receiving antibiotics, including prophylactic, will occur to ensure all antibiotics have appropriate monitoring and documentation for use. Frequency will be weekly. Three residents per week x 2 weeks; then, two residents per week x 2 weeks; then, one resident per week x 4 weeks. Consultant Pharmacist will review resident records and give Director of Nursing/designee recommendations monthly. Director of nursing/designee responsible for assuring that changes are sustained and in compliance. The Administrator/designee will report audit results to the facility QAPI who will recommend frequency and duration of audits. The goal is 90% in compliance.	

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F 881	Continued From page 27 infection preventionist (IP) stated a nursing assessment/infection note was ordered twice daily if a resident was on an antibiotic. ADON also stated the housing unit coordinator (HUC) enters the order for these assessments when an antibiotic was ordered. ADON stated there should be a stop date on antibiotics, however, prophylactic use was an exception. During an interview on 10/26/23 at 1:34 p.m., the director of nursing (DON) stated antibiotics treating an acute infection need an infection note from a nurse assessment every shift. DON also stated infection notes and end dates are not required for prophylactic antibiotics. DON stated medication orders require a rationale. During an interview on 10/26/23 at 1:48 p.m., the consulting pharmacist (CP) stated there are instances when an antibiotic could be ordered without an end date, including prophylactically. CP also stated a rationale for the antibiotic should be included in the order. During an interview on 10/26/23 at 2:12 p.m., the ADON stated the provider will make the decision on the continued necessity of an antibiotic, and nurses also monitor effectiveness and adverse effects. The facility's antibiotic stewardship protocol dated September 2022 indicates all antibiotics ordered and placed in the electronic health (EHR) record will display on the antibiotic clinical dashboard. The IP will then start the infection control data collection tool in the EHR that analyzes for the required criteria to merit using an antibiotic. The nurse is to follow-up in the chart 48 hours after the antibiotic is completed or infection cleared.	F 881		

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F 881	Continued From page 28 The infection is to be added to the care plan and resolved when the infection is cleared.	F 881		

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	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/25/2023**

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K 000	INITIAL COMMENTS The Minnesota Department of Public Safety conducted an annual Life Safety recertification survey, State Fire Marshal Division, on 10/25/2023. At the time of this survey, Maplewood Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Maplewood Care Center is a 3-story building was constructed in 1969 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 115 beds and had a census of 81 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.

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 6, 2023

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: 3BQY11

Dear Administrator:

The above facility was surveyed on October 23, 2023 through October 26, 2023 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:

Renee McClellan, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00520	A. BUILDING: _____ B. WING _____	C 10/26/2023

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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 10/23/23 through 10/26/23, 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: 1535. Please indicate in your electronic plan of correction you have reviewed these orders	2 000		

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2 000	Continued From page 1 and identify the date when they will be completed. The following complaints were reviewed during the survey: H 52766551C (MN89305) and H527666652 (MN97957). 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 corrected prior to electronically submitting to the Minnesota Department of Health. PLEASE DISREGARD THE HEADING OF THE	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00520	A. BUILDING: _____ B. WING _____	C 10/26/2023

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2 000	Continued From page 2 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to 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.	2 000		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for	21535		12/7/23

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21535	Continued From page 3 Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure antibiotic medications had appropriate monitoring, diagnosis, and indication for use for 1 of 1 resident (R15) reviewed for unnecessary medications. Findings include: R15's quarterly minimum data set (MDS) dated 9/20/23, indicates a brief interview for mental status (BIMS) score of 15, and R15 had an indwelling urinary catheter. R15's hospital progress plan note dated 8/9/23, had the order to continue Bacitracin three times daily to reduce catheter irritation. R15's provider orders (after visit summary) dated 8/11/23, included the medications Bacitracin (topical antibiotic ointment) and cefpodoxime (oral antibiotic). R15's order summary report printed 10/26/23, included provider orders since 8/1/23, which did not include an order for Bacitracin. However, the	21535	corrected	

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21535	Continued From page 4 follow-up visit dated 9/5/23, included Bacitracin for catheter care. R15's treatment administration record (TAR) for October 2023, has Bacitracin for catheter care discontinued on 10/26/23, and restarted 10/26/23, with the indication of prophylaxis to prevent urinary tract infection (UTI). No end date noted. R15's care plan printed 10/26/23, has a self-administration of medication plan starting 8/30/23, and antibiotic use dated 8/31/23. R15's medical record lacked evidence of the physician's rationale for continued use of Bacitracin ointment. During an interview on 10/25/23 at 12:36 p.m., R15 stated the nurses provide catheter care and antibiotic administration. During an observation on 10/25/23 at 12:54 p.m., R15's room revealed a cup with packets of Bacitracin at R15's bedside. During an interview on 10/26/23 at 8:19 a.m., registered nurse (RN)-A stated that nurses provide all catheter care and medications associated with catheter care. RN-A also stated R1's Bacitracin was ordered prophylactically after urinary stent removal. RN-A stated R15 was prone to infection, explaining the reason why there was no end date for administration. RN-A removed the cup with Bacitracin packets from R15's room. During an interview on 10/26/23 at 10:28 a.m., the assistant director of nursing (ADON) stated a nursing assessment/infection note was ordered twice daily if a resident was on an antibiotic.	21535		

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21535	Continued From page 5 ADON also stated the housing unit coordinator (HUC) enters the order for these assessments. ADON stated there should be a stop date on antibiotics, however, prophylactic use was an exception. During an interview on 10/26/23 at 1:34 p.m., the director of nursing (DON) stated antibiotics treating an acute infection need an infection note from a nurse assessment every shift. DON also stated infection notes and end dates are not required for prophylactic antibiotics. DON stated medication orders require a rationale. During an interview on 10/26/23 at 1:48 p.m., the consulting pharmacist (CP) stated there are instances when an antibiotic could be ordered without an end date, including prophylactically. CP also stated a rationale for the antibiotic should be included in the order. During an interview on 10/26/23 at 2:12 p.m., the ADON stated the provider will make the decision on the continued necessity of an antibiotic, and nurses also monitor effectiveness and adverse effects. The facility's antibiotic stewardship protocol dated September 2022 indicates all antibiotics ordered and placed in the electronic health (EHR) record will display on the antibiotic clinical dashboard. The IP will then start the infection control data collection tool in the EHR that analyzes for the required criteria to merit using an antibiotic. The nurse is to follow-up in the chart 48 hours after the antibiotic is completed or infection cleared. The infection is to be added to the care plan and resolved when the infection is cleared.	21535		

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21535	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications for adequate indications for use to treat a specific condition(s) as diagnosed and documented in the clinical record to ensure each resident's entire drug medication regimen is managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being and be consistent with manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies or evidence-based review articles that are published in medical and/or pharmacy journals. Audits should be developed to monitor medications for adequate indications for use and appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: 21 DAYS	21535		