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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: J77L

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 **03/02/2016** (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) :

12.Total Facility Beds **146** (L18)

13.Total Certified Beds **146** (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
	146			
(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 :
Susanne Reuss, Unit Supervisor — 03/02/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/03/2016 (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
Posted 04/13/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
02/19/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245276
March 3, 2016

Ms. Mary Brun, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Dear Ms. Brun:

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 February 12, 2016 the above facility is certified for or recommended for:

146 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 146 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 2, 2016

Ms. Mary Brun, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276026 & H5276089

Dear Ms. Brun:

On January 21, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 7, 2016 that included an investigation of complaint number H5276089. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on February 17, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 7, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 7, 2016, effective February 12, 2016 and therefore remedies outlined in our letter to you dated January 21, 2016, 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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 2, 2016

Ms. Mary Brun, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Re: Reinspection Results - Project Number S5276026 & H5276089

Dear Ms. Brun:

On March 2, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 7, 2016, that included an investigation of complaint number H5276089. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245276 Y1	A. Building B. Wing Y2	3/2/2016 Y3

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 F0160	Correction	ID Prefix F0161	Correction	ID Prefix F0226	Correction
Reg. # 483.10(c)(6)	Completed	Reg. # 483.10(c)(7)	Completed	Reg. # 483.13(c)	Completed
LSC	02/12/2016	LSC	02/12/2016	LSC	02/12/2016
ID Prefix F0280	Correction	ID Prefix F0309	Correction	ID Prefix F0323	Correction
Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed
LSC	02/12/2016	LSC	02/12/2016	LSC	02/12/2016
ID Prefix F0371	Correction	ID Prefix F0441	Correction	ID Prefix F0492	Correction
Reg. # 483.35(i)	Completed	Reg. # 483.65	Completed	Reg. # 483.75(b)	Completed
LSC	02/12/2016	LSC	02/12/2016	LSC	02/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	SR/KJ	03/02/2016	16022	03/02/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/7/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245276 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	2/17/2016 Y3

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	02/12/2016	LSC K0027	02/12/2016	LSC K0029	02/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0038	02/05/2016	LSC K0056	01/18/2016	LSC K0062	02/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	TL/KJ	03/02/2016	34764	02/17/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
1/6/2016

☐ 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: J77L

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: **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 **01/07/2016** (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) :

12.Total Facility Beds **146** (L18)

13.Total Certified Beds **146** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

And/Or Approved Waivers Of The Following Requirements:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	146			
(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 Capes, HFE NE II — 02/01/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 02/18/2016 (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
(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
Posted 02/19/2016 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 21, 2016

Ms. Mary Brun, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276026, H5276088, H5276089

Dear Ms. Brun:

On January 7, 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. In addition, at the time of the January 7, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5276088 and H5276089.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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 January 7, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5276088 (found to be unsubstantiated) and H5276089 (that was found to be substantiated at F323).

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
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Susanne.reuss@state.mn.us

Phone: (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 January 16, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by January 16, 2016 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 April 7, 2016 (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 July 7, 2016 (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 electronic 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.

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	01/07/2016

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's plan of correction (POC) will serve as your allegation of compliance upon the Department's 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 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. An investigation of complaints H5276088 and H5276089 was completed. Complaint H5276089 was substantiated. Deficiency issued at F323.	F 000		
F 160 SS=D	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide within 30 days of death, the resident funds and final statement of those funds to the individual or probate jurisdiction administering the resident's estate for 2 of 3 residents (R35 and R246) reviewed.	F 160	Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and final accounting of those funds, to the individual or probate jurisdiction administering the residents estate.	2/12/16

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

Electronically Signed | 01/29/2016

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 160	Continued From page 1 Findings include: Review of R35's most recent MDS dated 10/6/15, revealed R35 died in the facility on 10/6/15. Review of the personal funds ledger and trust statement, last revised 12/31/15 revealed R35's funds and an accounting of those funds had not yet been provided to the entity responsible for the personal funds remaining in R35's estate (86 days). Review of R246's most recent minimum data set (MDS), dated 9/28/15, revealed R246 died on 9/28/15. Review of the personal funds ledger and trust statement for R246 revealed the funds in R246's account were given to the individual responsible for R246's estate on 11/10/15 (45 days). On 1/6/16 at 10:25 a.m., the business manager reported the facility had not yet conveyed R35's funds and/or a statement of those funds to the responsible individual or entity. The business manager could not show any attempt was made to provide the funds in R35's account, and the final account statement to the individual or entity responsible for R35's and R246's estate within the 30 days following the death of R35 and R246.	F 160	Policy pertaining to disbursement of personal funds was reviewed and revised. Residents #R35 and #R246 personal fund account has been reviewed and a final accounting has been completed, funds conveyed and notification of deposition of funds made to the jurisdiction administering the account. The Business Office Manager and /or designee will review current facility records to determine if discharged residents have been properly dispersed, as indicated by the F-160 guidelines. Resident accounts relating to disbursement will be audited monthly. Results will be reported in QA. Business Office manager will be responsibe for maintaining compliance. Substantial compliance 2/12/16	
F 161 SS=C	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced	F 161		2/12/16

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F 161	Continued From page 2 by: The facility failed to ensure the surety bond covered the total amount of funds in the resident fund account. This had the potential to impact 81 residents out of 81 residents who held money in a personal funds account. Findings include: Review of the most current resident fund account ledger, current as of 1/6/16, and facility surety bond revealed the amount of the surety bond did not cover the amount in the resident fund account ledger. On 1/6/16 at 2:46 p.m. the business manager confirmed the surety bond did not cover the entire amount of money in the resident funds account.	F 161	The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. The facility has reviewed and revised the policies and procedures assuring that the bond paperwork meet current standards. An audit was conducted to reconcile the resident's accounts with the amount of surety bond. Business Office manager or designee will monitor and audit the bond paperwork quarterly. The Business Office Manaager will be responsible for maintaining compliance. Substantial compliance 2/12/16	
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their policies related to screening employees prior to hire and ensure	F 226	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse	2/12/16

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F 226	Continued From page 3 reference checks were completed for 1 of 5 (E1) new employees reviewed. This had the potential to impact 10 of 10 residents E1 had cared for in a direct care role. Findings include: The Resident/client/participant Protection Policy and Procedure, last revised 12/2012, directed staff "Before new employees are permitted to work with resident/client/participants, references provided by prospective employee will be checked as well as appropriate board registrations and certifications regarding the prospective employee's background before permitted to work with resident/client/participants." The policy on Hiring Employees, last revised 7/1/12, directed staff, "10. Reference Checking. Perform a reference check after extending a job offer; document the attempt, even if no response is received." A review of New Hire Profile for E1 revealed a date of hire of 8/11/15 in a direct care position. A review of E1's application revealed E1 had worked in a direct care position with another employer from 1/6/12 to 5/5/14. A review of E1's pre-employment screening revealed the facility made no attempt to contact E1's previous employer. On 11/27/15 at 12:45 p.m. the human resource manager confirmed E1 had previously worked for another employer in a direct care role. No attempts to contact E1's previous employer was located in E1's record.	F 226	of residents and misappropriation of resident property. Employee E1's file was reviewed to assure proper screening was conducted and documented. The facility has reviewed the policies and procedures for screening of employees. New employee files will be reviewed on a continuous basis to verify licensure, background checks along with reference checks. Appropriate action will be taken based on the results of the checks. All employee files have reviewed to assure the proper components are present pertaining to licensure, background checks and reference checks. Audits will be conducted for all new hires monthly for 3 months, then quarterly. Results of the audits will be reported to the QA committee for further review and recommendations. Upon this review system revisions and/or staff education will be implemented if indicated. The HR Manager will be responsible for overall compliance. Substantial Compliance on 2/12/16	

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F 280	Continued From page 4	F 280		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to reflect the refusal of wearing appropriate footwear during awake hours and gripper socks at hour of sleep for safety for 1 of 3 residents (R88) reviewed for accidents. Findings include: The clinical diagnosis information identified R88 with diagnoses that included dementia without behavioral disturbance, cerebrovascular disease,	F 280	F280 It is the policy of Volunteers of America Maplewood Care Center to have a comprehensive care plan with periodic review and revision by interdisciplinary team and after each assessment. R88 care plan was reviewed and revised to reflect refusal of appropriate footwear along with risks and benefits as a result of that refusal. Medical record reviewed and updated with documentation that family is	2/12/16

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F 280	Continued From page 5 Parkinsonism, anemia, restless legs syndrome, syncope and collapse and history of falls. The current care plan, dated 2/13/15, indicated the resident was able to reposition self in bed, staff assisted to go from sitting at edge of bed to lying and from lying to sitting at edge of bed. The care plan indicated R88 was extensive assist for transfers, use of a transfer belt, and was dependent on staff for ambulation with wheeled walker, gait belt with wheelchair behind. The current care plan, initiated 1/1/16 for falls, directed staff to offer and assist R88 with toileting if awake during night time, limit fluids after 7 p.m., orient resident to unit and routine throughout the day, and identified resident will self report falls. Other interventions included: administer pain meds as ordered, anticipate and meet resident's fluid, food, comfort, toileting and comfort needs, ensure frequently used items are within reach, observe for signs of gait and balance, assist resident in walking to activities, dining room and so forth, proper footwear, pharmacy review of psychotic medications, activities that minimize the potential for falls, and encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. The care plan identified behavior as a concern. Interventions included: to assist resident to adjust to new surroundings, re orient to room, routine of the day, activities and familiarize with staff. medications to be administered, and target behaviors of weeping and tearfulness were identified. Other interventions included to approach in a calm manner, explain procedures, support emotionally and praise any indication of progress.	F 280	aware of risks and benefits. Random audits will be conducted monthly for three months to ensure care plan interventions, risk/benefits, and medical record documentation and follow through is completed on areas identified by interdisciplinary team. Results of these audits will be reported monthly at the facility QA meeting for three months. Upon review of these audits, further changes will be implemented if indicated. DON/Nurse Managers and/or designee will be responsilbe for maintaining compliance. Completion date 2/12/16	

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F 280	Continued From page 6 The care plan did not identify the continued refusal to wear gripper socks at hours of sleep, or other appropriate foot wear while awake. A review of R88's medical record revealed no documentation that R88 or family was educated about the risks and benefits of refusing to wear proper footwear. The care plan did not identify the risks and benefits of refusal of proper footwear related to frequent falls. The undated Unit Accountability Sheets, used by the nursing assistants to direct care, indicated R88 was independent with repositioning and independent with transfers. It indicated to monitor resident while in room, and to encourage gripper socks at hour sleep. On 1/7/16 at approximately 1:15 p.m. the clinical nurse manager, registered nurse (RN)-D, indicated R88 would not stop wearing nylons and the open back shoes and would not wear gripper socks at hours sleep. This contributed to R88's falls. RN-D confirmed the care plan had not been revised to identified the behavior of refusing to wear gripper socks nor had an alternative been developed to provide alternative footwear. The care plan also lacked the explanation of risks versus benefits for the continual usage of nylons and open back shoes. RN-D verified these findings.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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, in	F 309		2/12/16

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F 309	Continued From page 7 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and coordinated plan of care with a hospice service for 1 of 1 resident (R47) reviewed for hospice and the faciity failed to follow up on a reddened area on a heel for 1 of 3 residents (R91) reviewed for skin breakdown. Findings include: Record review, for R47 on 1/5/16, revealed a hospice Facility Visit Documentation Record entry, dated 12/21/15, showing that R47 was admitted to hospice care that date with a diagnosis of cardiovascular disease. The facility's plan of care included hospice care in the area of recreation and nutrition only. There was no plan of care regarding comfort, activities of daily living, or psychosocial needs as related to hospice care. There was a separate plan of care in the record completed by the hospice service. The record also contained a consent form from the hospice provider showing that skilled nursing would visit 1-4 times per week, social services would visit 1-2 times per month, and there would be an "RN Supervisory" visit at least every 14 days. A hospice interdisciplinary anticipated visit schedule showed that a hospice aide was scheduled to visit R47 "1-2 times per week on Tuesday."	F 309	F309 It is the policy of Volunteers of America 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. A comprehensive and coordinated plan of care with Hospice service was reviewed and completed for R47. All staff were informed of Hospice coordinated care days. All nursing staff, unit Social Worker and TR staff were educated on said plan. All facility staff were re-educated on the coordination of care with residents receiving Hospice Care. Nurse assessment/body audit done on R91 on notification from surveyor regarding reported reddened heel. There were no areas of redness on heel or on skin check at all. Nurse involved was educated on policy and follow through regarding skin condition. All nursing staff were educated on reporting and follow through of nursing assitant reports of compromised skin conditions. Randon audits will be conducted weekly	

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F 309	Continued From page 8 When interviewed on 1/6/15, at 10:47 a.m. registered nurse (RN)-B, the nurse manager of this unit, was asked about the entries in R47's care plan regarding hospice care. She stated that the care plan is not finalized until the assessment period is over and the care conference held, which was scheduled for 1/7/16. She went on to explain that as soon as the resident is signed onto hospice care, she puts hospice entries into the resident's care plan. She was asked the visitation schedule of the hospice staff and she replied that the hospice nurse visits often. Social worker (SW)-B was interviewed at the same time as RN-B and asked the same questions. SW-B stated that the hospice service puts a care plan into the resident's record, but this facility's staff does not use that care plan. When asked about the schedule of the hospice staff, she replied that there didn't seem to be a particular schedule, rather, "They just show up." On 1/6/16 at 2:24 p.m. licensed practical nurse (LPN)-D was interviewed regarding the hospice care of R47. She stated that she knew that R47 was on hospice care. She also said that she believed that an aide and a nurse from hospice visited R47, the hospice aide visited on Tuesdays and the hospice nurse came once a week, but she was not sure when. LPN-D was also asked if R47 was comfortable or had any pain issues. She answered that she thought R47 was comfortable much of the time, but did have abdominal pain at times and received pain medication. Nursing assistant (NA)-D was interviewed on	F 309	for three months to ensure follow through with Hospice coordination of care and staff awareness of plan of care. Random audits will be conducted weekly for three months in addition to weekly wound rounds to ensure appropriate follow through with any changes in residents skin conditions. Results of these audits will be reported monthly to facility QA meeting for three months. Upon review of these audits, further changes will be implemented if indicated. DON/Nurse Managers and/or designee will be responsilbe for maintaining compliance. Completion date 2/12/16 The results of these audits will be	

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F 309	Continued From page 9 1/7/16 at 11:10 a.m. and asked about the hospice services of R47. NA-D stated that he was not sure if R47 was receiving hospice services, but could try to find the answer to that question. He then stated that he worked roughly half time and floated to other units, so he was not sure of the most current information for R47. He then stated that he had never seen hospice staff with R47, so he could not describe the type of services they provide for her. Staff did not follow up on a reddened area on R91's heel. During stage one review of R91's record on 1/5/16 at 11:00 a.m., revealed documentation on the Nurse bath skin check on 12/31/15 at 21:47 that indicated "Resident given bath skin intact except for the left heel which is red and painful to touch." No further documentation noted regarding reddened left heel. Document review revealed R91 had diagnosis including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of the left or right side of the body) following unspecified cerebrovascular disease affecting left non-dominant side. R91's care plan revealed R91 "wears Lt (left) AFO (ankle foot orthosis) to LE (lower extremity)." Interview with NA-A on 1/6/16 at 7:43 a.m., indicated he/she was the nursing assistant that gave R91 a bath last week and noticed the reddened area and notified the nurse. NA-A indicated R91 wears a splint on the left ankle and the heel doesn't touch any areas.	F 309		

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F 309	Continued From page 10 Review of the facility's policy and procedure for the prevention and treatment of skin breakdown received 1/6/16 at 2:45 p.m. revealed on page 2 under "Monitoring of Skin Integrity" bullet point 3, "If a skin concern is noted, refer to Treatment of Pressure Ulcers and Lower Extremity Ulcers procedure." Section II Treatment of Pressure Ulcers and Lower Extremity Ulcers indicated "If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented. 1. Initiate Would Care Protocols. 2. Notify Physician/NP and Family/Designee 3. Notify Supervisor/Designee as assigned 4. Notify Dietary for nutritional interventions 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions and other interdisciplinary team members as appropriate... 10. Initiate Weekly wound documentation progress sheet which will include:type of wound, location, date, stage, or indicate partial or full-thickness , length, width, and depth..." Interview with RN-D on 1/7/16 at 11:00 a.m., indicated no knowledge of any reddened areas to R91's heel. RN-D explained that a reddened area to a heel could be considered a stage one, or it could be an unstageable ulcer, however without examining the area would not know. RN-D stated that the expectation would be for the nursing assistant giving the bath to notifiy the nurse and the nurse would then complete a body check. If any any abnormal areas are found, the nurse would fill out the proper forms, notify the nurse manager, the physician and the resident's responsible party. RN-D verified what was	F 309		

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F 309	Continued From page 11 documented on the Nurse bath skin check dated 12/31/15, verified the lack of follow up documentation in the progress notes and bath form and acknowledged the procedure had not been followed. RN-D stated R91 would be given a bath that day and the left heel would be rechecked.	F 309		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure fall interventions had been developed and implemented following each fall and that risks and benefits were explained for 1 of 3 residents (R88) reviewed for accidents and failed to ensure necessary supervision to prevent accidents related to elopement from the facility for 1 of 3 resident (R190) reviewed for accidents. Findings include: The clinical diagnosis information identified R88 with diagnoses that included dementia without behavioral disturbance, cerebrovascular disease, Parkinsonism, anemia, restless legs syndrome, syncope and collapse and history of falls.	F 323	F323 It is the policy of Voluntees of America Maplewood Care Center to ensure that the resident environment remains free of accident hazards as is possible and each resident receives adaquate supervision and assistance devices to prevent accidents. Fall interventions were reviewed, revised and implemented for R88. Risks and benefits were explained and documented per plan. Resident R190 chart was updated and is no longer at facility. All residents who have had falls in the	2/12/16

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 _____	01/07/2016

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 323	Continued From page 12 R88 quarterly Minimum Data Set (MDS) dated 11/4/15 indicated R88 had had falls since the admission and at least one had resulted in injury such as skin tear, abrasion etc. The quarterly MDS indicated R88 needed extensive assistance of one staff for all transfers between surfaces i.e. bed, wheelchair and extensive assist of one staff person for ambulation in the hallways. The CAA indicated the resident had severe cognition impairment, and had short and long term memory loss. A review of recent incident reports for R88 falls included: -10/29/15 at 10:31 p.m. During a skin check after a evening bath, R88 reported the skin tear was obtained as she " fell early in the morning as I was getting up from my bed " and reported being barefoot. Staff note indicated gripper socks were put on at hours sleep. -11/19/15 7:10 a.m. Nursing assistant reported resident was on the floor. R88 was sitting on the floor facing the bed between the bed and window wall. Knees were drawn up to her chest, " her feet were bare'. Her pajamas were stained with blood. The night stand was directly to her right. Her w/c was directly to her left and in the locked position. Call light was clipped to resident's pillow. Resident has 3 cm (centimeter) x 2 cm laceration to left posterior scalp.. She had a 6.5 x 4 cm bruise to her left shoulder. She has a 3.2 abrasion to her left elbow. Her left ear is slightly bruised and below her left eye is slightly discolored. Resident was incontinent at the time of the fall. The fall report indicated the resident was barefooted at the time of the fall and	F 323	last 90 days were reviewed to ensure appropriate interventions aer care planned and that risk and benefits have been documented. Falls will continue to be reviewed per policy. The LOA policy has been reviewed and revised to adress residents who leave the facility and do not follow the LOA procedure. All residents, family members and staff will be informned and educated on new process through meetings, letters, and newsletter. Random audits will be conducted wekkly for three months on residents with falls, to include interventions, care planning and any risk?benefit concerns. Randon audits will be conducted weekly for three months on residents who have gone on LOA's to ensure safe practices were followed. Results of these audits will be repoted monthly to facility QA meeting for three months. Upon review of these audits, further changes will be implemented if indicated. Director of Social Service and/or designee will be responsible for compliance. Completion date 2/12/16	

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 _____	01/07/2016

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F 323	Continued From page 13	F 323		

attempted to get from the bed to the wheelchair to go to the bathroom.

The post note review, dated 11/24/15, indicated the resident was sick with cold symptoms and weak and not able to complete her transfer independently and included R88 needed additional assistance while having cold symptoms.

-12/25/15 at 9:36 p.m. R88 self-reported having a fall around 8:15 p.m. and stated she sat on the edge of the bed and slid to the floor. R88 denied injury, pain or hitting her head. R88 did have a reddened area on the right elbow. The post Incident review revealed the resident was wearing nylons and shoes without backs and refused to wear gripper socks. Interventions identified on the post incident review form included proper footwear, do not leave unattended on toilet, activities that minimize the potential for falls while providing diversion and distraction and encourage to participate in activities that promote exercise physical activity for strengthening and improved mobility.

-1/1/16 at 12:00 p.m. indicated the resident had been found on the floor. The resident was fully dressed, shoes were on the floor in front of her facing resident. R88 was wearing nylon stockings on her feet and appeared to have been ambulating on the floor without her shoes. R88 complained of left wrist and left knee pain. On 1/2/16 a X-ray was obtained and verified a fracture of the left distal radius.

1/5/15 at 4:05 p.m. indicated the resident had an unwitnessed fall. Although the form had not been completed at time of survey it was provided, the

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 _____	01/07/2016

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 323	Continued From page 14	F 323		

form identified R88 had reported sliding down off the mattress of the bed wearing nylons and shoes without backs. The report included the resident refused to wear gripper socks. Interventions put into place after the incident included increase activities in the sunroom during the day and evening.

The current care plan, dated 2/13/15, indicated the resident was able to reposition self in bed, staff assisted to go from sitting at edge of bed to lying and to sitting at edge of bed. The care plan indicated the R88 was extensive assist for transfers, use of a transfer belt, and was dependent on staff for ambulation with wheeled walker, gait belt with wheelchair behind.

The current care plan, initiated 1/1/16 for falls, directed staff to offer and assist toileting if awake during night time, limit fluids after 7 p.m., orient resident to unit and routine throughout the day, and identified resident will self report falls. Other interventions included: administer pain meds as ordered, anticipate and meet resident's fluid food, comfort, toileting and comfort needs, ensure frequently used items are within reach, observe for signs of gait and balance, assist resident in walking to activities, dining room and so forth, proper footwear, pharmacy review of psychotic medications, activities that minimize the potential for falls, and encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility.

The care plan initiated on 2/14/15 identified behavior as a concern. Interventions included: to assist resident to adjust to new surroundings, re orient to room, routine of the day, activities and familiarize with staff. medications to be

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 _____	01/07/2016

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 323	Continued From page 15	F 323		

administered, and target behaviors of weeping and tearfulness were identified. Other interventions included to approach in a calm manner, explain procedures, support emotionally and praise any indication of progress.

The care plan did not identify the continued refusal to wear gripper socks at hours of sleep, or other appropriate foot wear while awake. A review of R88's medical record revealed no documentation that R88 was educated about the risks and benefits of refusing to wear proper footwear. And the care plan did not identify the refusal behaviors or the recent left wrist fracture.

The undated Unit 4 Accountability Sheets, used by the nursing assistants to direct care, indicated R88 was independent with repositioning and independent with transfers. It indicated to monitor resident while in room, and to encourage gripper socks at hour sleep.

On 1/7/16 at approximately 1:15 p.m. the clinical nurse manager (RN)-D indicated R88 would not stop wearing nylons and the open back shoes and would not wear gripper socks at hours sleep. This contributed to R88's falls. RN-D confirmed the care plan had not identified the behavior of refusing to wear gripper socks nor had an alternative been developed to provide alternative footwear. The care plan also lacked the explanation of risks versus benefits for the continual usage of nylons and open back shoes.

The facility failed to provide adequate supervision to prevent accidents and injury related to elopement for R190.

Review of R190's most recent Minimum Data Set

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 _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 16 [MDS] and care area assessments, dated 10/22/15 revealed R190 was cognitively intact, showed signs of moderate depression, experienced frequent pain and showed no signs of verbal or physical aggression towards others. R190 had diagnoses including diabetes, anxiety, depression, bipolar disorder, asthma, chronic obstructive pulmonary disease (COPD) and recent infections including pneumonia. R190 was prescribed oxygen therapy. R190's most recent medication review report, dated December 2015, revealed R190 was prescribed oxycodone HCL concentrate 20 milligrams/millimeters [mg/ml]-give 10 mg every six hours for pain (narcotic pain medication), oxygen 1-4 liters per minute, Duoneb solution 0.5-2.5 (3) mg/3 ml inhaler every four hours for COPD, quetiapine fumarate tablet 35 mg bid and 200 mg at bed time, (anti-psychotic) and Humalog solution 100 unit/ml per sliding scale with meals and insulin glargine solution 100 unit/ml per sliding scale at bed time. Staff were directed to monitor R10 every shift for signs of isolating self, agitation and anxiety and pain. Review of R190's psychological consultation, dated 11/19/15 revealed: "He continues at moderate risk for self-harm given his historical attempts, current use of psychotropics (overdose history with this), severe depressive sx [symptoms] including low hope." and "He also is impulsive and may report and appear stable without any likelihood he remains this way from moment to moment. Maintaining vigilance and oversight re: his mental status re: safety to self will likely remain important." R190's diagnoses included Major depressive disorder, Recurrent episode, and Severe and Alcohol use disorder, Severe. Rule out diagnoses included PTSD [post	F 323		

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 _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 traumatic stress disorder] and Bipolar disorder An incident report, dated 12/6/15, revealed another resident, R235, had alleged R190 gave her alcohol in her cranberry juice without her knowledge. R190 reported "She said I gave her alcohol without her knowing it when she did." Action taken included R190 being asked to not go off his floor for the evening. R190 was noted as being alert and oriented to person, place and time. No futher assessment of environmental, physiological or situation factors was completed on this report. Review of progress note, dated 12/6/15, revealed "Behavior: At 9:50 pm. resident came to author at medication cart and stated 'I'm freaking out...I want to go have a ciggerette. (sic)' Author reminded resident he had been requested to stay up on the [assigned] floor by the charge nurse, author also stated 'There will be a meeting tomorrow, and you can explain your side of the story'. Resident became more aggitated (sic). Resident stated 'you can't force me to stay here, I will call the cops and have you arrested for kidnapping". Resident stated "I'm going downstairs and you can't stop me". Resident headed towards elevator, author called [name of nurse] PM [evening] Supporvisor (sic), and alerted that resident was heading downstairs to first floor. At 10:45 p.m., author had still not seen resident return to unit, or had been contacted by first floor staff. When author went to check on resident on first floor and outside, was informed that resident had been seen by staff leaving the VOA campus. Resident had not signed out in log book, no medications sent with resident." and "Resident left out (LOA) before the NOC (night) shift started. PM nurse stated that she already	F 323		

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 _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 18	F 323		

informed supervisor and DON [director of nursing] about the situation. Resident didn't come back to the building at this time." The notes did not include how R190 left the facility. The progress notes included no assessment of how R190's current medical and psychiatric diagnoses and conditions may have impacted his ability to safely leave the facility independently for the night, particularly after displaying signs of agitation, conflict with another resident and sharing alcohol. The progress note did not include futher actions taken by staff to keep R190 safe at the facility, if measures could be taken to assist R190 to leave the facility safely or how staff responded to R190 leaving the facility. It was not assessed if R190 had consumed alcohol. Review of Progress notes from October, November and December 2015 noted instances of leaving the facility. However, only one similar episode of agitation was noted, on 10/21/15. R190 swore at a staff after being advised not to transfer independently due to low blood pressure. R190 went outside to smoke but did not leave the grounds.

A report by R190, dated 12/7/15, revealed "Then I came back up to [assigned floor] and was told I had to stay in my room. Then I left. I went to [name of motel] on [location] on my scooter. I was in and out all noc [night]. They allowed me to warm up but they would not allow me to sleep there. Cops found me in the middle of the street. I was in ambulance when I came to. they told me my sugar was low. It wouldn't read. They bought me a sandwhich (sic), drink and bag of chips. They left me at [name of motel] I came back to center at 10:00 after leaving [name of motel] at 9:00 a.m."

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 _____	01/07/2016

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 323	Continued From page 19	F 323		

An incident report, dated 12/6/15 and revised on 12/19/15 revealed "resident reported that he fell outside the hotel on his scooter." Resident added "I feel my sugar was low." The reported indicated "Was out of the facility checked in at motel [name of motel unknown the circumstances that led up to the fall as to whether he ate or had consumed alcohol or any of the precipitating factors. EMT [emergency medical technicians] did respond and treated per hotel manager." No injures were noted.

A futher witness observation statement written by the hospice nurse [RN], dated 12/17/15 added "Patient fell in street in front of Hotel/Motel [Name of motel]; Police responded with ambulance. Ambulance treated low blood sugar ("6"); Ambulance gave him some sugar [illegible word]; Police and ambulance let him stay there in the lobby of hotel. Patient choose not to get a room, but just warm himself in lobby.'; patient arrived at SNF [skilled nursing facility] approx [approximately] 10:30 am as I was talking with staff at SNF about his whereabouts. I assess V.S [vital signs] he would allow; 24 Resp [respirations per minute], and 130 AP [pulse] sats [oxygen saturation] 97% RA [room air], off all pain meds for 14 hours rating pain 8/10 [severe pain]"

A report, dated 1/17/16, composed by SW-B confirmed emergency medical services [EMS] had assisted a person at the same motel as R190 stayed at that night. When patients have low blood sugars they typically do administer a sugar solution and return them to bed. EMS was unable to verify they assisted R190, due to privacy laws. A manager at the motel confirmed R190 rented a room for two nights and had not checked out. The manager had heard from staff a guest was

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 _____	01/07/2016

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 323	Continued From page 20	F 323		

brought in and helped to his room related to blood sugars but was unsure if it was R190.

On 1/10/16 at 8:57 a.m. the director of nursing (DON) and director of social service (DSS) were interviewed regarding R190 and the incident. DON and DSS were unable to determine how R190 left the facility that night. There was no documentation to clarify. DON and DSS reported no one assessed R190's ability to safely leave the facility that night. It was not clear if R190 used alcohol that night or if the status R190's medical and psychiatric conditions may have impacted his ability to safely leave the facility that night. There was no assessment of winter weather conditions the night of 12/6/15 or if R190 was dressed appropriately. DON and DSS were not aware of any steps or measures staff implemented that night to maintain R190 safely at the facility or steps implemented by staff to ensure R190 could stay as safe as possible the night away from the facility. DON and DSS were unaware of steps implemented to encourage R190 to return to the facility or ascertain the whereabouts of R190 after leaving the facility. The facility did not contact additional resources to assist, such as local crisis services or police. The facility had R190's cell phone number and the contact information for emergency contacts on his face sheet. However, no one contacted or attempted to contact R190 or his emergency contacts after he left. There was no indication staff attempted to assist R190 in having the necessary medications, snacks or meals to leave the facility for an overnight stay. There was no plan to allow R190 to have a cigarette while staff were encouraging him to stay off the same floor as R235. DSS reported "we cant stop people from being LOA [away from the facility]. Yes, he is

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 _____	01/07/2016

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 323	Continued From page 21	F 323		

on narcotics, medically compromised, possibly drinking. He came back. It is his right to leave." DON and DSS reported they did not follow the procedure for missing residents, as they did not classify him as a missing resident. DSS and DON reported staff were unaware of R190's whereabouts on the night of 12/6/15.

The policy of Wandering and Elopement procedures, last revised April 2011, directed staff "The facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering from the facility. The is facility will utilize monitoring and alarm systems; sign in and out books on all units and maintain pictures of all residents on their units. This facility will also maintain a response plan for implementation in the event of a missing resident." and "Missing Resident: A. The RN Supervisor on shift or Charge Nurse will be notified when a resident is missing. The following will be implemented immediately by the Charge Nurse/Unit Coordinator:

1. The charge nurse will announce the appropriate alert.
2. Assign staff to search all floors, including lower level and attached buildings.
3. Assign staff to search grounds and immediate block.
4. Contact Director of Nursing and Executive Director.
5. Interview Nurses/Nursing Assistants on residents unit to determine last known location, clothes if the resident wanted to go somewhere or see someone.
6. Make copies of resident picture with current description of resident and give to responders.

B. The Director of Nursing or Nurse Supervisor on call will assume the responsibility for Search

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 _____	01/07/2016

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 323	Continued From page 22 Investigation and communication until Executive Director arrives. 1. Notify physician. 2. Notify Family and identify places resident frequented in the past. 3. Assess information received and broaden search. 4. Ensure that all documentation is complete and accurate throughout the search. C. If resident is not located within 15 minutes, Executive Director will assume responsibility for Search Investigation and communication leader. The facility will: 1. Notify police. 2. Coordinate expansion of search. 3. Notify Medical Director. D. Executive Director or DON/Nurse Supervisor will also assess the need to contact the following and distribution of resident picture and description to: 1. Police 2. Local Hospital ER's 3. Cab Companies 4. Bus Company 5. Postal Service 6. Local Restaurants, businesses, gas stations, etc. 7. Households near the facility. E. Upon Return to the facility: 1. Charge nurse announces appropriate alert as all clear. 2. Director of Nursing or Designee will ensure that the resident's assessment is completed, documented and reported to their physician and the POC is updated. 3. Social Services Director or designee will notify family/guardian etc and updated POC as needed. 4. Resident Incident Report according to policy and procedure."	F 323		

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 _____	01/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store dry food in a sanitary manner which had the potential to affect residents who used disposable dishes. The faciity also failed to assure that staff persons had facial hair covered when preparing food. 115 of 117 residents ate food prepared in the kitchen, however, all residents may not have eaten the same food prepared. Findings include: During the initial kitchen tour on 1/4/16, at 12:32 p.m. there was a large laundry bag in a corner of the dry food storage room. The large laundry bag contained several plastic bags that contained linens. The dietary manager was present, and when asked about the laundry bag stated that the plastic bags contained soiled kitchen linens that are kept in this area until picked up by a laundry service weekly. During kitchen tour on 1/5/15, it was noted that dirty kitchen linens were piled up in and above an	F 371	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions. On Tuesday January 5th, the dirty linen bag was immediately moved to a location separate from any perishable or non-perishable foods. Corn flakes bag that was opened was immediately discarded on January 5th. On January 5th, staff that had beards were immediately given hairnets to cover their facial hair. DDepartment policies pertaining to the specific aareas were reviewed and revised. The dietary manager will conduct a mandatory meeting on February 4th, 2016	2/12/16

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 _____	01/07/2016

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 371	Continued From page 24 opaque linen hamper in the corner of the dry storage area (clean storage). The dirty linen hamper was placed between a four shelf rack of disposable plates and bowls, and a five shelf rack placed at 90 degree angle that contained new food items in boxes. On 1/5/15, at 12:40 p.m., assistant director of food service (ADFS) started the tour, and verified the open bag of corn flakes dated 12/20/15, was taped closed with masking tape (not stored in a pest proof container). An over flowing dirty linen hamper in the corner, was between two grated storage shelves. The linen was stacked up four bags high visible above the linen hamper with an opaque bag, which was also full. The top linen bag was not secured and the dirty linens were falling onto the stored clean disposable supplies and onto the four rack shelf. ADFS stated the linen service was expected to pick up, " any minute " At 12:50 p.m. the director of food service (DFS), joined the tour and reviewed the open corn flakes bag that was closed with masking tape and not in a pest proof container, the bag of corn flakes was disposed of. The linen hamper was stacked up and spilling over onto the disposable dishes. DFS lifted the open linen bag off the top, gathered the loose linens that had fallen on the disposable dishes, four shelf rack and onto the other bags, then tied up the bag and placed it back onto the stacked pile. DFS stated he had worked there for 11 years and the linen hamper had always been there, however the facility had used additional linen (table cloths and placemats) for the Holiday dinners on all of the units and so the hamper was overflowing. DFS stated he did not know the dirty linen could not be in the clean storage area.	F 371	to review these deficiencies. Staff will be reeducated on proper storage of opened foods, proper coverage of hair and facial hair and also informed of the new location of the dirty linen bag. All employees were given facility policy of dirty linen storage, food storage and grooming policy. The Director of Food Service or designee will monitor the compliance of these policies by conducting weekly audits of staff for proper grooming, proper storage of foods and continued appropriate placement of dirty linen storage. Upon completion of reviews/audits, corrective actions if applicable will be completed immediately. Additional education will be provided as derived as needed from results. The results of these reviews/audits will be reported to the facility QA committee for 6 months. Upon this review, system revisions and/or staff education will be implemented if indicated. Food Service Director will be responsible for maintaining compliance	

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F 371	Continued From page 25 DFS stated the linen service picks up every Wednesday morning, and he had relocated the dirty linen hamper to the entrance area which would make it easier for the linen service to pick up. At 1:00 p.m., during the kitchen tour, including food preparation area, DFS was noted to have uncovered facial hair. DFS stated he would order beard protectors. The Employee Sanitary Practices policy dated 2010, directed: All employees shall: 1. Wear hair restraints (hairnet, hat and/or beard restraint) to prevent hair from contacting exposed food. The Infection Control Dietary policy dated 2015, directed: Policy: The dietary department will meet accepted standards of safety and sanitation of food, equipment, and cleaning supplies. Procedures: A. The facilities Dietary Policy and Procedure manual contain operating policies, procedures, and practices that comply with the infection control and prevention guidelines. Refer to F371 in CMS SOM. D. All Food 3. Is properly stored Sanitary Conditions: Follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility's food handling processes. "Dry Storage" refers to storing/maintaining	F 371		

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F 371	Continued From page 26 dry foods (canned goods, flour, sugar, etc.) and supplies (disposable dishware, napkins, and kitchen cleaning supplies). The 2013 Food and Drug Administration (FDA) Food Code under the section of Hair Restraints read, "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES."	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		2/12/16

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F 441	Continued From page 27 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure staff utilized appropriate hand hygiene in the dining room during meal preparation process for 3 of 23 residents (R116, R197, R3) during the supper meal, failed to ensure staff utilized appropriate hand hygiene during resident cares for 1 of 4 residents (R49) observed during cares, and for 1 of 1 resident (R180) observed during blood glucose monitoring. The facility also failed to assure that storage of ice packs was separated from food in 1 of 5 freezers. Findings include: Facility failed to ensure proper hand hygiene was performed. During dining observations on 1/4/16 at 4:49 p.m., registered nurse (RN)-A donned gloves,	F 441	F441 It is the policy of Volunteers of America Maplewood Care Center to have and maintain an infection control program that provides safe sanitary and comfortable environment and to help prevent development and transmission of disease and infection. The policy and procedure for hand hygiene was reviewed. All facility staff were re-educated and skill tested out on appropriate hand hygiene. Random weekly audits will be conducted for the next three months to ensure ongoing knowledge and skill of appropriate hand hygiene and glove use.	

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F 441	Continued From page 28 prepared 2 slices of toast for resident (R116). At 4:54 p.m. RN-A removed gloves and threw gloves in the garbage then proceeded to pick up the plate with two pieces of toast and gave to R116 without washing hands. RN-A then opened the cupboard by touching cupboard knobs, RN-A went on to R197 who requested cottage cheese and took R197's used plate to get more cottage cheese. RN-A then opened a pack of sugar for R116's tea. RN-A then approached R3 and wheeled R3 out of the dining room to R3's room. RN-A did not wash hands in-between contact with the different residents. During an interview with RN-A on 1/4/16 at 5:09 p.m., stated, "I did not wash my hands when I took the gloves off but washed my hands in R3's room." On 1/4/16 at 5:50 p.m., nursing assistant (NA)-B NA-B and NA-C were observed to don gloves without washing hands or use hand sanitizer, and then assisted R197 from the wheelchair to bed via mechanical lift. At 5:58 p.m. NA-C removed gloves, opened the door and took the mechanical lift out and came back in R197's room to assist resident with cares. At 5:59 p.m., NA-C washed hands and applied gloves. At 6:05 p.m. NA-C, removed the gloves, touched uniform pants, then applied a towel on resident's chest for tooth brushing without washing hands or use hand sanitizer. At 6:07 p.m. NA-C applied another pair of gloves without washing hands in between, rearranged R197's room. At 6:16 p.m. NA-C took gloves off but did not wash hands or use hand sanitizer. At 6:16 p.m. NA-B used the same gloves to open the door, took the dirty linen to the utility room and took gloves off and came out of utility room without washing hands or use hand sanitizer. During an interview with NA-B on 1/4/16 at 6:18	F 441	All med room freezers/fridges were checked for food items and if present were removed. Policy and procedure was reviewed regarding use of med room fridge/freezers. Staff were re-educated on purpose for med room fridges and freezers for medical supplies needing refridgeration, not food items. Random weekly audits will be conducted for three months to ensure compliance with no food items in fridges/freezers in all med rooms. Results of these audits will be reported monthly to the facility QA meeting for three months. Upon review of these audits, further changes will be implemetned if indicated. Staff Development/Infection Control nurse and/or designee will be responsible for maintaining compliance.	

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F 441	Continued From page 29 p.m. NA-B acknowledged, he came out of R197's room with gloves on, went to R49's room with the same gloves, took gloves off in R49's room, grabbed the Hoyer sling there and went back to R197's room and placed it under R197, and called for help. NA-B then applied another pair of gloves without washing hands or use hand sanitizer in between and stated, "I cannot deny the fact that was a mistake." During an interview with NA-C on 1/4/16 at 6: 19 p.m. NA-C indicated, he normally has hand sanitizer in his pocket and uses it in between gloves changes, but forget to do it today before putting on gloves and when changing gloves in between cares. In addition, NA-C specified, "It is a mistake." On 1/5/16 at 11:04 a.m. licensed practical nurse (LPN)-B was observed during a blood sugar check for R180 at the nursing station. LPN-B used hand sanitizer then donned gloves. LPN-B cleaned R180'S right index finger with alcohol wipe, prepared the accu-check machine, and obtained a blood sample to the strip. At 11:06 a.m. LPN-B used the same gloves to document the readings and checked in the computer how many units R180 needed due to R180's sliding scale. At 11:07 a.m. LPN-B removed gloves, did not use hand sanitizer or wash hands, but went ahead to don another pair of gloves administered insulin to R180. At 11:09 a.m., LPN-B removed the gloves and continued with documentation in the computer without washing hands or use hand sanitizer. During an interview with LPN-B on 1/5/16 at 11:05 a.m. LPN-B verified, did not wash hands or use hand sanitizer in between glove changes. In addition, LPN-B mentioned, "Normally I always do."	F 441		

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F 441	Continued From page 30 During observation of the first floor med room refrigerator, on 1/7/16 at 1:51 p.m., the freezer compartment contained 21 small ice packs, 4 medium ice packs, and one large gel-based ice pack (approximately two feet long). On the door of the freezer compartment were three cups of orange sherbet. When interviewed on 1/7/16, at 2:00 p.m. registered nurse (RN)-C was asked the purpose of the ice packs in the freezer and she stated that the small packs were put into pharmacy packs with drugs and the medium and large packs were used on body parts of residents. She explained that the ice packs were put into pillow cases, then put onto residents. After the resident was done with the ice pack, staff removed the pillow case and wiped the ice packs clean with a germicidal cleanser and put it back into the freezer. When the proximity of the sherbet to the ice packs was pointed out to RN-C, the sherbert was immediately removed. Staff did not perform appropriate hand hygiene during morning cares for R49. Observation of morning cares on 1/7/16 at 9:30 a.m., nursing assistant (NA) -A was observed to completed R49's morning cares. NA-A brushed R49's teeth. Upon completion, NA-A changed gloves, but did not wash her hands in between. NA-A and NA-E completed perineum cares, removed gloves and applied new gloves without handwashing or hand sanitizing. After R49 was transferred into the wheelchair, NA-A removed the gloves, put R49;s glasses on and combed R49's hair. NA-A did not wash her hands after removing her gloves.	F 441		

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F 441	Continued From page 31 Interview with NA-A at 9:45 a.m., no reason why appropriate hand hygiene was not performed after gloves were removed was given. Interview with the Director of Nursing (DON) and infection control nurse (RN)-E on 1/7/16 at 12:20 p.m., indicated all staff have been trained on appropriate hand hygiene, and all should know that hand hygiene needs to be performed following the removal of gloves. Review of the facility's Infection Control Standard Precaution policy for Hand Hygiene received on 1/6/16 at 2:45 p.m., indicated the following: Hand hygiene must be performed after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves were worn; immediately after gloves are removed and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and or the environment. Specific examples include but are not limited to: 3. Before and after direct resident care. 4. Before and after performing invasive procedure (e.g. catheterrization, starting IV's, fingerstick blood sampling) 8. Before and after eating or handling food. 9. Before and after assisting a resident with meals 11. Before and after assisting a resident with personal care. 27. After removing gloves, gowns, mask, etc.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with	F 492		2/12/16

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F 492	Continued From page 32 accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to stop charging a resident for a demand bill while a decision was pending for 1 of 1 residents (R34) who appealed liability notice. Findings include: R34 received a facility form, dated 9/4/15, for Skilled Nursing Facility Determination on Continued Stay notice, indicated the last day of covered services would be 9/5/15. On that same day, R34/family requested to have the decision appealed to the Medicare A Contractor (MAC). The facility sent out a statement dated 10/1/15 and on 11/1/15 another billing statement was sent to R34 for the balance due. On 1/6/16 at 2:00 p.m. the business office manager provided copies of the requests and the billing statements. When asked why were statements sent to the R34, the business manager could not offer an explanation. The manager did reply that she usually tells people it takes time to get results and if they want to go ahead and pay the bill we would always reimburse.	F 492	The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. The policy from the Medicare manual pertaining to demand bill was reviewed. The bill from resident R34 was reviewed to assure that all services were reconciled, and there were no further concerns. All residents with a demand bill from the last 6 months were reviewed to assure that no billing took place. All new demand bills will be audited monthly for 3 months, then quarterly. Results will be reported to QA. Business Office Manager will be responsible for overall compliance.	

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	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2016**

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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 not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/29/2016

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

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency 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 121 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of	K 025	Deficiency will be corrected by 2-5-2016. A yearly check of all smoke barriers will be added to the preventative maintenance	2/12/16

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	Continued From page 2 2000 NFPA 101, Section 19.3.7.3, and 8.3.4.1. The deficient practice could affect all patients Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed: 1. Above NorthWest 90 min rated doors on the 2nd floor there is a 4" X 4" with a 4 inch deep hole in the wall with cables and conduit penetrating the wall. There is other areas that the fire caulk needs to be replaced. 2. 2nd Floor NorthWest door has a 1/2 inch gap in the doors. 3. East and West on the 1st floor has both penetrations in the firewall above the fire doors and both sets of doors of gaps over an 1/8". All smoke barriers throughout the facility needs to be checked. This deficient practice was verified by the Director of Environmental Services (TB).	K 025	book. The Director of Environmental Services will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	K 027		2/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/06/2016**

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K 027	Continued From page 3 This STANDARD is not met as evidenced by: Based on observations and interview, the facility has failed to maintain smoke/fire barrier doors in accordance with LSC 19.3.7.5. This deficient practice could affect all patients. Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed: 1. 2nd Floor NorthWest door has a 1/2 inch gap in the doors. 2. East and West on the 1st floor both sets of doors of gaps over an 1/8". This deficient practice was verified by the Director of Environmental Services (TB).	K 027	Deficiency will be corrected by 4-1-2016. New steel fire doors have been ordered with a 6-8 week lead time and will be installed as soon as they arrive. In the interim, Astragils will be added to and adjusted to proper gap by 2/12/16. A monthly check for proper door operation and gaps will be added to the preventative maintenance book. The Director of Environmental Services will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke-resisting partitions and doors in accordance with the	K 029	New steel exist discharge door has been ordered and will be installed as soon as it arrives and any obstructions will be	2/12/16

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K 029	Continued From page 4 following requirements of 2000 NFPA 101, Section 19.3.2.1. The deficient practice could affect 15 out of 72 residents. Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed: 1. Open penetrations around several conduits and pipes in the walls in Boiler Room. 2. The integrity of the door is compromised of Exit discharge door and has the water line coming through it in the boiler room. This deficient practices was verified by the Director of Environmental Services (TB).	K 029	removed. Purchase order has been provided. All penetration in the boiler will be checked and corrected by 2-5-2016. These will both be part of the preventative maintenance for K25 and K27. The Director of Environmental Service will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility has failed to provide proper exit hardware on exit doors to the stairwell exit access doors. This deficient practice could affect the safe and rapid evacuation of all residents, visitors and staff in the event of an emergency that may require quick evacuation in accordance with section 7.1. 19.2.1	K 038	Deficiency was corrected on 1-18-2016. The door handle was lowered to the proper height. The Director of Environmental Services will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	2/12/16

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K 038	Continued From page 5 Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed: 1) The corridor door to the laundry room has a door handle that is 72 inches off the finished floor. This deficient practices was verified by the Director of Environmental Services (TB).	K 038		
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Observations indicated that the automatic sprinkler system has not been maintained in accordance with NFPA 13 Standard for the Installation of Sprinkler System 1999 edition section 5-5.6. This deficient practice may allow a fire to grow uncontrolled which will negatively impact all the residents, visitors and staff. Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed:	K 056	Deficiency was corrected on 1-8-2016. Top shelf was removed from closet and maximum storage height marked on the wall. A monthly check of all storage checks will be added to the preventative maintenance book. The Director of Environmental Services will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	2/12/16

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K 056	Continued From page 6 1) Storage within 18 inches of the sprinkler heads in the activity storage closet. This deficient practices was verified by the Director of Environmental Services (TB).	K 056		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the complete automatic fire sprinkler system is not being maintained in accordance with NFPA 25(99) Section 9.2.7. This deficient practice could effect all patients. Findings include: On facility tour between 08:30 AM and 1:30 PM on 01/06/2016, observation revealed: 1) 2 sprinkler heads in the wheelchair wash area are corroded, one of which is painted, 2)The facility sprinkler heads that are 50 years old that should be tested and/or replaced. This deficient practices was verified by the Director of Environmental Services (TB).	K 062	Deficiency will be corrected by 2-1-2016. General Sprinkler Corporation will be onsite on 2-1-2016 to replace the 2 corroded sprinkler heads and replace sprinkler heads to send in for the 50 year test. Test results will determine course of action. If they pass the test will be repeated in ten years, if they fail all heads of that age will be replaced as soon as possible. All paperwork and test results will be kept in the Fire Marshal Book. The Director of Environmental Services will be responsible for maintaining compliance. Substantial Compliance 02/12/2016	2/12/16

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 21, 2016

Ms. Mary Brun, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5276026, H5276089, H5276088

Dear Ms. Brun:

The above facility was surveyed on January 4, 2016 through January 7, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5276088 that was found to be unsubstantiated and complaint number H5276089 that was found to be substantiated. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency 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 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. 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 after the statement, "This Rule 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 Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us**.

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

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

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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 _____	01/07/2016

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000	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.	

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2 000	Continued From page 1 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. On January 4th, 5th, 6th, and 7th, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. In addition, complaint investigations were also completed at the time of the recertification survey: H5276089 was substantiated and a correction order was issued at State Licensing #0830. H5276088 was not substantiated. 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	2 000	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 which are in violation of the state statute after the statement, "This Rule 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.	

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2 000	Continued From page 2 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.	2 000		
2 500	MN Rule 4658.0275 Subp. 2 Return of Funds After Discharge or Death Subp. 2. Death of a resident. Upon the death of a resident, a nursing home must convey the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide within 30 days of death, the resident funds and final statement of those funds to the individual or probate jurisdiction administering the resident's estate for 2 of 3 residents (R35 and R246) reviewed. Findings include: Review of R35's most recent MDS dated 10/6/15, revealed R35 died in the facility on 10/6/15. Review of the personal funds ledger and trust statement, last revised 12/31/15 revealed R35's funds and an accounting of those funds had not yet been provided to the entity responsible for the	2 500	Completed	2/12/16

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2 500	Continued From page 3 personal funds remaining in R35's estate (86 days). Review of R246's most recent minimum data set (MDS), dated 9/28/15, revealed R246 died on 9/28/15. Review of the personal funds ledger and trust statement for R246 revealed the funds in R246's account were given to the individual responsible for R246's estate on 11/10/15 (45 days). On 1/6/16 at 10:25 a.m., the business manager reported the facility had not yet conveyed R35's funds and/or a statement of those funds to the responsible individual or entity. The business manager could not show any attempt was made to provide the funds in R35's account, and the final account statement to the individual or entity responsible for R35's and R246's estate within the 30 days following the death of R35 and R246. SUGGEST METHOD OF CORRECTION: The administrator or designee, could review and revise policies and procedures, conduct audits related to return of funds after discharge or death to ensure proper procedure is conducted after the death of a resident. The administrator or designee could ensure staff training is conducted on an ongoing basis as well. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 500		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an	2 570		2/12/16

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2 570	Continued From page 4 interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise a care plan to reflect the refusal of wearing appropriate footwear during awake hours and gripper socks at hour of sleep for safety for 1 of 3 residents (R88) reviewed for accidents. Findings include: The clinical diagnosis information identified R88 with diagnoses that included dementia without behavioral disturbance, cerebrovascular disease, Parkinsonism, anemia, restless legs syndrome, syncope and collapse and history of falls. The current care plan, dated 2/13/15, indicated the resident was able to reposition self in bed, staff assisted to go from sitting at edge of bed to lying and from lying to sitting at edge of bed. The care plan indicated the R88 was extensive assist for transfers, use of a transfer belt, and was dependent on staff for ambulation with wheeled walker, gait belt with wheelchair behind. The current care plan, initiated 1/1/16 for falls, directed staff to offer and assist toileting if awake	2 570	Completed	

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2 570	Continued From page 5	2 570		

during night time, limit fluids after 7 p.m., orient resident to unit and routine throughout the day, and identified resident will self report falls. Other interventions included: administer pain meds as ordered, anticipate and meet resident's fluid, food, comfort, toileting and comfort needs, ensure frequently used items are within reach, observe for signs of gait and balance, assist resident in walking to activities, dining room and so forth, proper footwear, pharmacy review of psychotic medications, activities that minimize the potential for falls, and encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility.

The care plan identified behavior as a concern. Interventions included: to assist resident to adjust to new surroundings, re orient to room, routine of the day, activities and familiarize with staff. medications to be administered, and target behaviors of weeping and tearfulness were identified. Other interventions included to approach in a calm manner, explain procedures, support emotionally and praise any indication of progress.

The care plan did not identify the continued refusal to wear gripper socks at hours of sleep, or other appropriate foot wear while awake. A review of R88's medical record revealed no documentation that R88 or family was educated about the risks and benefits of refusing to wear proper footwear. The care plan did not identify the risks and benefits of refusal of proper footwear related to frequent falls.

The undated Unit Accountability Sheets, used by the nursing assistants to direct care, indicated R88 was independent with repositioning and independent with transfers. It indicated to

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2 570	Continued From page 6 monitor resident while in room, and to encourage gripper socks at hour sleep. On 1/7/16 at approximately 1:15 p.m. the clinical nurse manager, registered nurse (RN)-D, indicated R88 would not stop wearing nylons and the open back shoes and would not wear gripper socks at hours sleep. This contributed to R88's falls. RN-D confirmed the care plan had not been revised to identified the behavior of refusing to wear gripper socks nor had an alternative been developed to provide alternative footwear. The care plan also lacked the explanation of risks versus benefits for the continual usage of nylons and open back shoes. RN verified these findings. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out	2 830		2/12/16

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 _____	01/07/2016

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2 830	Continued From page 7 of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive and coordinated plan of care with a hospice service for 1 of 1 resident (R47) reviewed for hospice,and the facility failed to ensure fall interventions had been developed and implemented following each fall and that risks and benefits were explained for 1 of 3 residents (R88) reviewed for accidents and 1 of 3 resident (R190) received the necessary supervision to prevent accidents related to elopement from the facility. Findings include: Record review, for R47 on 1/5/16, revealed a hospice Facility Visit Documentation Record entry, dated 12/21/15, showing that R47 was admitted to hospice care that date with a diagnosis of cardiovascular disease. The facility's plan of care included hospice care in the foci of recreation and nutrition only, but there was no plan of care regarding comfort, activities of daily living, or psychosocial needs as related to hospice care. There was a separate plan of care in the record completed by the hospice service. The record also contained a consent form from the hospice provider showing that skilled nursing	2 830	Completed	

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2 830	Continued From page 8 would visit 1-4 times per week, social services would visit 1-2 times per month, and there would be an "RN Supervisory" visit at least every 14 days. A hospice interdisciplinary anticipated visit schedule showed that a hospice aide was scheduled to visit R47 "1-2 times per week on Tuesday." When interviewed on 1/6/15, at 10:47 a.m. registered nurse (RN)-B, the nurse manager of this unit, was asked about the entries in R47's care plan regarding hospice care. She stated that the care plan is not finalized until the assessment period is over and the care conference held, which was scheduled for 1/7/16. She went on to explain that as soon as the resident is signed onto hospice care, she puts hospice entries into the resident's care plan. She was asked the visitation schedule of the hospice staff and she replied that the hospice nurse visits often. Social worker (SW)-B was interviewed at the same time as RN-B and asked the same questions. SW-B stated that the hospice service puts a care plan into the resident's record, but this facility's staff does not use that care plan. When asked about the schedule of the hospice staff, she replied that there didn't seem to be a particular schedule, rather, "They just show up." On 1/6/16 at 2:24 p.m. licensed practical nurse (LPN)-D was interviewed regarding the hospice care of R47. She stated that she knew that R47 was on hospice care. She also said that she believed that an aide and a nurse from hospice visited R47, the hospice aide visited on Tuesdays and the hospice nurse came once a week, but she was not sure when. LPN-D was also asked if R47 was comfortable or had any pain issues.	2 830		

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2 830	Continued From page 9 She answered that she thought R47 was comfortable much of the time, but did have abdominal pain at times and received pain medication. Nursing assistant (NA)-D was interviewed on 1/7/16 at 11:10 a.m. and asked about the hospice services of R47. NA-D stated that he was not sure if R47 was receiving hospice services, but could try to find the answer to that question. He then stated that he worked roughly half time and floated to other units, so he was not sure of the most current information for R47. He then stated that he had never seen hospice staff with R47, so he could not describe the type of services they provide for her. The facility failed to ensure fall interventions had been developed and implemented following each fall, and that risks and benefits were explained to R88. The clinical diagnosis information identified R88 with diagnoses that included dementia without behavioral disturbance, cerebrovascular disease, Parkinsonism, anemia, restless legs syndrome, syncope and collapse and history of falls. R88 quarterly Minimum Data Set (MDS) dated 11/4/15 indicated R88 had had falls since the admission and at least one had resulted in injury such as skin tear, abrasion etc. The quarterly MDS indicated R88 needed extensive assistance of one staff for all transfers between surfaces i.e. bed, wheelchair and extensive assist of one staff person for ambulation in the hallways. The CAA indicated the resident had severe cognition impairment, and had short and long term memory loss.	2 830		

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2 830	Continued From page 10 A review of recent incident reports for R88 falls included: -10/29/15 at 10:31 p.m. During a skin check after a evening bath, R88 reported the skin tear was obtained as she " fell early in the morning as I was getting up from my bed " and reported being barefoot. Staff note indicated gripper socks were put on at hours sleep. -11/19/15 7:10 a.m. Nursing assistant reported resident was on the floor. R88 was sitting on the floor facing the bed between the bed and window wall. Knees were drawn up to her chest, " her feet were bare'. Her pajamas were stained with blood. The night stand was directly to her right. Her w/c was directly to her left and in the locked position. Call light was clipped to resident's pillow. Resident has 3 cm (centimeter) x 2 cm laceration to left posterior scalp.. She had a 6.5 x 4 cm bruise to her left shoulder. She has a 3.2 abrasion to her left elbow. Her left ear is slightly bruised and below her left eye is slightly discolored. Resident was incontinent at the time of the fall. The fall report indicated the resident was barefooted at the time of the fall and attempted to get from the bed to the wheelchair to go to the bathroom. The post note review, dated 11/24/15, indicated the resident was sick with cold symptoms and weak and not able to complete her transfer independently and included R88 needed additional assistance while having cold symptoms. -12/25/15 at 9:36 p.m. R88 self-reported having a fall around 8:15 p.m. and stated she sat on the edge of the bed and slid to the floor. R88 denied injury, pain or hitting her head. R88 did have a	2 830		

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2 830	Continued From page 11	2 830		

reddened area on the right elbow. The post Incident review revealed the resident was wearing nylons and shoes without backs and refused to wear gripper socks. Interventions identified on the post incident review form included proper footwear, do not leave unattended on toilet, activities that minimize the potential for falls while providing diversion and distraction and encourage to participate in activities that promote exercise physical activity for strengthening and improved mobility.

-1/1/16 at 12:00 p.m. indicated the resident had been found on the floor. The resident was fully dressed, shoes were on the floor in front of her facing resident. R88 was wearing nylon stockings on her feet and appeared to have been ambulating on the floor without her shoes. R88 complained of left wrist and left knee pain. On 1/2/16 a X-ray was obtained and verified a fracture of the left distal radius.

1/5/15 at 4:05 p.m. indicated the resident had an unwitnessed fall. Although the form had not been completed at time of survey it was provided, the form indicated R88 had reported sliding down off the mattress of the bed wearing nylons and shoes without backs. The report included the resident refused to wear gripper socks. Interventions put into place after the incident included increase activities in the sunroom during the day and evening.

The current care plan, dated 2/13/15, indicated the resident was able to reposition self in bed, staff assisted to go from sitting at edge of bed to lying and to sitting at edge of bed. The care plan indicated the R88 was extensive assist for transfers, use of a transfer belt, and was dependent on staff for ambulation with wheeled

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2 830	Continued From page 12 walker, gait belt with wheelchair behind. The current care plan, initiated 1/1/16 for falls, directed staff to offer and assist toileting if awake during night time, limit fluids after 7 p.m., orient resident to unit and routine throughout the day, and identified resident will self report falls. Other interventions included: administer pain meds as ordered, anticipate and meet resident's fluid food, comfort, toileting and comfort needs, ensure frequently used items are within reach, observe for signs of gait and balance, assist resident in walking to activities, dining room and so forth, proper footwear, pharmacy review of psychotic medications, activities that minimize the potential for falls, and encourage to participate in activities that promote exercise, physical activity for strengthening and improved mobility. The care plan initiated on 2/14/15 identified behavior as a concern. Interventions included: to assist resident to adjust to new surroundings, re orient to room, routine of the day, activities and familiarize with staff. medications to be administered, and target behaviors of weeping and tearfulness were identified. Other interventions included to approach in a calm manner, explain procedures, support emotionally and praise any indication of progress. The care plan did not identify the continued refusal to wear gripper socks at hours of sleep, or other appropriate foot wear while awake. A review of R88's medical record revealed no documentation that R88 was educated about the risks and benefits of refusing to wear proper footwear. And the care plan did not identify the refusal behaviors or the recent left wrist fracture. The undated Unit 4 Accountability Sheets, used	2 830		

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2 830	Continued From page 13 by the nursing assistants to direct care, indicated R88 was independent with repositioning and independent with transfers. It indicated to monitor resident while in room, and to encourage gripper socks at hour sleep. On 1/7/16 at approximately 1:15 p.m. the clinical nurse manager (RN)-D indicated R88 would not stop wearing nylons and the open back shoes and would not wear gripper socks at hours sleep. This contributed to R88's falls. RN-D confirmed the care plan had not identified the behavior of refusing to wear gripper socks nor had an alternative been developed to provide alternative footwear. The care plan also lacked the explanation of risks versus benefits for the continual usage of nylons and open back shoes. The facility failed to provide adequate supervision to prevent accidents and injury related to elopement for R190. Review of R190's most recent Minimum Data Set [MDS] and care area assessments, dated 10/22/15 revealed R190 was cognitively intact, showed signs of moderate depression, experienced frequent pain and showed no signs of verbal or physical aggression towards others. R190 had diagnoses including diabetes, anxiety, depression, bipolar disorder, asthma, chronic obstructive pulmonary disease (COPD) and recent infections including pneumonia. R190 was prescribed oxygen therapy. R190's most recent medication review report, dated December 2015, revealed R190 was prescribed oxycodone HCL concentrate 20 milligrams/millimeters [mg/ml]-give 10 mg every six hours for pain (narcotic pain medication), oxygen 1-4 liters per minute, Duoneb solution 0.5-2.5 (3) mg/3 ml inhaler every four hours for COPD, quetiapine	2 830		

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2 830	Continued From page 14 fumarate tablet 35 mg bid and 200 mg at bed time, (anti-psychotic) and Humalog solution 100 unit/ml per sliding scale with meals and insulin glargine solution 100 unit/ml per sliding scale at bed time. Staff were directed to monitor R10 every shift for signs of isolating self, agitation and anxiety and pain. Review of R190's psychological consultation, dated 11/19/15 revealed: "He continues at moderate risk for self-harm given his historical attempts, current use of psychotropics (overdose history with this), severe depressive sx [symptoms] including low hope." and "He also is impulsive and may report and appear stable without any likelihood he remains this way from moment to moment. Maintaining vigilance and oversight re: his mental status re: safety to self will likely remain important." R190's diagnoses included Major depressive disorder, Recurrent episode, and Severe and Alcohol use disorder, Severe. Rule out diagnoses included PTSD [post traumatic stress disorder] and Bipolar disorder An incident report, dated 12/6/15, revealed another resident, R235, had alleged R190 gave her alcohol in her cranberry juice without her knowledge. R190 reported "She said I gave her alcohol without her knowing it when she did." Action taken included R190 being asked to not go off his floor for the evening. R190 was noted as being alert and oriented to person, place and time. No futher assessment of environmental, physiological or situation factors was completed on this report. Review of progress note, dated 12/6/15, revealed "Behavior: At 9:50 pm. resident came to author at medication cart and stated 'I ' m freaking out...I want to go have a ciggerette. (sic)' Author	2 830		

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2 830	Continued From page 15 reminded resident he had been requested to stay up on the [assigned] floor by the charge nurse, author also stated 'There will be a meeting tomorrow, and you can explain your side of the story'. Resident became more aggitated (sic). Resident stated 'you can't force me to stay here, I will call the cops and have you arrested for kidnapping". Resident stated "I'm going downstairs and you can't stop me". Resident headed towards elevator, author called [name of nurse] PM [evening] Supporvisor (sic), and alerted that resident was heading downstairs to first floor. At 10:45 p.m., author had still not seen resident return to unit, or had been contacted by first floor staff. When author went to check on resident on first floor and outside, was informed that resident had been seen by staff leaving the VOA campus. Resident had not signed out in log book, no medications sent with resident." and "Resident left out (LOA) before the NOC (night) shift started. PM nurse stated that she already informed supervisor and DON [director of nursing] about the situation. Resident didn't come back to the building at this time." The notes did not include how R190 left the facility. The progress notes included no assessment of how R190's current medical and psychiatric diagnoses and conditions may have impacted his ability to safely leave the facility independently for the night, particularly after displaying signs of agitation, conflict with another resident and sharing alcohol. The progress note did not include futher actions taken by staff to keep R190 safe at the facility, if measures could be taken to assist R190 to leave the facility safely or how staff responded to R190 leaving the facility. It was not assessed if R190 had consumed alcohol. Review of Progress notes from October, November and December 2015 noted instances of leaving the facility. However, only one similar episode of	2 830		

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2 830	Continued From page 16	2 830		

agitation was noted, on 10/21/15. R190 swore at a staff after being advised not to transfer independently due to low blood pressure. R190 went outside to smoke but did not leave the grounds.

A report by R190, dated 12/7/15, revealed "Then I came back up to [assigned floor] and was told I had to stay in my room. Then I left. I went to [name of motel] on [location] on my scooter. I was in and out all noc [night]. They allowed me to warm up but they would not allow me to sleep there. Cops found me in the middle of the street. I was in ambulance when I came to. they told me my sugar was low. It wouldn't read. They bought me a sandwhich (sic), drink and bag of chips. They left me at [name of motel] I came back to center at 10:00 after leaving [name of motel] at 9:00 a.m."

An incident report, dated 12/6/15 and revised on 12/19/15 revealed "resident reported that he fell outside the hotel on his scooter." Resident added "I feel my sugar was low." The reported indicated "Was out of the facility checked in at motel [name of motel unknown the circumstances that led up to the fall as to whether he ate or had consumed alcohol or any of the precipitating factors. EMT [emergency medical technicians] did respond and treated per hotel manager." No injures were noted.

A futher witness observation statement written by the hospice nurse [RN], dated 12/17/15 added "Patient fell in street in front of Hotel/Motel [Name of motel]; Police responded with ambulance. Ambulance treated low blood sugar ("6"); Ambulance gave him some sugar [illegible word]; Police and ambulance let him stay there in the lobby of hotel. Patient choose not to get a room,

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2 830	Continued From page 17 but just warm himself in lobby.'; patient arrived at SNF [skilled nursing facility] approx [approximately] 10:30 am as I was talking with staff at SNF about his whereabouts. I assess V.S [vital signs] he would allow; 24 Resp [respirations per minute], and 130 AP [pulse] sats [oxygen saturation] 97% RA [room air], off all pain meds for 14 hours rating pain 8/10 [severe pain]" A report, dated 1/17/16, composed by SW-B confirmed emergency medical services [EMS] had assisted a person at the same motel as R190 stayed at that night. When patients have low blood sugars they typically do administer a sugar solution and return them to bed. EMS was unable to verify they assisted R190, due to privacy laws. A manager at the motel confirmed R190 rented a room for two nights and had not checked out. The manager had heard from staff a guest was brought in and helped to his room related to blood sugars but was unsure if it was R190. On 1/10/16 at 8:57 a.m. the director of nursing (DON) and director of social service (DSS) were interviewed regarding R190 and the incident. DON and DSS were unable to determine how R190 left the facility that night. There was no documentation to clarify. DON and DSS reported no one assessed R190's ability to safely leave the facility that night. It was not clear if R190 used alcohol that night or if the status R190's medical and psychiatric conditions may have impacted his ability to safely leave the facility that night. There was no assessment of winter weather conditions the night of 12/6/15 or if R190 was dressed appropriately. DON and DSS were not aware of any steps or measures staff implemented that night to maintain R190 safely at the facility or steps implemented by staff to ensure R190 could stay as safe as possible the	2 830		

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2 830	Continued From page 18 night away from the facility. DON and DSS were unaware of steps implemented to encourage R190 to return to the facility or ascertain the whereabouts of R190 after leaving the facility. The facility did not contact additional resources to assist, such as local crisis services or police. The facility had R190's cell phone number and the contact information for emergency contacts on his face sheet. However, no one contacted or attempted to contact R190 or his emergency contacts after he left. There was no indication staff attempted to assist R190 in having the necessary medications, snacks or meals to leave the facility for an overnight stay. There was no plan to allow R190 to have a cigarette while staff were encouraging him to stay off the same floor as R235. DSS reported "we cant stop people from being LOA [away from the facility]. Yes, he is on narcotics, medically compromised, possibly drinking. He came back. It is his right to leave." DON and DSS reported they did not follow the procedure for missing residents, as the did not classify him as a missing resident. DSS and DON reported staff were unaware of R190's whereabouts on the night of 12/6/15. The policy of Wandering and Elopement procedures, last revised April 2011, directed staff "The facility promotes the least restrictive environment for all residents while recognizing the potential of residents wandering from the facility. The is facility will utilize monitoring and alarm systems; sign in and out books on all units and maintain pictures of all residents on their units. This facility will also maintain a response plan for implementation in the event of a missing resident." and "Missing Resident: A. The RN Supervisor on shift or Charge Nurse will be notified when a resident is missing. The following will be implemented immediately by the Charge	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 Nurse/Unit Coordinator: 1. The charge nurse will announce the appropriate alert. 2. Assign staff to search all floors, including lower level and attached buildings. 3. Assign staff to search grounds and immediate block. 4. Contact Director of Nursing and Executive Director. 5. Interview Nurses/Nursing Assistants on residents unit to determine last known location, clothes if the resident wanted to go somewhere or see someone. 6. Make copies of resident picture with current description of resident and give to responders. B. The Director of Nursing or Nurse Supervisor on call will assume the responsibility for Search Investigation and communication until Executive Director arrives. 1. Notify physician. 2. Notify Family and identify places resident frequented in the past. 3. Assess information received and broaden search. 4. Ensure that all documentation is complete and accurate throughout the search. C. If resident is not located within 15 minutes, Executive Director will assume responsibility for Search Investigation and communication leader. The facility will: 1. Notify police. 2. Coordinate expansion of search. 3. Notify Medical Director. D. Executive Director or DON/Nurse Supervisor will also assess the need to contact the following and distribution of resident picture and description to: 1. Police 2. Local Hospital ER's 3. Cab Companies	2 830		

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	00520	A. BUILDING: _____ B. WING _____	01/07/2016

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2 830	Continued From page 20 4. Bus Company 5. Postal Service 6. Local Restaurants, businesses, gas stations, etc. 7. Households near the facility. E. Upon Return to the facility: 1. Charge nurse announces appropriate alert as all clear. 2. Director of Nursing or Designee will ensure that the resident's assessment is completed, documented and reported to their physician and the POC is updated. 3. Social Services Director or designee will notify family/guardian etc and updated POC as needed. 4. Resident Incident Report according to policy and procedure." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to care and services provided to residents receiving care for hospice and accidents,based on their assessed needs. Staff could be re-educated on these policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the	2 900		2/12/16

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2 900	Continued From page 21 comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure the necessary care and services were provided for 1 of 3 residents (R91) in the sample reviewed for skin breakdown. Findings include: Staff did not follow up on a reddened area on R91's heel. During stage one review of R91's record on 1/5/16 at 11:00 a.m., revealed documentation on the Nurse bath skin check on 12/31/15 at 21:47 that indicated "Resident given bath skin intact except for the left heel which is red and painful to touch." No further documentation noted regarding reddened left heel. Document review revealed R91 had diagnosis including hemiplegia (paralysis of one side of the body) and hemiparesis (weakness of the left or	2 900	Completed	

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2 900	Continued From page 22 right side of the body) following unspecified cerebrovascular disease affecting left non-dominant side. R91's care plan revealed R91 "wears Lt (left) AFO (ankle foot orthosis) to LE (lower extremity)." Interview with NA-A on 1/6/16 at 7:43 a.m., indicated he/she was the nursing assistant that gave R91 a bath last week and noticed the reddened area and notified the nurse. NA-A indicated R91 wears a splint on the left ankle and the heel doesn't touch any areas. Review of the facility's policy and procedure for the prevention and treatment of skin breakdown received 1/6/16 at 2:45 p.m. revealed on page 2 under "Monitoring of Skin Integrity" bullet point 3, "If a skin concern is noted, refer to Treatment of Pressure Ulcers and Lower Extremity Ulcers procedure." Section II Treatment of Pressure Ulcers and Lower Extremity Ulcers indicated "If a resident is admitted with or there is a new development of a pressure ulcer or lower extremity ulcer the following procedure is to be implemented. 1. Initiate Would Care Protocols. 2. Notify Physician/NP and Family/Designee 3. Notify Supervisor/Designee as assigned 4. Notify Dietary for nutritional interventions 5. Notify Therapy Department for seating surface evaluation and possible treatment interventions and other interdisciplinary team members as appropriate... 10. Initiate Weekly wound documentation progress sheet which will include:type of wound, location, date, stage, or indicate partial or full-thickness , length, width, and depth..." Interview with RN-D on 1/7/16 at 11:00 a.m., indicated no knowledge of any reddened areas to	2 900		

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2 900	Continued From page 23 R91's heel. RN-D explained that a reddened area to a heel could be considered a stage one, or it could be an unstageable ulcer, however without examining the area would not know. RN-D stated that the expectation would be for the nursing assistant giving the bath to notifiy the nurse and the nurse would then complete a body check. If any any abnormal areas are found, the nurse would fill out the proper forms, notify the nurse manager, the physician and the resident's responsible party. RN-D verified what was documented on the Nurse bath skin check dated 12/31/15, verified the lack of follow up documentation in the progress notes and bath form and acknowledged the procedure had not been followed. RN-D stated R91 would be given a bath that day and the left heel would be rechecked. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policies and procedures and assure that staff are trained to follow through with identified alterations of residents skin when reported. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 995	MN Rule 4658.0610 Subp. 3 Dietary Staff Requirements -Grooming. Subp. 3. Grooming. Dietary staff must wear clean outer garments. Hairnets or other hair	2 995		2/12/16

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2 995	Continued From page 24 restraints must be worn to prevent the contamination of food, utensils, and equipment. Hair spray is not an acceptable hair restraint. This MN Requirement is not met as evidenced by: Based on observation and interview and document review the facility failed ensure employees with facial hair wore beard protectors. 115 of 117 residents ate food prepared in the kitchen, however, all residents may not have eaten the same food prepared. Findings include: At 1:00 p.m., during the kitchen tour, including food preparation area, the Director of Food Service (DFS) was noted to have uncovered facial hair. DFS stated he would order beard protectors. The Employee Sanitary Practices policy dated 2010, directed: All employees shall: 1. Wear hair restraints (hairnet, hat and/or beard restraint) to prevent hair from contacting exposed food. The Infection Control Dietary policy dated 2015, directed: Policy: The dietary department will meet accepted standards of safety and sanitation of food, equipment, and cleaning supplies. Procedures: A. The facilities Dietary Policy and Procedure manual contain operating policies, procedures, and practices that comply with the infection control and prevention guidelines. Refer to F371	2 995	Completed	

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2 995	Continued From page 25 in CMS SOM. D. All Food 3. Is properly stored Sanitary Conditions: Follow proper sanitation and food handling practices to prevent the outbreak of foodborne illness. Safe food handling for the prevention of foodborne illnesses begins when food is received from the vendor and continues throughout the facility ' s food handling processes. " Dry Storage " refers to storing/maintaining dry foods (canned goods, flour, sugar, etc.) and supplies (disposable dishware, napkins, and kitchen cleaning supplies). The 2013 Food and Drug Administration (FDA) Food Code under the section of Hair Restraints read, "(A) Except as provided in (B) of this section, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD; clean EQUIPMENT, UTENSILS, and LINENS; and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLES." SUGGESTED METHOD OF CORRECTION: The Director of Food Service or designee, could review policies and procedures related to proper food sanitation and hair restraints. The Direcrotr of Food Service or designee, could provide training for all dietary staff related to the policy. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 995		

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