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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: Q4CB

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00520

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/09/2015** (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 **149** (L18)

13.Total Certified Beds **149** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	149			
(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 :
Sue Reuss, Supervisor 02/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 02/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/14/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5276

February 10, 2015

Ms. Kari Everson, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Dear Ms. Everson:

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

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

Effective January 16, 2015 the above facility is certified for:

149 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 149 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,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

February 10, 2015

Ms. Kari Everson, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276025

Dear Ms. Everson:

On December 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 18, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On February 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 16, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 18, 2014, effective January 16, 2015 and therefore remedies outlined in our letter to you dated December 30, 2014, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245276	A. Building B. Wing	2/9/2015

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **01/16/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **01/16/2015**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **01/16/2015**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **01/16/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	02/10/2015	16022	02/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
12/18/2014			

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

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ID: Q4CB

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/18/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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

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To (b) :

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13.Total Certified Beds **149** (L17)

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Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	149			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 01/09/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 01/13/2015 (L20)

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

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1670 0000 8044 5445

December 30, 2014

Ms. Kari Everson, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Number S5276025 and Complaint Number H5276081

Dear Ms. Everson:

On December 18, 2014, 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 December 18, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5276081. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the December 18, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5276081 that was found to be unsubstantiated.

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

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

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

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 17, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's PoC if the PoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable PoC 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 PoC 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 PoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by March 18, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 18, 2015 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulations Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	12/18/2014

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed for H5276081 at the time of the standard licensing survey and was unsubstantiated.	F 000	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the facility, its Administrator or any employee, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance within ten days of the receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance with this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admissions by the facility.	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow facility policy in an effort to resolve grievances verbalized by 1 of 1 resident (R15) reviewed who expressed a grievance to facility staff. Findings include: During initial interview with R15 on 12/15/14 at 11:36 a.m. stated, "My phone charger has been missing for 3 months now and I reported it to the			

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

Executive Director 1/5/15

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.

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 _____	12/18/2014

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 166	Continued From page 1 social worker ". R15 explained that reporting was what she was supposed to do and indicated that nothing had been done about it and, "I want it back." R15 added, that the social worker (SW)-A, "did not follow up with me about it and they never reimburse me because they don't do that here." Policy and procedure titled, Concern or Problem Resolution Policy, revised 9/10 reads, "5. Grievances will be routed and tracked by social services. They will be given to the appropriate department manager for follow-up, according to the nature of the concern. In assisted living settings they will be routed and tracked by the Residence Director. 6. Grievances will be responded to within 72 hours for non-emergency concerns. The facility will notify the complainant to provide updates on resolution for the complaint. 7. The manager responsible for investigating and resolving the concern will complete the Resolution Form, including a plan for resolution. 8. The complainant will be informed of the final outcome and resolution. All communications will be documented on the Concern or Resolution Form. Attach any relevant/supporting documents to the form. 13. Social Services/Residence Director will utilize a tracking system of all complaints to ensure proper follow-up. 14. Tracking system will be used for quality assurance, identifying any trends, systemic problems, and improvement efforts. 15. Completed Concern or Problem Resolution Forms and supporting documents are to be kept confidential, except as required by law." During an interview with SW-A on 12/17/14 at 11:15 a.m. stated, R15 had reported this incident last summer and a new phone charger was obtained for her by SW-C.	F 166	F 166 It is the policy of Volunteers of America Maplewood Care Center to make prompt efforts to resolve grievances the residents may have. A concern form was filed for resident 15 regarding cell phone charger on previous occasion but facility was unable to produce documentation. New concern form written and follow up completed according to policy to residents satisfaction. Policies and procedures were reviewed and found to be appropriate. Re-education provided to Social Service and Nurse management staff to ensure compliance with said policy and procedure. Random audits will be done monthly. The results of these audits will be reported to the facility QA meeting monthly for three months. Upon this review, system changes will be implemented if indicated. Social Service Director and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. 2/15	

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	245276	A. BUILDING _____ B. WING _____	12/18/2014

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F 166	Continued From page 2 Review of R15's electronic and hard chart, revealed no evidence of documentation regarding a grievance or missing item form. During an interview with SS-B on 12/18/14 at 11:21 a.m. stated, SW-C assisted R15 to get a new phone charger, however, could not find the documentation. SW-C, who no longer worked at the facility, was contacted by SS-B to inquire about the phone charger and the grievance form. On 12/18/14 at 1:30 p.m. SW-B provided a paper with documentation from SW-C regarding the grievance that R15 had reported to SW-C. The information from SW-C indicated that when SW-C was the social worker, R15 had reported her phone charger missing and requested that SW-C contact the service provider where R15 had gotten the phone from to get a free replacement. The service provider was contacted and it was learned that replacement phone chargers were not provided and that R15could purchase a new one for a relatively low cost at any local store. The information was relayed to R15 and R15 opted not to purchase a new phone charger explaining that R15 doesn't use the phone much anyways. Although SW-C had recalled the incident, R15 did not recall that the grievance had been followed up on and wanted the phone charger back. There was no evidence of documentation that the grievance had been reported and followed through with, per facility policy.			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS			

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F 329	Continued From page 3 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure side effects of anticoagulant medications were monitored for 1 of 1 resident (R156) reviewed and failed to ensure that a scheduled and as needed (PRN) medication would not potentially exceed the safe dosage amount for 1 of 5 residents (R192) in the sample. Finding include:	F 329	F 329 It is the policy of Volunteers of America Maplewood Care Center to promote unnecessary drug use from the residents drug regimen. Resident 156 had side effect monitoring added to his anticoagulant therapy. All residents receiving anticoagulant therapy had orders audited immediately for side effect monitoring to ensure safe practice and compliance. Resident 192 acetaminophen orders reviewed and physician contacted for clarification and correction of dosing. All residents receiving acetaminophen had order review done to ensure safe practice and compliance for unnecessary medications. Policies and procedures were reviewed for unnecessary medication use and monitoring protocols. Nursing staff were re-educated on unnecessary medications, maximum dosing orders and side effect monitoring. Random audits of residents on anticoagulant therapy for side effect monitoring, and random audits for residents receiving appropriate dosing of acetaminophen will be done monthly for three months. The results of this auditing will be reported to the QA committee for three months. Upon this review, revisions will be made if indicated. continued	

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F 329	Continued From page 4 R156 received Coumadin (anticoagulant - commonly known as a blood thinner) and the medical records lacked evidence of monitoring for side effects to identify possible adverse reactions the medication. R156's admission Minimum Data Set (MDS) dated 9/29/15, indicated that R156 had a severe cognitive impairment. Face sheet dated 9/22/14, indicated R156 had a diagnosis of personal history of venous thrombosis (commonly known as blood clots that develop in the veins), and embolism (commonly known as a blood clot that breaks away and travels in the blood stream), and hypertension. The signed physician orders dated 12/15/14, directed staff to administer Coumadin 5 milligrams (MG) daily for a diagnosis of personal history, venous thrombosis and embolism (order started 11/24/14). R156 was periodically observed on 12/17/14, from 7:32 a.m. to 8:09 a.m. and 12/18/14, at 10:44 a.m. with no evidence of bruising or bleeding noted. R156's care plan lacked direction to staff regarding R156 being on Coumadin and identification of possible adverse reactions of the medication that staff should monitor for. On 12/17/2014, at 12:04 p.m. registered nurse (RN)-C stated Coumadin was not addressed on the care plan. RN-C stated the monitoring of the medication should be on the care plan and verified it had not been addressed. On 12/18/2014 at approximately 2:30 p.m. the	F 329	continued Maplewood Care Center will continue to have pharmacist perform medication regimen reviews monthly. The review will continue to include preventing, identifying, reporting, and resolving medication related problems or irregularities and collaborate with other members of disciplinary team. The pharmacist will provide a summary of all recommendations and irregularities to the facility QA committee monthly for three months and then quarterly. Upon review of this report, system changes will be implemented if indicated. Director of Nursing and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. 1/16/15	

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F 329	Continued From page 5 director of nursing (DON) verified the care plan should address monitoring interventions related to the potential risks and side effects of the Coumadin. The facility did not provide a policy addressing monitoring for the potential risks and side effects of Coumadin. According to the current physician orders, R192 had the potential to receive an excessive amount of acetaminophen. The current physician order sheets revealed R192 was admitted to the facility on 8/23/13 with diagnoses of dementia, and peripheral vascular disease. The current physician orders indicated R192 had physician orders that read: ...Tylenol Extra Strength Tablet 500 mg (milligrams) three times a day for pain. ... Acetaminophen (Tylenol) tablet 325 mg: give two tablets by mouth every 4 hours as needed for pain, NOT FEVER - CALL NP/MD FOR ALL NEW FEVER EPISODES. DO NOT EXCEED 3 GRAMS IN 24 HOURS. The scheduled Tylenol Extra Strength amount equaled 3000 mg. One dose of the Tylenol 325 mg two tablets (650 mg) every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours. A review of the last three months of the medication administration sheets indicated R192 had not received excessive amount of acetaminophen. On 12/19/14 at 1:35 p.m. RN-C verified the			

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F 329	Continued From page 6 physician orders and agreed there was the potential to exceed 3 grams of acetaminophen. RN-C indicated she would review the orders with the physician. A policy was requested but not provided.			
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356	F 356 It is the policy of Volunteers of America Maplewood Care Center to post the nurse staffing data on a daily basis and that it is placed in a prominent place readily available to residents and visitors. Policies and procedures regarding the posting of nursing hours were reviewed and revised, with the addition of a more precise staff hours posting form. Education of new process was done with staffing coordinator, receptionists, and Nurse Managers to ensure compliance with regulation. Random audits will be done to ensure compliance with new process. The results of this monitoring will be reported to the QA committee monthly for three months. Upon this review, revisions will be made if indicated. DON and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. 1/16/15	

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F 356	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to post the actual hours worked for nursing staff directly responsible for resident care per shift. This had the potential to affect 128 residents in the facility. Findings include: During the initial tour on 12/15/14 at approximately 2:30 p.m. the daily staff positing was observed posted on the interior wall of the first floor entrance. The posting form did not identify the actual hours worked for each shift and each classification of staff. During the three remaining days of the survey, 12/16/14-12/18/14, the posting was observed during random times and continued to not identify the actual hours worked for each shift During interview on 12/18/14 at 11:02 a.m., the director of nursing (DON) reported the nursing staff fill out the daily form and have the receptionist update the form as changes are made. The DON verified the forms did not identify the actual hours worked by each classification and shift worked. A policy was requested but not provided.			
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.	F 428		

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F 428	Continued From page 8 The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure pharmacist advice the facility irregularity of medication administration for 1 of 5 residents (R192) reviewed for unnecessary medications. Findings include: The current physician order sheets revealed R192 was admitted to the facility on 8/23/13 with diagnoses of dementia, and peripheral vascular disease. The current physician orders indicated R192 had physician orders that read: ...Tylenol Extra Strength Tablet 500 mg (milligrams) three times a day for pain. ... Acetaminophen (Tylenol) tablet 325 mg: give two tablets by mouth every 4 hours as needed for pain, NOT FEVER - CALL NP/MD FOR ALL NEW FEVER EPISODES. DO NOT EXCEED 3 GRAMS IN 24 HOURS. The scheduled Tylenol Extra Strength amount equaled 3000 mg. One dose of the Tylenol 325 mg two tablets (650 mg) every 4 hours as needed for pain would exceed the limit of 3 grams in 24 hours. A review of the last three months of the	F 428	F 428 It is the policy of Volunteers of America Maplewood Care Center to have the medication regimen of each resident reviewed at least once a month by a licensed pharmacist and the pharmacist must report any irregularities to the MD and DON, and be acted upon. Resident 192 medication regimen was reviewed by licensed pharmacist at time of survey. Recommendation made, physician contacted for order clarification, resulting in discontinuation of prn acetaminophen. Registered Pharmacist provided audit of all residents receiving acetaminophen regimen to ensure no potential to exceed maximum dosing. Recommendations were made in accordance to policy. Maplewood Care Center will continue to have the pharmacist perform medication regimen reviews monthly. The review will continue to include preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team. The pharmacy consultant will provide a summary of all recommendations and irregularities to the facility QA meeting monthly for three months and then quarterly. Upon review of this report, system changes will be implemented if indicated. Director of Nursing and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. 1/16/15	

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F 428	Continued From page 9 medication administration sheets indicated R192 had not received excessive amount of acetaminophen. On 12/18/14 at 1:35 p.m. registered nurse (RN)-C verified the physician orders and agreed there was the potential to exceed 3 grams of acetaminophen. The clinical manager indicated she would talk with the physician regarding the orders On 12/18/14 at 1:50 p.m. the pharmacist reviewed the current physician orders and agreed there was potential to exceed the 3 grams of acetaminophen and verified the as needed order should be discontinued.			

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maplewood Care Center was found to be in 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. 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 131 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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