CENTERS FOR MEDICARE & MEDICAID SERVICES

			ARE/MEDICAII TO BE COMPI						ID: T7G9 Facility ID: 00520
1. MEDICARE/MEDIC. (L1) 245276 2.STATE VENDOR OR (L2) 010343800	AID PROVIDER NO.		3. NAME AND AE (L3) MAPLEWO (L4) 1900 SHERF (L5) MAPLEWO	DRESS OF FAC OD CARE CE REN AVENUE	CILITY E NTER		55109	 TYPE OF ACTIO Initial Termination Validation On-Site Visit 	•
5. EFFECTIVE DATE ((L9)	CHANGE OF OWNER	SHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP	22 CLIA	8. Full Survey Afte	
 6. DATE OF SURVEY 8. ACCREDITATION S 0 Unaccredited 2 AOA 	03/01/2018 TATUS:	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 IIIA 06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF	22 (114	FISCAL YEAR ENDI 12/31	NG DATE: (L35)
11LTC PERIOD OF CE From (a) : To (b) :	ERTIFICATION		10.THE FACILITY A. In Complia Program Re Compliance	nce With equirements	AS:		nical Personnel	The Following Requirem 6. Scope of S 7. Medical D	ervices Limit
12. Total Facility Beds 13. Total Certified Beds		(L18) (L17)	X B. Not in Com	cceptable POC pliance with Prog and/or Applied V	-	5. Life	ay RN (Rural SN Safety Code B *	F) 8. Patient Roo 9. Beds/Room (L12)	
14. LTC CERTIFIED BE	ED BREAKDOWN					15. FACILITY N		(=)	
18 SNF	18/19 SNF 130	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)	
(L37)	(L38)	(L39)	(L42)	(L43)					
your facility was in of complaints H5276093 and H52	and 3/1/18, a stand compliance with rec 76097. The were co	ard survey quirements	and complaint inve of 42 CFR Part 483 nd found to be unsu	stigations were 3, Subpart B, an	also compl	nents for Long	Ferm Care Faci	lities. At the time of the	f Health to determine if he survey, investigation
17. SURVEYOR SIGNA	ATURE		Date :			18. STATE SUR	RVEY AGENCY	APPROVAL	Date:
Momodou Fatt	y, HFE NE II		04/04/2	018	(L19)	Amy Johns	son, Enforce	ment Specialist	04/17/2018 (L20)
	PART II -	TO BE	COMPLETED F	BY HCFA RE	EGIONAL	OFFICE OR	R SINGLE S	FATE AGENCY	
-	OF ELIGIBILITY is Eligible to Participat <i>i</i> is not Eligible	e (L21)		PLIANCE WITH ITS ACT:	1 CIVIL	2. C		acial Solvency (HCFA-25' l Interest Disclosure Stmt : 	
22. ORIGINAL DATE	23. LI	C AGREEN	MENT 24	. LTC AGREEN	MENT .	26. TERMINA	TION ACTION:		(L30)
OF PARTICIPATIO 05/01/1985	N E	BEGINNING	6 DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Clos	00		NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfactio	on W/ Reimburse	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION			VE SANCTIONS			03-Risk of Involu 04-Other Reason	-	OTHER	er Status Change

	A. Suspension of Admissions:		04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	(L44) B. Rescind Suspension Date:			00-Active
	(L45)			
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.		30. REMARKS	
	03001			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAL	DATE		
	(L32)	(L33)	DETERMINATION APPROVAL	



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 19, 2018

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

RE: Project Numbers S5276028, H5276093, H5276097

Dear Ms. Sterling:

On March 1, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567 whereby corrections are required. In addition, at the time of the March 1, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5276093 and H5276097 that were 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>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor Metro A Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900 Email: susie.haben@state.mn.us Phone: (651) 201-3794 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 April 10, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

Maplewood Care Center March 19, 2018 Page 3

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

Maplewood Care Center March 19, 2018 Page 4 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 June 1, 2018 (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

Maplewood Care Center March 19, 2018 Page 5

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 September 1, 2018 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 Maplewood Care Center March 19, 2018 Page 6

St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Metatylan

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	Сом	E SURVEY IPLETED
		245276	B. WING _			C 01/2018
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
	OOD CARE CENTER			1900 SHERREN AVENUE		
		•		MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted 2/26/18 recertification surve	nce with CMS Appendix Z edness Requirements, was through 3/1/18, during a ey. The facility is in compliance Z Emergency Preparedness	F 00	00		
	survey and complai completed at your f Department of Hea was in compliance Part 483, Subpart E Term Care Facilities investigation of com	76097. The were completed				
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.				
F 561 SS=D	revisit of your facilit validate that substa regulations has bee your verification. Self-Determination	acceptable POC an on-site y may be conducted to intial compliance with the en attained in accordance with I)-(3)(8)	F 56	51		4/10/18
	§483.10(f) Self-dete The resident has th	ermination. e right to and the facility must				
LABORATOR	Y DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE
Electron	ically Signed					03/28/2018

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.

PRINTED: 04/17/2018

		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• · ·		E CONSTRUCTION	(X3) DATE COMI	E SURVEY PLETED
		245276	B. WING				C 01/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	VOOD CARE CENTER	ł			900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 561	promote and facilita through support of inot limited to the rig (1) through (11) of the §483.10(f)(1) The mactivities, schedules waking times), heal care services consi- assessments, and in applicable provision §483.10(f)(2) The michoices about aspe- facility that are sign §483.10(f)(3) The michoices about aspe- facility that are sign §483.10(f)(3) The michoices about aspe- facility. §483.10(f)(8) The michoices of the community activities facility. §483.10(f)(8) The michoices of the community activities facility. §483.10(f)(8) The michoices of the community activities facility. This REQUIREMENT by: Based on interview review, the facility fra assess bathing pre- care plan based up 1 resident (R99) rev Findings include: During interview on asked about bathin	ate resident self-determination resident choice, including but ghts specified in paragraphs (f) this section. esident has a right to choose s (including sleeping and th care and providers of health stent with his or her interests, plan of care and other ns of this part. esident has a right to make tects of his or her life in the ificant to the resident. esident has a right to interact e community and participate in s both inside and outside the esident has a right to activities, including social, nunity activities that do not ghts of other residents in the NT is not met as evidenced γ , observation, and document ailed to comprehensively ferences, and implement a on resident preference for 1 of	F 5	561	F000 It is the policy of Maplewood Care O to follow all Federal, State, and loca guidelines, laws, regulations and sta This plan of correction is not to be construed as an admission of defici practice by the facility administrator employees, agents, or other individ The response to the alleged deficie practice cited in this statement of	al atutes. ient ', uals.	

Facility ID: 00520

If continuation sheet Page 2 of 27

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	IPLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		245276	B. WING_		C 03/01/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	•
MAPLEV	OOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 561	added that sometin be pushed back a of R99 said he unders cleanliness, but des that made showerin asked whether staf options, such as a aware that was an he had received be hospital stay, and a as bad during a bed shower. During the to wince in pain mut mid-sentence with to hold his breath u being able to open R99 described his p through his body wit Review of the elect R99 had diagnoses (inflammation of a t at its insertion into ankylosing spondyl can cause vertebra multiple sites, cram R99's care plan ind of one staff for bath section specific to p pain related to the s	one shower a week. R99 also nes staff allowed his shower to couple days due to his pain. stood the importance of scribed having constant pain ng uncomfortable. When f had offered other bathing bed bath, R99 said he was not option. R99 further explained d baths during a recent icknowledged his pain was not d bath as it was during a interview, R99 was observed litiple times, stopping squinted eyes. R99 appeared ntil the pain was gone, before his eyes and speak again. pain as spasms that shot ith any body movement. ronic medical record revealed a including spinal enthesopathy tendon, ligament, or cartilage the spine) at multiple sites, itis (inflammatory disease that the in the spine to fuse) at	F 5	 deficiencies does not constitu agreement with citations. The submission and implementat plan of correction will serve a credible allegation of complia F561 The bathing preferences for were noted on his Kardex an bath list specifying his prefer bed bath in the evening. All residents have the potent affected by this practice. Nu will audit admission/readmiss assessments to assure that I preferences for day, time and are accommodated. Audits will be conducted wee weeks, then monthly for 2 moneeded based on the recomm the QAPI committee. Policy a Procedure was reviewed for Determination and Resident Staff education will be provid on bathing preference and do refusals. Responsible: Director of Nur- designee Date of Correction: 4/10/18 	e preparation, tion of this as our ance. resident R99 Id the unit ence for a ial to be rse Managers sion bathing d type of bath ekly for four onths and as mendation of and Self Preference. ed by 4/10/18 pocumenting
	pain related to the s need for pain media showering. During interview on asked about how th for bathing preferen	spinal conditions, and R99's		designee	sing or

Facility ID: 00520

If continuation sheet Page 3 of 27

		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	`´co⊮	E SURVEY IPLETED C
		245276	B. WING				01/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER	2			000 SHERREN AVENUE APLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 561 F 641 SS=D	assessment. RN-G Admission/Readmis R99, dated 2/19/18 about bathing prefe with the following bo QUESTION: Ask the for bathing and pass for their plan of care check a box to idem be appropriate for t but were not limited bathing/showering p bath, I prefer baths. None of the boxes I R99's bathing prefe unsure whether stat bathing preferences preference had bee could not say for ce specifically about bo nurse who'd comple said she would follo options and prefere preferences were a On 3/1/18, at 4:08 p asked about whether regarding resident of preferences were s the Admission/Read Accuracy of Assess	s during an initial admission reviewed the most recent ssion assessment form for , and referred to the section rences. This section began olded text, "REQUIRED re resident their preferences t routine, mark answers here e." Staff also had an option to tify interventions assessed to he resident. Options included, I to, "I do not have specific preferences, I prefer a bed , and I prefer showering." had been checked to specify rences. RN-G sated she was ff had asked R99 about his s because no boxes indicating en checked. RN-G said she ertain whether R99 was asked athing, since she was not the eted the assessment. RN-G ow-up with R99 about bathing ences, and ensure current ccommodated.	F 5				4/10/18
	8403.20(g) Accurac	by of Assessments.					

If continuation sheet Page 4 of 27

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
245276	B. WING			C 01/2018
		STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	01/2010
		1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOU	LD BE	(X5) COMPLETIO DATE
ge 4 ust accurately reflect the NT is not met as evidenced and document review, the ure the Minimum Data Set e for 1 of 1 residents (R26) DS as having a mental health R26's mental health was found rd to indicate the 12/13/17, indicated R26 had a bipolar rate. dated 12/13/17, indicated R26 on and manic depression of e 12/17 annual MDS was the liagnosis appeared on an n MDS dated 12/15/16, and ed 3/15, 6/14, and 9/13/17, did d a bipolar disorder. ory and physical dated dress a bipolar disorder eview indicated R26 returned thy after admission and the summary dated 1/11/17, received the antipsychotic rexa and Seroquel for cinations, related to diagnosis , the discharge summary did d a bipolar disorder, and R26 on the antipsychotic	F 64	F641 The bipolar diagnosis was remove R26¶ s diagnosis list. All residen diagnosis lists will be reviewed by to ensure correct diagnoses. State education will be provided by 4/10 MDS coordinators will review the diagnosis list each time they com MDS for accuracy and update as The Interdisciplinary team will rev accuracy of diagnoses when con their Psychoactive medication rev assure they are current as require Audits will be conducted weekly for weeks, monthly for 2 months and needed based on recommendation QAPI committee.	t¶ s / 4/10/18 f)/18. The plete an needed. iew the ducting /iew to ed. or four as on of the	
	245276 TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) ge 4 ust accurately reflect the IT is not met as evidenced and document review, the ure the Minimum Data Set e for 1 of 1 residents (R26) S as having a mental health R26's mental health was found d to indicate the 12/13/17, indicated R26 had a bipolar ate. dated 12/13/17, indicated R26 on and manic depression of e 12/17 annual MDS was the iagnosis appeared on an MDS dated 12/15/16, and d 3/15, 6/14, and 9/13/17, did d a bipolar disorder. ory and physical dated ress a bipolar disorder eview indicated R26 returned ly after admission and the summary dated 1/11/17, eceived the antipsychotic exa and Seroquel for cinations, related to diagnosis the discharge summary did d a bipolar disorder, and R26	IDENTIFICATION NUMBER: A. BUILDIN 245276 B. WING	IDENTIFICATION NUMBER: A. BUILDING 245276 B. WING 245276 STREET ADDRESS, CITY, STATE, ZIP CODE 1900 SHERREN AVENUE MAPLEWOOD, MN 55109 PREFIX 7EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CODENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY) ge 4 F 641 IT is not met as evidenced and document review, the tree the Minimum Data Set e for 1 of 1 residents (R26) F 641 S as having a mental health F 641 R26's mental health was found d to indicate the 12/13/17, indicated R26 had a bipolar ate. F 641 R26's mental health was found d to indicate the 12/13/17, indicated R26 had a bipolar ate. F 641 R26's mental health was found d to indicate the 12/13/17, indicated R26 on and manic depression of e 12/17 annual MDS was the iagnosis appeared on an MDS dated 12/15/16, and d 3/15, 6/14, and 9/13/17, did d a bipolar disorder. F 641 my and physical dated ress a bipolar disorder. Audits will be conducted weekly f weeks, monthly for 2 months and needed based on recommendatic QAPI committee. Responsible: Director of Nursing designee Date of Correction: 4/10/18 Up after admission and the ummary dated 1/11/17, cecived the antipsychotic exa and Scroquel for cinations, related to diagnosis the discharge summary did d a bipolar disorder, in the antipsychotic Date of	IDENTIFICATION NUMBER: A BUILDING COM 245276 B. WING 03// 245276 B. WING 03// STREET ADDRESS, CITY, STATE, ZIP CODE 10 PROVIDER'S PLAN OF CORRECTION MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE Jee 4 F 641 F 641 IT is not met as evidenced and document review, the ret he Minimum Data Set of or 1 of 1 residents (R26) F 641 S as having a mental health F 641 The bipolar diagnosis list. All resident[s education will be reviewed by 4/10/18. The MDS coordinators will review the diagnosis list each time they complete an MDS for accuracy and update as needed. The Interdisciplinary team will review the accuracy of diagnoses when conducting their Psychoactive medication review to assure they are current as required. Audits will be conducted weekly for four weeks, monthly for 2 months and as needed based on recommendation of the QAPI committee. QAPI committee. ress a bipolar disorder. Responsible: Director of Nursing or designee Date of Correction: 4/10/18 ware the antipsychotic exa and Seroquel for cinations, related to diagnosis the discharge summary did a bipolar disorder, and R26 on the antipsychotic Date of Correction: 4/10/18

If continuation sheet Page 5 of 27

DEPARTMENT OF HEALTH AND HUMAN CENTERS FOR MEDICARE & MEDICAID				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SI	UPPLIER/CLIA (X2) M		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
245	5276 B. WI	NG) 01/2018
NAME OF PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER			900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID SUMMARY STATEMENT OF DEFIC PREFIX (EACH DEFICIENCY MUST BE PRECED TAG REGULATORY OR LSC IDENTIFYING IN	DED BY FULL PRI	ID EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
 F 641 Continued From page 5 Bipolar Disorder; and the first physical mission and dated 1/5/17, did not diagnosis of Bipolar Disorder. Although physician visit notes dated 7/21 and 10/12/17; and nurse praced dated 2/16, 4/3, 5/4, 8/14, 9/7, 11/8 1/10/18, indicated R26 had a Bipolithe medical record lacked evidence the diagnosis had an impact on the current functional status, cognitive or behavior status, medical treatm monitoring, or risk of death during back period. On 2/28/18, at 11:45 a.m. registered (RN)-H, an MDS coordinator revier medical record to determine where diagnosis had originated. RN-H ide psychology note dated 1/2/17, whe given a history of a "near" bipolar diagnosis. RN-H verified to the bipolar diagnosis had shown u was at the time of the annual dated RN-H confirmed there may be discrelated to the bipolar diagnosis and record and stated she would speal primary physician to determine whe bipolar diagnosis for R26 was app a subsequent interview with RN-H 2/28/18, RN-H provided a hospita Physical (H&P) dated 1/16/17 white disorder, however there was no interview with R2/28/18 at 10:08 a.m., RN-H stat spoken with R26's primary physicia 	sician visit after ot list a ad 3/13, 4/17, ctitioner visits 3/17 and lar Disorder, be to indicate e resident's status, mood ents, nurse the 7 day look antse wed R26's e the bipolar entified a ere R26 had episode ver, visit current bipolar the first time p on an MDS d 12/13/17. crepancy d the medical k with the ether the ropriate. During at 1:54 p.m. I History and ch listed bipolar dication diagnosis.	F 641			

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If continuation sheet Page 6 of 27

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED
		245276	B. WING			С
	PROVIDER OR SUPPLIER	245276		STREET ADDRESS, CITY, STATE, ZIP CO		/01/2018
	VOOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 641	formal psychiatric v	n said if there had been no risit, with a diagnosis listed, er should be removed from	F 64	1		
F 656 SS=D		t Comprehensive Care Plan 1)	F 650	6		4/10/18
	implement a compr care plan for each in resident rights set f §483.10(c)(3), that objectives and time medical, nursing, a needs that are iden assessment. The c describe the followi (i) The services that or maintain the resi physical, mental, an required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation w resident's represen	t are to be furnished to attain ident's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the				

Facility ID: 00520

If continuation sheet Page 7 of 27

						0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	IPLE CONSTRUCTION		E SURVEY PLETED
					(2
		245276	B. WING		03/0	01/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 656	Continued From pa	nge 7	F 65	56		
	whether the resider community was ass local contact agend entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMED by: Based on observat review, the facility f care for 1 of 1 resid transferring betwee Findings include: On 2/27/18 at 9:41 placed a transfer bor resident with a trans sitting in her wheeld R42 stiffened up ar physically pull R42 her hold on to her w R42 and guided R4 then placed the wa calling out. When F NA-G again held or back to the wheelch wheelchair was obs NA-G then grabbed the breaks. NA-G s R42 with transferrir because of R42's "	s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced tion, interview and document ailed to implement the plan of dent (R42) reviewed for en surfaces. a.m., nursing assistant (NA)-G elt on R42 prior to assisting the sfer. R42 was observed to be chair and began calling out. nd NA-G was observed to to a standing position to help walker. NA-G had to hold on to to a standing position to help walker. NA-G had to hold on to to a standing position to help walker. NA-G had to hold on to to to a standing position to help walker. NA-G had to hold on to to to a standing position to help walker. NA-G had to hold on to to R42 was done on the toilet, n to R42 to physically guide her hair. During this process, the served to tip back slightly. d the wheelchair and applied stated it was "scary" to help ng with just one person behaviors." NA-G also stated 2 without additional staff		F656 Resident R42¶ s care plan, acco sheets and Kardex have been re assure they continue to be accu care plans, accountability sheets Kardex will be reviewed to ensur match by 4/10/18. Nursing staff received re-education regarding necessity to follow the care plan and task list to provide care. Nu have received re-education rega importance of informing the mar discrepancies between the Care the actual care provided so that is consistent. Managers will confer with NARs IDT to assure the Care Plan mar care being provided. Policy and Procedure was reviewed for Care Audits of weekly Care Plans will conducted for consistent interve 3 months and as needed based recommendation of the QAPI co	eviewed to rate. All s and re they have the , Kardex ursing staff inding the hager of Plan and the care prior to tches the re Plans. be ntions for on immittee.	

Facility ID: 00520

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATI	E SURVEY
		IDEINI IOMIONINOMIDEN.	A. BUILDI	NG _			C
		245276	B. WING				01/2018
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER	1			00 SHERREN AVENUE APLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 656	Continued From pa On 2/27/18 at 10:01	ge 8 I a.m., registered nurse	F 6	56	Date of Correction: 4/10/18		
	(RN)-E, the nurse n interviewed and sta auto-populated from and that she believe transfer with one or However, RN-E ack recall the last time s transfer. RN-E state care plan to determ	hanager of the unit, was ted R42's care plan had been in completed assessments, ed R42 was appropriate to two staff assistance. Knowledged she could not she'd actually observed R42 ed staff should read the entire ine whether they could he or two staff assistance.					
	"Resident has a sel cognitive impairmer [related to] Dement persons for transfer the care plan that so use one or two staff	t revised 7/28/17, included: f care deficit r/t [related to] nt and impaired mobility r/t ia dx [diagnosis]. I use two rs." There was no indication in taff could interpret when to f for transfers. R42's ets dated 2/26/18, indicated: it of two]"					
F 677 SS=D		for Dependent Residents 2)	F 6	77			4/10/18
	out activities of daily services to maintain personal and oral h	ident who is unable to carry y living receives the necessary n good nutrition, grooming, and ygiene; NT is not met as evidenced					
	Based on observat review, the facility fa hygiene to 2 of 4 res	ion, interview and document ailed to provide personal sidents (R19 and R41) for activities of daily living			F677 Residents R19 and R41 have had t facial hair shaved. Nursing staff ha received re-education re: shaving a	ave	

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PRINTED: 04/17/2018

		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```			(X3) DATI COM	E SURVEY PLETED
		245276	B. WING				C 01/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER	2			900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 9	F 6	677			
	Findings include: R19 was observed	to have several long facial			residents and the importance of rep and documenting refusals by 4/10/ Policy and Procedure was reviewed Shaving Residents.	18.	
		f 2/26/18, and during f the survey on 2/27/18, and			Daily observations of shaving will be conducted for 2 weeks, weekly for 4 weeks, monthly for 1 month then as needed based on recommendation	4 S	
	sitting on the edge	p.m., R19 was observed of the bed. R19 was observed ind her right eye and on her			the QAPI committee. Responsible: Director of Nursing or		
	eyelashes. In additi hairs around the ch long. The hairs were asked whether staff how she felt about I stated, "Staff do not face and I get short	on, she had several long facial in area approximately 1 inch e gray, white and black. When f helped her with shaving, or having the facial hair, R19 t help to shave or wash my of breathe when I try to shave lps me when I need help right			designee Date of Correction: 4/10/18		
	in bed. The resider gray, white and blac and chin area. At 1 sitting up at the edg	a.m., R19 was observed lying nt still had numerous long ck facial hairs to her upper lip 1:57 a.m., R19 was observed ge of the bed with oxygen sal cannula. She had not					
	in bed with the oxyg gray, white and blac	a.m., R19 was observed lying gen on. R19 still had the long ck facial hair. At that time, R19 ike having the whiskers.					
	admitted to the facil including: paranoid	cord identified R19 had been lity on 3/15/14, with diagnoses schizophrenia, dementia, trapyramidal movement nosis.					

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		AND HUMAN SERVICES						FORM	04/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			ONSTRUCTION		(X3) DATI COM	E SURVEY PLETED
		245276	B. WING	i					C 01/2018
NAME OF F	PROVIDER OR SUPPLIER			5	STRE	EET ADDRESS, CITY, STATE, ZIP COL	DE	•	
MAPLEV	VOOD CARE CENTER	L .				SHERREN AVENUE PLEWOOD, MN 55109			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG			PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD	BE	(X5) COMPLETION DATE
F 677	Continued From pa	ge 10	F	677	7				
	12/6/17, identified F	imum Data Set (MDS) dated R19 required extensive assist rsonal hygiene needs,							
	documentation relation care plan dated 8/1 R19 with grooming.	edical record lacked any ted to refusal of cares. The /14, directed staff to assist An undated Nursing Assistant included: "Grooming-A-1 one]".							
	practical nurse (LPI LPN-B verified R19 stated she would sh nursing assistant (N asked R19 if wished replied, "The nursin	ion of R19 with licensed N)-B on 2/28/18 at 11:28 a.m., had long facial hairs. LPN-B have R19 or would ask the NA) to shave her. LPN-B d to be shaven and R19 ng assistant combed my hair he and I would like to be							
	hairs the evening of	to have several long facial f 2/26/18, and during f the survey on 2/27/18, and							
	sitting in her wheeld and white facial hai asked whether staff	p.m., R41 was observed chair. She had numerous gray rs on her chin area. When f assisted her with shaving, or having facial hair, R41 stated,							
	sitting in her wheeld numerous gray and	4 a.m., R41 was observed chair again. She still had I white facial hairs noted on hin area. R41 stated she							

Facility ID: 00520

If continuation sheet Page 11 of 27

		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATI COM	E SURVEY PLETED
		245276	B. WING				C 01/2018
NAME OF	PROVIDER OR SUPPLIER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLEV	WOOD CARE CENTER	ł			900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 677	would like staff to si On 2/28/18 at 9:12 in bed in her room. shaved, and had th hairs. R41 again sta would shave her da assisted R41 with h grooming. However R41 with shaving er obvious gray and w NA-A assisted R41 NA-A still did not off a.m., R41 was obse stated, "They did no still had the long gra R41's admission re admitted to the faci including: type two depression, restless of breath and mixed R41's quarterly MD R41 required exten personal hygiene no On 2/28/18 at 11:33 medical record was evidence the reside undated Nursing As indicated, "Groomir During an observati on 2/28/18 at 11:42 facial hair. LPN-A to reported R41 had re	have her daily. a.m., R41 was observed lying She had still not been e long gray and white facial ated she would prefer if staff aily. At 9:45 a.m., NA-A her morning cares, including r, NA-A did not offer or assist ven though the resident had thite facial hairs. At 11:05 a.m., to get up to use the toilet. fer to shave R41. At 11:19 erved in the dining room. She of shave me." The resident ay and white facial hairs. cord noted R41 had been lity on 11/8/16, with diagnoses diabetes mellitus, major sness and agitation, shortness d anxiety disorders. S dated 12/27/17, indicated sive assist of one staff with eeds including shaving. B a.m., review of R41's a reviewed, and lacked any ent refused cares. R41's assistant Assignment Sheet	F	577			

		& MEDICAID SERVICES		IPLE CONSTRUCTION		. 0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED
		245276	B. WING			C /01/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		01/2010
MAPLEW	OOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 677		ige 12 2006, included: "To remove ove the resident's appearance	F 67	77		
F 688 SS=D		ecrease in ROM/Mobility 1)-(3)	F 68	38		4/10/18
	resident who enters range of motion do range of motion unl condition demonstr of motion is unavoid §483.25(c)(2) A res	ident with limited range of				
	services to increase	propriate treatment and e range of motion and/or to rease in range of motion.				
	receives appropriat assistance to main the maximum pract reduction in mobility	ident with limited mobility te services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced				
	Based on observat review, the facility fa motion (ROM) serv identified with limite extremities.	tion, interview and document ailed to provide range of ices for 1 of 1 residents (R26) ed range of motion of the lower		F688 Resident R26¶ s care plan, Kar POC documentation have beer and revised to reflect the currer AROM and appropriate docume	n reviewed nt order for entation.	
	bed with the right for noticeable foot drop	p.m. R26 was observed in bot and ankle uncovered. A b/flexion was observed on the ne, R26 stated ROM to both		Nursing staff has received re-erregarding the necessity of docu care when completed. Audits of physician orders have been corr assure they are included on the POC and treatment sheets for	menting of ROM mpleted to	

Facility ID: 00520

If continuation sheet Page 13 of 27

STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	· · ·	E SURVEY PLETED
		245276	B. WING			C 01/2018
	PROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP C 1900 SHERREN AVENUE MAPLEWOOD, MN 55109	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COF	SHOULD BE	(X5) COMPLETIO DATE
F 688	daily basis, but did During observation 8:20 a.m. nursing a to lotion R26's right Range of motion w a slight foot drop/fle foot/ankle. On 3/1/18, at 8:25 asked about ROM NA-B stated ROM the Hoyer sling, bu NA-C stated ROM assignment sheet. very limited and R2 foot/ankle. R26 the "sometimes" done a.m. NA-B lotioned did not provide RO On 3/1/18, at 9:38 stated R26's ROM RN-A stated compl was monitored whe medications. RN-A giving the ROM. RI ROM was identified also be on the NA a RN-A showed the s sheet for R26. ROM assignment sheet a there."	s suppose to be done on a not always happen. of morning cares on 3/1/18, at assistant (NA)-B was observed t lower leg, feet and ankle. as not provided. At that time, exion was noted to the left a.m. NA-B and NA-C were to R26's bilateral feet/ankles. was done when R26 got up in t R26 never got out of bed. was not listed on the NA NA-B stated R26's ROM was 26 could hardly flex the right in stated the ROM was while R26 was in bed. At 8:30 R26's left lower extremity, but	F	documentation of completio Procedure was reviewed for Audits will be conducted we weeks, monthly for 2 month needed as recommended b committee. Person responsible: Directo designee Date of Correction: 4/10/18	ROM. ekly for 4 s and as y the QAPI	

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		AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM	04/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			3) DATE COM	E SURVEY PLETED
		245276	B. WING	i			C 01/2018
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	1			000 SHERREN AVENUE APLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 688	be completed as for range of motion to a in EZ lift (mechanic back to bed. 15 rep documentation revir range of 2/1 to 2/28 revealed R26 was r twice a day. A physician's order exercises to R26's a before and after pla lifted back to bed. T ROM was to be dor A review of the care verified R26's need frequency of 15 rep left lower extremitie Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s This REQUIREMEN by: Based on observat review, the facility fa was administered a	lows: "Restorative active ankles before and after getting al lift device) and after getting s twice a day." The ewed with RN-A had a date /18. The review with RN-A not consistently receiving ROM dated 9/5/17, revealed ROM ankles was to be completed ucing R26 in a lift; and after The physician's order indicated he "two times a day." e plan revised on 2/12/18, for active ROM, with a s twice a day to the right and s, feet and ankles. ostomy Care and Suctioning tory care, including and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced ion, interview and document ailed to ensure oxygen therapy ccording to physician orders (R154, R156, R206) observed	F 6		F695 Residents R154 and R206 have discharged. R156 had their med and treatment sheets reviewed and revise	d to	4/10/18

Facility ID: 00520

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE				FORM /	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
	245276	B. WING _		03/0	C 01/2018
NAME OF PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER	ł		1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695 Continued From pa	ige 15	F 69	15		
Findings include: On 2/26/18, at 1:21 bed, the head of the cannula was in R15 was attached to a p (who had diagnose pulmonary hyperter surveyor at that tim portable tank. The p be set at 3 liters (L) she was "surprised not been brought be the call light on and responded prompth oxygen tank was er On 3/1/18, at 11:10 also run out of oxyg the weekend. R154 always check the p enough oxygen, bu to ask nursing staff be sure there is end A review of physicia revealed R154 was continuously. On 2/26/18, at 1:41 heard to ask staff to tank because it was spouse was asked run out of oxygen ir R156 had been at t	p.m. R154 was observed in e bed was elevated, a nasal 54's nares and oxygen tubing portable oxygen tank. R154 s including pneumonia, nsion and ascites) told the le, there was no oxygen in the portable tank was observed to) per minute (PM). R154 stated " the larger oxygen tank had ack to the room. R154 turned I nursing assistant (NA)-D y and verified R154's portable	F 69	 include licensed staff documenting portable tanks are filled at least ond shift and more often if indicated by ordered liter flow. NARs have been re-educated on the correct techniqu filling portable tanks, filling prior to t of shift and responding promptly to requests to fill portable tanks. Polic Observation audits of residents por 02 will be conducted daily for 2 wee weekly for four weeks and monthly month. Further audits will be conducted the QAPI committee. Person responsible: Director of Nur designee Date of Correction: 4/10/18 	table by table bks, for one ucted led by	

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		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245276	B. WING	·			C 01/2018
NAME OF	PROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
MAPLEV	VOOD CARE CENTER	2			1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	On 2/27/18, at 9:20 if the oxygen in the and the spouse sta felt she was not get was not observed to (discoloration due t time. At 9:23 a.m. t answered by NA-D oxygen tank was se empty. At 10:03 a.m oxygen tank had be 7:45 a.m. NA-E que was leaking and sta nurse. A physician's order was to receive 2-6 review of progress documentation of F on 2/26 or 2/27/18. recorded as follows and 2/13/18- 90%. On 3/1/18, at 7:44 a service technician s set at 2 LPM should at 3 LPM the portat four (4) hours. The there was a custom estimated duration based on the LPM the service technician p Customer Handboor revealed portable o LPM, such as what about 5.3 hours; if s last about 4.1 hours	ge 16 a.m. R156 asked the spouse portable tank was working ted it was. R156 stated she tting enough oxygen. R156 o have any cyanosis o lack of oxygen) noted at that he call light was turned on and who verified the portable et at 3 LPM, but the tank was n. NA-E stated the portable een filled that morning around estioned if the portable tank ated she would inform the dated 2/20/18, revealed R156 LPM of oxygen continuously. A notes for R156 did not reveal R156 having run out of oxygen Oxygen saturation levels were s: 2/12/17-94%; 2/13/17-94%; a.m. the oxygen supplier's stated a portable oxygen tank d last about six (6) hours; if set ble oxygen should last about service technician stated her handbook which gave of portable oxygen tanks the tank was set at. The provided the surveyor the ok. A review of the handbook xygen for a resident on 3 R156 was on, should last set at 4 LPM the tank would s. The service technician cygen tank would most likely because of humidity and the	F	595	5		

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		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245276	B. WING	;			C 01/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
MAPLEV	VOOD CARE CENTER	R			900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 695	service technician of the tanks correctly if faster than anticipa On 3/1/18, at 7:49 a assistants were resportable oxygen tar ensure there was et tank. On 3/1/18, at 9:44 a stated nursing assis oxygen tanks every check the tanks on RN-A verified reside able to breath if the A review of the facil policy dated 2010, it tanks were to be fill manufacturer's inst regular intervals to policy also indicated oxygen saturation for regular intervals to oxygen therapy who oxygen has been d During observation was in his room and large tank via nasal small, portable oxyg back of his wheelch his small oxygen ta than once since he stated the small tar shift. He couldn't re	questioned if staff were filling if the oxygen was running out ted. a.m. NA-F stated nursing sponsible for checking the hks periodically on the shift to mough oxygen in the portable a.m. registered nurse (RN)-A stants were to fill the portable or morning and RN-A would her unit during the noon meal. ents will complain of not being e oxygen tank ran empty. lity's Oxygen Administration indicated portable oxygen led according to ructions and checked at ensure adequate supply. The d resident's respirations and evels were to be completed at assess need for further en necessary, as well as after	F	695			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		LE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245276	B. WING				C 01/2018
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER	1			1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 695	Continued From pa	ge 18	F€	695			
	When interviewed of on 2/28/18 at 11:00 no problems with his oxygen the previous When interviewed of registered nurse (R stated she was una oxygen tanks on he RN-A about the cor RN-A stated she wo immediately and as She went on to exp have a specific sch tank function, but of throughout the day. During interview on practical nurse (LPI aware of any oxyge her unit. She stated approximately a con the first floor dining bit cyanotic (bluish when she'd checked set to 2 liters/minute." LPN R206's oxygen satu had registered in th small oxygen tank t the flow of the oxyg LPN-C stated after	on 2/27/18 at 10:29 a.m. and a.m., R206 stated he'd had is oxygen tank running out of is night or current day. on 3/1/18 at 10:30 a.m., N)-A, unit manager for R206, ware of any concerns with er unit. The surveyor informed ocern R206 had described. ould call the oxygen supplier k for a new tank for R206. lain that nursing staff does not edule for checking oxygen hecks it periodically					
	immediately come us she'd reported this day and assumed F small oxygen tank.	LPN-C was unable to verify nad happened and stated she					

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	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY MPLETED	
	ST CONNECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG		C	
		245276	B. WING _		03	/01/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	CODE		
MAPLEV	VOOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 695	Continued From pa	ge 19	F 69	95			
		ning about oxygen tanks not					
	Pharmacy Srvcs/Pr	ocedures/Pharmacist/Records	F 75	55		4/10/18	
SS=E	CFR(s): 483.45(a)(b)(1)-(3)					
	drugs and biologica them under an agre §483.70(g). The fa personnel to admin	Services ovide routine and emergency als to its residents, or obtain eement described in cility may permit unlicensed ister drugs if State law oder the general supervision of					
	pharmaceutical ser that assure the acc dispensing, and ad	ures. A facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and t the needs of each resident.					
		Consultation. The facility ain the services of a licensed					
		ides consultation on all ision of pharmacy services in					
		blishes a system of records of tion of all controlled drugs in nable an accurate					
	order and that an a is maintained and p	rmines that drug records are in ccount of all controlled drugs periodically reconciled. NT is not met as evidenced					

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		& MEDICAID SERVICES			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	Сом	E SURVEY PLETED
		245276	B. WING			C 01/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/	01/2010
	VOOD CARE CENTER	R		1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 755	review, the facility f expired/outdated m for use for 10 of 66 storage was review R103, R159, R160, ensure stock medic when expired which any residents who Findings include: During observation 3/1/18, at 12:33 p.r licensed practical m place two tablets of medication cup for acetaminophen. W stock bottle of acet date of 6/17. LPN- administering the m date was pointed o medication label inter Stock medications medication cart we p.m. The following	tion, interview and document	F 75	 F755 All med carts have been reviewed outdated and discontinued media have been removed. Nursing stareceived re-education on dating medications when opened, expired dates and removal of discontinual medication from the carts promption. Night staff will clean medication remove outdated, expired medicaless than weekly. Medications was reviewed from the cart when dis The Policy and Procedure for Ex Medications was reviewed. Audia conducted weekly for one month for 2 months and as needed bas recommendation of the QAPI conducted from the cart with the text of text of the text of the text of text of the text of the text of text of text of the text of tex of	cations aff have ration ed otly. carts and cations no vill be continued. cpired ts will be n, monthly sed on the ommittee.	
	calcium with an exp stated none of the residing on the 3 so these stock medicat medication (Advair opened; two bottles R56 were not dated the laxative polyeth was labeled with an	date of 1/17, and oyster shell biration date of 1/17. LPN-D current eight (8) residents buth unit were currently taking ations. An inhalation asthma) for R13 was not dated when s of olapatadine eye drops for d when opened, and a bottle of hylene glycol prescribed to R56 in expiration date of 12/17. was no longer using the				

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/17/2018 APPROVED 0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	```	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C	
245276		B. WING				_ 01/2018		
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE			
MAPLEWOOD CARE CENTER					1900 SHERREN AVENUE MAPLEWOOD, MN 55109			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
Ac explosion eyar eyar eyth boas will ww Ri will dr op La O ca fo bo a ha 1/ re re At m th st tir re	kpiration date was nger used that me ye drops should hat nd confirmed R56 ye drops. Also in the ere was a bottle of ere not dated whe bottle of latanosproses is having been ope hich according to latenosproses is having been ope hen opened; and a rops for R86 which beened on 1/17/18. atanoprost drops w n 3/1/18 at 1:00 p. art was reviewed a llowing stock med bottle of vitamin C ad been opened of 18. Registered nu esidents on the 2 n eceiving these stock t 1:10 p.m. on 3/1/ edication and treat e 3 north medications w g expired 4/17, ma aproxen expired 1 nd vitamin B comp me, LPN-E stated esidents on the 3 n	the polyethylene glycol 12/17, but stated R56 also no edication. LPN-D verified the ave been dated when opened was currently receiving the ne 3 south medication cart f atropine mouth drops which n opened for R103; and a st eye drops which were dated ned on 1/17/18, for R53 and LPN-D were still in use. There is of gatifloxacin eye drops for en, but had not been dated a bottle of Latanoprost eye n were dated as having been LPN-D verified the vere still in use. m., the two north medication ind observed to contain the ications that had expired: a for pain) expired on 1/18; and 500 milligrams (mg) which n 10/16, and had expired on rse (RN)-C stated no orth unit were currently	F 7	755				

Facility ID: 00520

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DEPARTMENT OF HEALTH					FORM	04/17/2018 APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	245276	B. WING	i			C 01/2018
NAME OF PROVIDER OR SUPPLIER			٤	STREET ADDRESS, CITY, STATE, ZIP CODE	·	
MAPLEWOOD CARE CENTER				1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
 north medication can date of 8/17. LPN-E residents on the 3 medication no specific routine for checking medications, and stat assignment for a num medications for expise tried to check the weekends when she expired medications At 1:25 p.m. on 3/1/⁻ stored in the first floor unit)-1 medication can been dated when op Novolog and Lantus and Levemir for R16 RN D stated came fir another bottle of Nov or dated when opened. RN-D the medication cart a upon herself to check medications had been stated there was oth looking at the medications. Manufacturer guidar Novolog insulin indic discarded 28 days a insulin pen was to be according manufacturer 	e 10 mg) observed in the 3 rt which had an expiration stated there were "lots" of orth unit who frequently used n. LPN-E stated there was or nurses to follow regarding n carts for expired ated there was not a specific rse or shift to check ration dates. LPN-E stated re medication carts on e worked to identify any 18, 6 of 6 bottles of insulin or TCU (transitional care art were identified to have not bened. This included bottles of for R162; a bottle of Novolog 61; a bottle of Novolog, which rom the emergency kit; and volog which was not labeled ed. RN-D verified none of the cation cart had been dated o stated she had gone through about a month ago and took it ex the medications in her expiration dates and to ensure en dated when opened. RN-D nerwise no specific system for ation carts for expired	F	755	5		

Facility ID: 00520

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ì í		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245276	B. WING				C 01/2018
NAME OF PROVIDER OR SUPPLIER					STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER					1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755	On 3/1/18 at 1:34 p medication cart was seven bottles of ins was not dated wher Basaglar insulin per R160, which was no stated insulins were and verified the bot Basaglar insulin per opened. On 3/1/18 at 1:40 p medication cart was stock acidophilus w LPN-C stated no or taking the acidophil On 3/1/18, at 2:59 p (DON) stated the fa for checking medication atted the facility fo pharmacy's policy a expired medications. The DON provided 2013 policy titled St Medications, Biolog The policy indicated biological package follow manufacturer respect to expiration	d 42 days after opening. .m., the first floor TCU-2 s noted to contain one of ulin (Humalog for R159) which n opened. There was also one n in the medication cart for ot dated when opened. RN-B e to be dated when opened, the of Humalog and the n had not been dated when .m. the first floor TCU-3 s noted to contain a bottle of thich had expired on 6/17. ne on her unit was currently us. o.m. the director of nursing icility had no system in place ation carts for expired ON stated the facility also did policy to follow regarding ns for expiration dates or for s when opened. The DON llowed the contracted and procedures regarding s and dating when opened. a copy of the pharmacy's sorage and Expiration of jicals, Syringes and Needles. d that once a medication or was opened the facility should r/supplier guidelines with	F 7	755			

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l` í		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245276	B. WING	i			C 01/2018
NAME OF F	PROVIDER OR SUPPLIER			;	STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER					1900 SHERREN AVENUE MAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 755 F 883 SS=D	expiration. The pharmacy polic medications should when there was a m outdated/expired m destroyed by the fac pharmacy. The polic frequently staff were expiration. Influenza and Pneu CFR(s): 483.80(d)(edications with a shortened by also indicated that be destroyed and reordered hissing label, and indicated edications should be cility or returned to the cy did not address how e to check medications for mococcal Immunizations	F 7		5		4/10/18
	policies and proced (i) Before offering the each resident or the receives education potential side effect (ii) Each resident is immunization Octobe annually, unless the contraindicated or the immunized during the (iii) The resident or has the opportunity (iv) The resident's me documentation that following: (A) That the resider was provided educe and potential side e immunization; and (B) That the resider	the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the nt or resident's representative ation regarding the benefits					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED		
	245276					03/0	;)1/2018
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER				900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 883		ge 25 o medical contraindications or	F٤	883			
	must develop polici that- (i) Before offering th immunization, each representative rece benefits and potent immunization; (ii) Each resident is immunization, unles medically contraind already been immu (iii) The resident or has the opportunity (iv)The resident's m documentation that following: (A) That the resider was provided educa and potential side e immunization; and (B) That the resider pneumococcal imm the pneumococcal in contraindication or This REQUIREMEN by: Based on interview failed to ensure pneuton to 1 of 5 residents r with recommended Findings include: R26's most recent r	resident or the resident's ives education regarding the ial side effects of the offered a pneumococcal so the immunization is icated or the resident has nized; the resident's representative to refuse immunization; and hedical record includes indicates, at a minimum, the of or resident's representative ation regarding the benefits ffects of pneumococcal int either received the funization or did not receive mmunization due to medical refusal. NT is not met as evidenced or and record review the facility eumonia vaccines were offered eviewed (R26) for compliance			F883 Resident R26 has been offered and received a PCV 13 vaccination. All residents were reviewed and any mis vaccinations were given by 4/10/18. facility Infection Preventionist will monitor all new and readmissions to the facility for compl	The d	

Facility ID: 00520

		AND HUMAN SERVICES				FORM	04/17/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245276	B. WING			03/0) 01/2018
NAME OF	NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER					900 SHERREN AVENUE IAPLEWOOD, MN 55109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 883	to the facility on 1/2 65 years old. Review of R26's im R26 had received a polysaccharide vac had turned 65 years no record of a PCV On 3/1/18 at 9:39 a preventionist and re staff should have of vaccination at the ti was eligible and the having received on The facility's Pneur dated 2017, include years who have alre	20/17 and was over the age of munization record revealed a PPSV23 (pneumococcal cine) on 4/1/15, after R26 s of age. However, there was '13 vaccination. , the facility's infection egistered nurse (RN)-F stated ffered R26 a PCV13 ime of admission since R26 ere was no record of her e previously. nococcal Vaccine protocol ed: "Adults > [older than] 65 eady received a dose of so receive a dose of PCV13 a	F	383	with recommended vaccinations. T Policy and Procedure for Pneumoc Immunization has been reviewed. A will be conducted monthly for 3 mo and as needed based on the recommendations of the QAPI com Person responsible: Director of Nut designee Date of Correction: 4/10/18	occal Audits nths imittee.	

Facility ID: 00520

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	MENT OF HEALTH			F	6276026	FORM	03/07/2018 APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				1 · ·	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245276		B. WING		02/2	7/2018
MAPLEWOOD CARE CENTER 1900 S			1900 SH	RESS, CITY, S IERREN A WOOD, MI			
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	(X5) COMPLETION DATE	
K 000	A Life Safety Code Minnesota Departm Fire Marshal Divisio (Facility name) was requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I (NFPA) Standard 1 Chapter 19 Existing This 3-story building was determined to construction. It has fire sprinklered thro alarm system with a corridors and space	Survey was conduct nent of Public Safety on. At the time of this found in compliance articipation in at 42 CFR, Subpart ety from Fire, and the Fire Protection Assoc 01, Life Safety Code g Health Care. g was constructed in	- State s survey, e with the e 2012 ciation (LSC), 1964 and is fully has a fire ne ors that is	K 000			
	beds and had a cer survey.	cility has a capacity on non-cility has a capacity on non-cility of 116 at the time time the time the time the time the table of tabl	ne of the				
			-	×	а — — — — — — — — — — — — — — — — — — —		
						ÿ	12
							1 C - 1
-					0		
							2
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	NATURE	TITLE	`w	(X6) DATE

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



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 19, 2018

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

Re: State Nursing Home Licensing Orders - Project Numbers S5276028, H5276093, H5276097

Dear Ms. Sterling:

The above facility was surveyed on February 26, 2018 through March 1, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint numbers H5276093 and H5276097 that were found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the

Maplewood Care Center March 19, 2018 Page 2

statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susie Haben, Unit Supervisor at (651) 201-2731 or at <u>susie.haben@state.mn.us</u>.

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.

Please feel free to call me with any questions.

Sincerely,

Montylen

Michaelyn Bruer, Enforcement Specialist Minnesota Department of Health Health Regulation Division Program Assurance Unit phone 651-201-4117 fax 651-215-9697 email: <u>michaelyn.bruer@state.mn.us</u>

cc: Licensing and Certification File

Minnesc	ta Department of He	alth				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00520	B. WING		03/0) 1/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	OOD CARE CENTER		RREN AVEN OOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defict herein are not corrected shall with a schedule of f the Minnesota Depart Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been				
	that may result fron orders provided tha the Department wit	hearing on any assessments n non-compliance with these t a written request is made to hin 15 days of receipt of a nt for non-compliance.				
	the following correct					
	H5276097 were co	nplaint H5276093 and mpleted and found to be				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 03/28/18

Electronically Signed

STATE FORM

If continuation sheet 1 of 26

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED
		00520	B. WING		03/01/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	2	ERREN AVENL VOOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	unsubstantiated					
	receipt of State lice the Minnesota Dep Informational Bulle http://www.health.s obul.htm The State delineated on the a Department of Hea you electronically. / is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th corrected prior to e Minnesota Departm	tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are attached Minnesota alth orders being submitted to Although no plan of correction ate Statutes/Rules, please trected" in the box available for n indicate in the electronic cess, under the heading he date your orders will be electronically submitting to the nent of Health.				
	the State Licensing federal software.	nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for				
	column entitled "ID statute/rule out of c "Summary Stateme and replaces the "T correction order. Th findings which are after the statement evidence by." Follo	number appears in the far left Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUM	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	E SURVEY PLETED
		00520	B. WING		C 03/01/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
MAPLEV	OOD CARE CENTER		ERREN AVEN VOOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
2 000	Continued From pa	ge 2	2 000			
		ERAL DEFICIENCIES ONLY. R ON EACH PAGE.				
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 270	MN Rule 4658.009	0 Use of Oxygen	2 270			4/10/18
		ist develop and implement lures for the safe storage and				
	by: Based on observative review, the facility f was administered a	ent is not met as evidenced on, interview and document ailed to ensure oxygen therap according to physician orders (R154, R156, R206) observed arapy.		Corrected		
	Findings include:					
	bed, the head of the cannula was in R15 was attached to a p (who had diagnose pulmonary hyperter surveyor at that tim portable tank. The be set at 3 liters (L) she was "surprised not been brought b the call light on and	p.m. R154 was observed in e bed was elevated, a nasal 54's nares and oxygen tubing portable oxygen tank. R154 s including pneumonia, nsion and ascites) told the e, there was no oxygen in the portable tank was observed to per minute (PM). R154 stated " the larger oxygen tank had ack to the room. R154 turned I nursing assistant (NA)-D y and verified R154's portable mpty.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		00520	B. WING		C 03/01/2018	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
	VOOD CARE CENTER	1900 SHF	RREN AVENU			
		MAPLEW	OOD, MN 55	109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 270	Continued From pa	ige 3	2 270			
	also run out of oxyg the weekend. R154 always check the p enough oxygen, bu to ask nursing staff be sure there is end A review of physicia revealed R154 was continuously. On 2/26/18, at 1:41 heard to ask staff to tank because it was spouse was asked run out of oxygen ir R156 had been at t	a.m. R154 stated she had gen from the portable tank over stated therapy services ortable tank to ensure there is t R156 said she "always" has to check the portable tank to ough oxygen to last the day. an orders dated 2/19/18, to receive 4 LPM of oxygen p.m. R156's spouse was o fill R156's portable oxygen s empty. At that time, the by the surveyor if R156 had in the past. The spouse stated the facility for about 7-10 days e oxygen tank frequently ran				
	if the oxygen in the and the spouse sta felt she was not get was not observed to (discoloration due to time. At 9:23 a.m. to answered by NA-D oxygen tank was see empty. At 10:03 a.m. oxygen tank had be 7:45 a.m. NA-E que was leaking and sta nurse. A physician's order was to receive 2-6	a.m. R156 asked the spouse portable tank was working ted it was. R156 stated she tting enough oxygen. R156 o have any cyanosis o lack of oxygen) noted at that he call light was turned on and who verified the portable et at 3 LPM, but the tank was n. NA-E stated the portable een filled that morning around estioned if the portable tank ated she would inform the dated 2/20/18, revealed R156 LPM of oxygen continuously. A notes for R156 did not reveal				

STATEMEN	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	E CONSTRUCTION	СОМ	E SURVEY PLETED
		00520	B. WING			C 01/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		RREN AVENI OOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 270	on 2/26 or 2/27/18. recorded as follows and 2/13/18- 90%. On 3/1/18, at 7:44 a service technician s set at 2 LPM should at 3 LPM the portate four (4) hours. The there was a custom estimated duration based on the LPM f service technician p Customer Handboor revealed portable o LPM, such as what about 5.3 hours; if s last about 4.1 hours stated a portable op leak in the summer service technician of the tanks correctly if faster than anticipa On 3/1/18, at 7:49 a assistants were res portable oxygen tar	Oxygen saturation levels were :: 2/12/17-94%; 2/13/17-94%; a.m. the oxygen supplier's stated a portable oxygen tank d last about six (6) hours; if set ble oxygen should last about service technician stated her handbook which gave of portable oxygen tanks the tank was set at. The provided the surveyor the bk. A review of the handbook xygen for a resident on 3 R156 was on, should last set at 4 LPM the tank would s. The service technician kygen tank would most likely because of humidity and the questioned if staff were filling if the oxygen was running out	2 270	DEFICIENC		
	stated nursing assist oxygen tanks every check the tanks on RN-A verified reside	a.m. registered nurse (RN)-A stants were to fill the portable morning and RN-A would her unit during the noon meal. ents will complain of not being oxygen tank ran empty.				
magazia D		lity's Oxygen Administration ndicated portable oxygen ed according to				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	E CONSTRUCTION	COM	E SURVEY PLETED C
		00520	B. WING		03/01/2018	
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MAPLEV	VOOD CARE CENTER	2	ERREN AVENU VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 270	Continued From pa	age 5	2 270			
	regular intervals to policy also indicate oxygen saturation I regular intervals to oxygen therapy wh oxygen has been d During observation was in his room an large tank via nasa small, portable oxy back of his wheelch his small oxygen ta than once since he stated the small tar shift. He couldn't r particular time of d When interviewed on 2/28/18 at 11:00 no problems with h oxygen the previou When interviewed registered nurse (F stated she was una oxygen tanks on he RN-A about the con RN-A stated she w immediately and as She went on to exp have a specific sch	tructions and checked at ensure adequate supply. The d resident's respirations and evels were to be completed at assess need for further en necessary, as well as after liscontinued. on 2/26/18 at 7:10 p.m., R206 d had oxygen applied from a l cannula at 2 liters/minute. A gen tank was hanging on the hair. At this time, R206 stated ank had run out of oxygen more had been in the facility. He hk is filled by staff once every emember if there was a ay that he ran out of oxygen. on 2/27/18 at 10:29 a.m. and 0 a.m., R206 stated he'd had is oxygen tank running out of is night or current day. on 3/1/18 at 10:30 a.m., RN)-A, unit manager for R206, aware of any concerns with er unit. The surveyor informed ncern R206 had described. ould call the oxygen supplier sk for a new tank for R206. Dain that nursing staff does not redule for checking oxygen				
	throughout the day During interview or practical nurse (LP					

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
			A. BUILDING.			с
		00520	B. WING			01/2018
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
APLEW	OOD CARE CENTER		ERREN AVENL VOOD, MN 55'			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 270	Continued From pa	age 6	2 270			
	the first floor dining bit cyanotic (bluish when she'd checke set to 2 liters/minut liters/minute." LPN R206's oxygen satu had registered in th small oxygen tank it the flow of the oxyg LPN-C stated after tank in his room, hi immediately come she'd reported this day and assumed f small oxygen tank. the date when this	uple weeks ago, R206 was in room and his lips appeared a discoloration). LPN-C said ed his portable oxygen tank, e, the flow "didn't felt like 2 I-C stated she'd checked uration level at that time and it the 80s, so she'd refilled the that R206 was using and then gen seemed appropriate. having switched to the large s oxygen saturation level had up to the 90s. LPN-C stated to staff during shift report that R206 would receive a new LPN-C was unable to verify had happened and stated she hing about oxygen tanks not in that unit since.				
	The director of nurs observe nursing as tanks to ensure a c complete filling is n teaching could be c compliance with the filling of portable ox nursing staff could oxygen to ensure p	THOD OF CORRECTION: ses (or designee) could sistants filling portable oxygen complete filling is achieved. If a ot achieved additional conducted to ensure e facility's policy regarding kygen tanks. A member of the randomly audit residents on ortable oxygen tanks were full filled if necessary at the time				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	COM	
		00520	B. WING		C 03/01/2018	
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MAPLEW	OOD CARE CENTER					
			OOD, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	ge 7	2 565			
		omprehensive plan of care personnel involved in the 				
	by: Based on observati review, the facility fa	ent is not met as evidenced on, interview and document ailed to implement the plan of lent (R42) reviewed for n surfaces.		Corrected.		
	Findings include:					
	placed a transfer be resident with a trans sitting in her wheeld R42 stiffened up an physically pull R42 her hold on to her w R42 and guided R4 then placed the wal calling out. When R NA-G again held or back to the wheelch wheelchair was obs NA-G then grabbed the breaks. NA-G s R42 with transferrin because of R42's "I she had helped R42 assistance because	a.m., nursing assistant (NA)-G elt on R42 prior to assisting the sfer. R42 was observed to be chair and began calling out. Ind NA-G was observed to to a standing position to help valker. NA-G had to hold on to 2 to sit on the toilet. NA-G ker in front of R42 who was R42 was done on the toilet, in to R42 to physically guide her hair. During this process, the served to tip back slightly. If the wheelchair and applied tated it was "scary" to help ing with just one person behaviors." NA-G also stated 2 without additional staff is there was no one else at that time and R42 needed to				
	On 2/27/18 at 10.01	1 a.m., registered nurse				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		A. BUILDING:		A. BUILDING:		С
		00520	B. WING		03/01/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
MAPLEV	WOOD CARE CENTE		ERREN AVENL VOOD, MN 55'			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	interviewed and sta auto-populated from and that she beliew transfer with one of However, RN-E act recall the last time transfer. RN-E stat care plan to detern transfer R42 with of R42's care plan las "Resident has a set cognitive impairmet [related to] Demen persons for transfet the care plan that set use one or two stat Accountability She "Transfer: A2 [assi SUGGESTED MET The director of nur develop and implet interdisciplinary tea individual needs ar resident. The facilit procedures to ensu assessed, educate audit periodically to preferences of resi Random audits con compliance and re committee.	manager of the unit, was ated R42's care plan had been m completed assessments, ved R42 was appropriate to r two staff assistance. knowledged she could not she'd actually observed R42 ted staff should read the entire nine whether they could one or two staff assistance. At revised 7/28/17, included: eff care deficit r/t [related to] ent and impaired mobility r/t tia dx [diagnosis]. I use two ers." There was no indication in staff could interpret when to ff for transfers. R42's ets dated 2/26/18, indicated: st of two]" THOD OF CORRECTION: sing, or designee could ment a plan of care by the am to accurately reflect the nd preferences of each ty could update policies and ure resident preferences are e staff on these changes, and o ensure the needs and ident(s) are respected. uld be conducted to ensure ported back to the QAPI R CORRECTION: Twenty-one				

ota Department of He	alth			FORMAPPROVED
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			3) DATE SURVEY COMPLETED
	00520	B. WING		C 03/01/2018
PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
	1900 SHE	ERREN AVEN	IUE	
	MAPLEW	/OOD, MN 5	5109	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG		
Continued From pa	ge 9	2 830		
		2 830		4/10/18
custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the resident must reman	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a he attending physician that the in in bed or the resident			
by: Based on interview review, the facility fa assess bathing pre- care plan based up	, observation, and document ailed to comprehensively ferences, and implement a on resident preference for 1 of		Corrected.	
Findings include:				
asked about bathing facility staff seemed residents receiving added that sometim be pushed back a of R99 said he unders cleanliness, but des that made showering asked whether staff options, such as a b	g preferences, R99 said d to have firm rules about one shower a week. R99 also nes staff allowed his shower to couple days due to his pain. stood the importance of scribed having constant pain ng uncomfortable. When f had offered other bathing bed bath, R99 said he was not			
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LI Continued From pa MN Rule 4658.0520 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from th resident must rema prefers to remain in This MN Requireme by: Based on interview, review, the facility fa assess bathing preficate on the comprehensive plan of care as des 4658.0405. Proper the care of the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the comprehensive asses bathing preficate as des 4658.0405. A nursi of bed as much as written order from the comprehensive care plan based up 1 resident (R99) rev Findings include: During interview on asked about bathing facility staff seemed residents receiving added that sometim be pushed back a comprehensive clean liness, but des that made showering added that sometim be pushed back as a factor (Care as a factor (Care as	OF CORRECTION IDENTIFICATION NUMBER: 00520 00520 PROVIDER OR SUPPLIER STREET AL YOOD CARE CENTER 1900 SHI MAPLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 9 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 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 interview, observation, and document review, the facility failed to comprehensively assess bathing preferences, and implement a care plan based upon resident preference for 1 of 1 resident (R99) reviewed for choices. Findings include: During interview on 2/26/18, at 1:39 p.m. when asked about bathing preferences, R99 said facility staff seemed to have firm rules about residents receiving one shower a week. R99 also added that sometimes staff allowed his shower to be pushed back a couple days due to his pain. R99 said he understood the importance of cleanliness, but described having constant pain that made showering uncomfortable. When asked whether staff had offered other bathing	NT OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPL A. BUILDING 00520 B. WING	tab Department of Health OF DEPERSIONE (X1) PROVIDERSUPPLERCUA IDENTIFICATION NUMBER. 00520 (X2) MULTIPLE CONSTRUCTION A BULDING: B. WING (X2) AULTIPLE CONSTRUCTION A BULDING: B. WING (X2) AULTIPLE CONSTRUCTION A BULDING: B. WING (X2) AULTIPLE CONSTRUCTION B. WING (X2) AULTIPLE CONSTRUCTION (EACH OORSCHER TAGE (X2) AULTIPLE CONSTRUCTION (EACH OORSCHER TAGE (X2) AULTIPLE CONSTRUCTION (EACH OORSCHER TAGE AULTIPLE CONSTRUCTION (EACH OORSCHER TAGE AULTIPLE (EACH OORSCHER TAGE AULTIPLE (EACH OORSCHER TAGE AULTIPLE CONSTRUCTION (EACH OORSCHER TAGE AULTIPLE (EACH OORSCHER TAGE

	OF DEFICIENCIES F CORRECTION	alth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:	CONSTRUCTION	СОМ	E SURVEY PLETED C
		00520	B. WING		03/	01/2018
NAME OF PR	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
MAPLEWO	OOD CARE CENTER		ERREN AVENU /OOD, MN 55 [,]			
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hhastintibFtt FF((aaon Fospins DafisbaAFavOf	as bad during a beck shower. During the o wince in pain mu nid-sentence with s o hold his breath un being able to open h R99 described his p hrough his body wi Review of the electric R99 had diagnoses inflammation of a t at its insertion into t ankylosing spondyli can cause vertebrain nultiple sites, cram R99's care plan indi- of one staff for bath section specific to p bain related to the s heed for pain medic showering. During interview on asked about how th or bathing preferences assessment. RN-G Admission/Readmis R99, dated 2/19/18 about bathing preferences about bathing preferences about bathing preferences assessment. RN-G Admission/Readmis R99, dated 2/19/18 about bathing preferences about bathing prefer	d baths during a recent cknowledged his pain was not bath as it was during a interview, R99 was observed ltiple times, stopping squinted eyes. R99 appeared ntil the pain was gone, before his eyes and speak again. bain as spasms that shot th any body movement. ronic medical record revealed including spinal enthesopathy endon, ligament, or cartilage he spine) at multiple sites, tis (inflammatory disease that e in the spine to fuse) at				

STATEME	ota Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	СОМ (°СОМ	E SURVEY PLETED C
		00520	B. WING		03/	01/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		ERREN AVENU VOOD, MN 55'			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 830	be appropriate for the but were not limited bathing/showering properties of the boxes of R99's bathing preferences of the boxes of R99's bathing preferences are bathing preferences are bathing preferences had been could not say for cells preference had been could not say for cells and she would follow options and prefere preferences were a On 3/1/18, at 4:08 preferences. The are did not have a writter residents for bathing preferences were so the Admission/Read SUGGESTED MET. The director of nurse develop and impleminiter disciplinary tea individual needs an resident. The facility procedures to ensure assessed, educate audit periodically to preferences of reside Random audits course of the solution of the sol	he resident. Options included, to, "I do not have specific preferences, I prefer a bed and I prefer showering." had been checked to specify rences. RN-G sated she was ff had asked R99 about his s because no boxes indicating en checked. RN-G said she wrtain whether R99 was asked athing, since she was not the beted the assessment. RN-G ow-up with R99 about bathing nces, and ensure current ccommodated.	2 830			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
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		00520	B. WING			C 101/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	STATE, ZIP CODE			
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(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
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2 830	Continued From pa	ge 12	2 830				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
2 890	MN Rule 4658.052 Motion	5 Subp. 2 A Rehab - Range of	2 890			4/10/18	
	that is directed towa through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which					
	without a limited ran experience reduction	ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is					
	by: Based on observati review, the facility f motion (ROM) serv	ent is not met as evidenced ion, interview and document ailed to provide range of ices for 1 of 1 residents (R26) ed range of motion of the lower		Corrected.			
	Findings included:						
	bed with the right for noticeable foot drop right foot. At that tin ankles and feet was	p.m. R26 was observed in bot and ankle uncovered. A b/flexion was observed on the ne, R26 stated ROM to both s suppose to be done on a not always happen.					

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	Сом Сом	E SURVEY PLETED C
		00520	B. WING		03/01/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		RREN AVENU			
(X4) ID	SUMMARY STA		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	COMPLET
2 890	Continued From pa	ge 13	2 890			
	During observation of morning cares on 3/1/18, at 8:20 a.m. nursing assistant (NA)-B was observed to lotion R26's right lower leg, feet and ankle. Range of motion was not provided. At that time, a slight foot drop/flexion was noted to the left foot/ankle.					
	asked about ROM to NA-B stated ROM to the Hoyer sling, but NA-C stated ROM assignment sheet. very limited and R2 foot/ankle. R26 the "sometimes" done	a.m. NA-B and NA-C were to R26's bilateral feet/ankles. was done when R26 got up in t R26 never got out of bed. was not listed on the NA NA-B stated R26's ROM was 6 could hardly flex the right n stated the ROM was while R26 was in bed. At 8:30 R26's left lower extremity, but M.				
	stated R26's ROM RN-A stated comple was monitored whe medications. RN-A giving the ROM. RN ROM was identified also be on the NA a RN-A showed the s sheet for R26. ROM	a.m. registered nurse (RN)-A should be done every shift. etion of ROM for residents en RN-A was giving said she would see staff N-A stated although R26's d on the care plan, it should assignment sheet. At that time, surveyor the NA assignment A was not identified on the and RN-A stated, "It's not on				
	computerized point pertaining to R26's RN-A. The docume be completed as fo range of motion to a	/18, the "Task" section of the of care documentation ROM was reviewed with entation indicated ROM was to llows: "Restorative active ankles before and after getting al lift device) and after getting				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED	
		00520	B. WING			C 03/01/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE			
MAPLEV	VOOD CARE CENTE	2	ERREN AVENU /OOD, MN 551				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 890	Continued From pa	age 14	2 890				
	documentation rev range of 2/1 to 2/2	os twice a day." The iewed with RN-A had a date 8/18. The review with RN-A not consistently receiving ROM					
	exercises to R26's before and after pl lifted back to bed.	dated 9/5/17, revealed ROM ankles was to be completed acing R26 in a lift; and after The physician's order indicated ne "two times a day."					
	verified R26's need frequency of 15 rep	e plan revised on 2/12/18, d for active ROM, with a os twice a day to the right and es, feet and ankles.					
	The therapy depar resident's specific instruct staff on ho well as the frequen then be added to the assignment sheet. could be assigned staff to ensure range	THOD OF CORRECTION: tment staff could reassess the range of motion needs and w to do the range of motion, as ney. The information should the nursing assistant A member of the nursing staff the responsibility to monitor ge of motion was being planned and ordered.					
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one					
2 920	MN Rule 4658.052	5 Subp. 6 B Rehab - ADLs	2 920			4/10/18	
	comprehensive res home must ensure B. a resident who	of daily living. Based on the sident assessment, a nursing that: o is unable to carry out <i>i</i> ng receives the necessary					

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00520	B. WING		C 03/01/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE, ZIP CODE			
MAPLEV	VOOD CARE CENTER		ERREN AVENUE VOOD, MN 55109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE / TAG CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLET DATE	
2 920	Continued From pa	ige 15	2 920			
	services to maintain and personal and o	n good nutrition, grooming, ral hygiene.				
	by:	ent is not met as evidenced				
	review, the facility f hygiene to 2 of 4 re	ion, interview and document ailed to provide personal sidents (R19 and R41) for activities of daily living				
	Findings include:					
	hairs the evening o	to have several long facial f 2/26/18, and during f the survey on 2/27/18, and				
	sitting on the edge to have matter arou eyelashes. In additi hairs around the ch long. The hairs wer asked whether staf how she felt about stated, "Staff do no face and I get short	p.m., R19 was observed of the bed. R19 was observed and her right eye and on her on, she had several long facia in area approximately 1 inch re gray, white and black. Wher f helped her with shaving, or having the facial hair, R19 t help to shave or wash my t of breathe when I try to shave approximately 1 inch t help to shave or wash my t of breathe when I try to shave				
	in bed. The resider gray, white and blac and chin area. At 1 sitting up at the edg	a.m., R19 was observed lying nt still had numerous long ck facial hairs to her upper lip l1:57 a.m., R19 was observed ge of the bed with oxygen sal cannula. She had not				

If continuation sheet 16 of 26

Department of He OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COM	E SURVEY PLETED
	00520	B. WING		C 03/01/2018	
OVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD CARE CENTER	2				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
On 2/28/18 at 7:57 n bed with the oxyg gray, white and bla stated she did not I R19's admission re admitted to the faci- ncluding: paranoid anxiety disorder, ex- disorder, and psych R19's quarterly Min 12/6/17, identified F of one staff with pe ncluding shaving. Review of R19's m documentation rela- care plan dated 8/1 R19 with grooming Assignment Sheet grooming assist of During an observate oractical nurse (LP -PN-B verified R19 stated she would shours in assist of the shave eplied, "The nursin put did not shave n shaved daily."	a.m., R19 was observed lying gen on. R19 still had the long ck facial hair. At that time, R19 ike having the whiskers. cord identified R19 had been ility on 3/15/14, with diagnoses schizophrenia, dementia, ktrapyramidal movement nosis. himum Data Set (MDS) dated R19 required extensive assist rsonal hygiene needs, edical record lacked any ted to refusal of cares. The /14, directed staff to assist . An undated Nursing Assistant included: "Grooming-A-1 one]". tion of R19 with licensed N)-B on 2/28/18 at 11:28 a.m., had long facial hairs. LPN-B have R19 or would ask the NA) to shave her. LPN-B d to be shaven and R19 ng assistant combed my hair ne and I would like to be to have several long facial f 2/26/18, and during				
	CORRECTION OVIDER OR SUPPLIER OD CARE CENTER SUMMARY STA (EACH DEFICIENC' REGULATORY OR L Continued From pa On 2/28/18 at 7:57 n bed with the oxyg gray, white and bla stated she did not l R19's admission re admitted to the fac including: paranoid anxiety disorder, ex lisorder, and psych R19's quarterly Mir 2/6/17, identified I of one staff with pe including shaving. Review of R19's m locumentation rela- care plan dated 8/1 R19 with grooming Assignment Sheet grooming assist of Ouring an observato practical nurse (LP .PN-B verified R19 stated she would s bursing assistant (I usked R19 if wishe eplied, "The nursir out did not shave n shaved daily."	CORRECTION IDENTIFICATION NUMBER: 00520 000000000000000000000000000000000000	FORRECTION IDENTIFICATION NUMBER: A. BUILDING:	ECORRECTION IDENTIFICATION NUMBER: 00520 A. BUILDING: B. WING OVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE NOD CARE CENTER 1900 SHERREN AVENUE MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL AG PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2010 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX (EACH DEFICIENCY MUST TAG PROVIDER'S PLAN OF (EACH DEFICIENCY MUST TAG Continued From page 16 2 920 2 920 CONTINUER (EACH DEFICIENCY MUST TAG PROVIDER'S PLAN OF (EACH DEFICIENCY MUST TAG Continued From page 16 2 920 2 920 2 920 CONTINUER (EACH DEFICIENCY MUST TAG CROSS-REFERENCED TO DEFICIENC Continued From page 16 2 920 2 920 2 920 CONTINUER (EACH DEFICIENCY MUST TAG CROSS-REFERENCENCES (EACH DEFICIENCY MUST TAG 2 920 CONTINUER (EACH DEFICIENCY MUST TAG 2 920 Continued From page 16 2 920 2 920 2 920 CONTINUER (EACH DEFICIENCY MUST TAG CROSS-REFERENCED (EACH DEFICIENCY MUST	FORRECTION IDENTIFICATION NUMBER: A. BUILDING: COM 00520 B. WING 03/ 00DC CARE CENTER 1900 SHERREN AVENUE 03/ SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY Continued From page 16 2 920 COM COM D's 2/28/18 at 7:57 a.m., R19 was observed lying hed with the oxygen on. R19 still had the long pray, white and black facial hair. At that time, R19 tated she did not like having the whiskers. 2 920 R19's admission record identified R19 had been idmitted to the facility on 3/15/14, with diagnoses cluding: paranoid schizophrenia, dementia, inxidely disorder, extrapyramidal movement lisorder, and psychosis. R19's quarterly Minimum Data Set (MDS) dated 2/6/17, identified R19 required extensive assist for one staff with personal hygiene needs, ncluding shaving. Review of R19's medical record lacked any locumentation related to refusal of cares. The are plan dated b/1/14, directed staff to assist 119 with grooming. An undated Nursing Assistant taseignment Sheet included: "Grooming-A-1 grooming assist of one]". During an observation of R19 with licensed raractical nurse (LPNL)-B on 2/28/18 at 11:28 a.m., PN-B verified R19 at ong facial hair. LPN-B tated she would shave R19 or would ask the tursing assistant (NA) to shave her, LPN-B skeed R19 if wished to be shaven and R10 epiled, 'The nursing assistant combed my hair

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00520	B. WING	B. WING		01/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		ERREN AVENU VOOD, MN 55 [.]			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	ge 17	2 920			
	and white facial hairs on her chin area. When asked whether staff assisted her with shaving, or how she felt about having facial hair, R41 stated, "I do not like it."					
	sitting in her wheel numerous gray and	4 a.m., R41 was observed chair again. She still had I white facial hairs noted on hin area. R41 stated she have her daily.				
	in bed in her room. shaved, and had th hairs. R41 again st would shave her da assisted R41 with h grooming. However R41 with shaving e obvious gray and w NA-A assisted R41 NA-A still did not of a.m., R41 was obse stated, "They did not	a.m., R41 was observed lying She had still not been e long gray and white facial ated she would prefer if staff aily. At 9:45 a.m., NA-A her morning cares, including r, NA-A did not offer or assist ven though the resident had thite facial hairs. At 11:05 a.m. to get up to use the toilet. fer to shave R41. At 11:19 erved in the dining room. She of shave me." The resident ay and white facial hairs.				
	admitted to the faci including: type two depression, restles	cord noted R41 had been lity on 11/8/16, with diagnoses diabetes mellitus, major sness and agitation, shortness d anxiety disorders.				
	R41 required exten	S dated 12/27/17, indicated sive assist of one staff with eeds including shaving.				
	medical record was evidence the reside	3 a.m., review of R41's reviewed, and lacked any ent refused cares. R41's ssistant Assignment Sheet				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00520			COM	E SURVEY PLETED C 01/2018
					03/	01/2010
	PROVIDER OR SUPPLIER	1900 SH	DDRESS, CITY, ST ERREN AVENU			
MAPLEV	VOOD CARE CENTER		VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 18	2 920			
	indicated, "Groomir	ig-A-1".				
	on 2/28/18 at 11:42 facial hair. LPN-A to	ion and interview with LPN-A a.m., LPN-A verified R41's old the surveyor NA-A had efused to be shaven.				
	RESIDENT dated 2	edure titled SHAVING THE 2006, included: "To remove ove the resident's appearance				
	director of nursing a responsible staff to dependant on facili comprehensively as designee could con	HOD OF CORRECTION: The and/or designee could educate provide care to residents' ty staff, based on residents' ssessed needs. The DON or iduct audits of dependent nsure their personal hygiene sistently.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21426	MN St. Statute 144 Prevention And Co	A.04 Subd. 3 Tuberculosis ntrol	21426			4/10/18
	maintain a compret infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must	e provider must establish and nensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of nation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students				

STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	COM	SURVEY PLETED
		00520	B. WING			01/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	2	RREN AVE			
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21426	residents, and volu Health shall provide regarding implement	nteers. The Department of technical assistance ntation of the guidelines.	21426			
	by: Based on interview facility failed to ens	ent is not met as evidenced and document review, the ure 1 of 5 newly hired was screened for tuberculosis		Corrected.		
	dated 11/28/17, rev (TST), TB blood tes screening tool reve 12/12/17 and was h patients. A clinic TS	mployee TB screening tool, realed no tuberculin skin test st or chest x-ray. The aled E-A's date of hire was hired to work directly with ST result was attached, ed 7/26/17, more than 90 days late.				
	dated 2017, directed receiving the two-si- may begin work aft negative." and "It is all healthcare work tuberculosis upon h unless contraindicat two-step procedure	ention and Control Manual, ed staff "Employees who will be tep Tuberculin Skin Test (TST) er the first step results are the policy of this facility that ers will be tested for hire and yearly thereafter ted. Initial testing will be a e with the first dose given ork and the second "booster"				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00520		A. BUILDING:		COM	E SURVEY PLETED C
	00520	B. WING	B. WING 0		
PROVIDER OR SUPPLIER					
VOOD CARE CENTER					
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
Continued From pa	age 20	21426			
director of nursing (review policies and components of the monitoring program educated on the TE The director of nurs	(DON) and/or designee could procedures related to the infection control and TB n. Facility staff could be B regulations and procedures. sing and/or designee could	3			
TIME PERIOD FOR (21) days.	R CORRECTION: Twenty one-				
MN Rule 4658.134	5 Labeling of Drugs	21620			4/10/18
-	-				
by: Based on observative review, the facility for expired/outdated me for use for 10 of 66 storage was review R103, R159, R160, ensure stock medic when expired which any residents who review	ion, interview and document ailed to ensure redications were not available residents whose medication ved (R13, R53, R56, R78, R86 , R161, R162), and failed to cations were not discarded n had the potential to affect		corrected.		
	OF CORRECTION PROVIDER OR SUPPLIER VOOD CARE CENTER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From pa dose given 7-21 da dose given 7-21 da dose is negative all screening tool." On 3/1/18 at 1:55 p worker confirmed fi SUGGESTED MET director of nursing review policies and components of the monitoring program educated on the TE The director of nursi develop a monitorin compliance. TIME PERIOD FOI (21) days. MN Rule 4658.134 Drugs used in the r in accordance with This MN Requirem by: Based on observat review, the facility f expired/outdated m for use for 10 of 66 storage was review R103, R159, R160 ensure stock medic when expired which	OF CORRECTION IDENTIFICATION NUMBER: 00520 PROVIDER OR SUPPLIER STREET AI YOOD CARE CENTER 1900 SHI MAPLEY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 20 dose given 7-21 days after the first if the first dose is negative along with an employee risk screening tool." On 3/1/18 at 1:55 p.m. the human resource worker confirmed findings. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and procedures. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one- (21) days. MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired/outdated medications were not available for use for 10 of 66 residents whose medication storage was reviewed (R13, R53, R56, R78, R86, R103, R159, R160, R161, R162), and failed to ensure stock medications were not discarded when expired which had the potential to affect any residents who may use those medications.	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00520 B. WING	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00520 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE YOOD CARE CENTER 1900 SHERREN AVENUE MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDENCIES) D PROVIDER'S PLAN OF OF (EACH DEFICIENCY MUST BE PRECEDENCIES) Continued From page 20 21426 dose given 7-21 days after the first if the first dose is negative along with an employee risk screening tool." Continued From page 20 On 3/1/18 at 1:55 p.m. the human resource worker confirmed findings. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to the components of the infection control and TB monitoring program. Facility staff could be educated on the TB regulations and procedures. The director of nursing and/or designee could develop a monitoring system to ensure ongoing compliance. 21620 TIME PERIOD FOR CORRECTION: Twenty one- (21) days. 21620 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure expired/outdated medications were not available for use for 10 of 66 residents whose medication storage was reviewed (R13, R53, R56, R76, R76, R86, R103, R159, R160, R161, R162), and failed to ensure stock medications were not discarded when expired which had the potential to affect any residents who may use those medications. corrected.	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00520 B. WING 037 PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 037 SUMMARY STATEMENT OF DEPERDENCIES IMAPLEWOOD, NM 55109 IMAPLEWOOD, NM 55109 Image: Continued From page 20 21426 Image: Continued From page 20 Continued From page 20 Continued From page 20 21426 Construction of the spectree of the spectrate of

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STATEMEN	ota Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	COM	E SURVEY PLETED C
		00520	B. WING		03/01/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
	VOOD CARE CENTER	1900 SHI	ERREN AVENL	JE		
	VOOD CARE CENTER	MAPLEW	/OOD, MN 55 [,]	109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21620	Continued From pa	ge 21	21620			
	3/1/18, at 12:33 p.n licensed practical n place two tablets of medication cup for acetaminophen. W stock bottle of aceta date of 6/17. LPN-1 administering the m date was pointed of medication label ind Stock medications medication cart wer p.m. The following identified: a bottle of with an expiration d calcium with an exp stated none of the of residing on the 3 so these stock medication (Advair) opened; two bottles R56 were not dated the laxative polyeth	of a medication pass on h. on the three (3) south unit, urse (LPN)-D was observed to acetaminophen into a R78 from a bottle of stock hen observed at that time, the aminophen had an expiration D was stopped before hedication and the expiration ut to LPN-D, who verified the dicated it had expired on 6/17. in the three (3) south re reviewed on 3/1/18 at 12:35 outdated medications were of stock vitamin B12 labeled ate of 1/17, and oyster shell biration date of 1/17. LPN-D current eight (8) residents buth unit were currently taking tions. An inhalation asthma of or R13 was not dated when s of olapatadine eye drops for d when opened, and a bottle of ylene glycol prescribed to R56 n expiration date of 12/17.				
	Advair, and verified expiration date was longer used that me eye drops should ha	was no longer using the the polyethylene glycol 12/17, but stated R56 also no edication. LPN-D verified the ave been dated when opened was currently receiving the				
	eye drops. Also in t there was a bottle of were not dated whe bottle of latanospro	was currently receiving the he 3 south medication cart of atropine mouth drops which en opened for R103; and a st eye drops which were dated ened on 1/17/18, for R53 and				
	which according to	LPN-D were still in use. There es of gatifloxacin eye drops for				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00520	. ,	E CONSTRUCTION	СОМ	E SURVEY PLETED C 01/2018
					03/	01/2010
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
MAPLEW	VOOD CARE CENTER	2	ERREN AVEN VOOD, MN 55			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
21620	Continued From pa	age 22	21620			
	when opened; and drops for R86 whic	en, but had not been dated a bottle of Latanoprost eye h were dated as having been . LPN-D verified the were still in use.				
c fr b r f r r	cart was reviewed a following stock med bottle of Naproxen a bottle of vitamin (had been opened of 1/18. Registered nu	o.m., the two north medication and observed to contain the dications that had expired: a (for pain) expired on 1/18; and C 500 milligrams (mg) which on 10/16, and had expired on urse (RN)-C stated no north unit were currently ck medications.				
	medication and treat the 3 north medicat stock medications of mg expired 4/17, m 11/17, glucosamine Naproxen expired 7 and vitamin B comp time, LPN-E stated residents on the 3 m medications. There medication (loratidi north medication ca date of 8/17. LPN-E residents on the 3 m this stock medication no specific routine checking medication medications, and s assignment for a m	tated there was not a specific urse or shift to check	,			
	she tried to check t	biration dates. LPN-E stated the medication carts on the worked to identify any s.				

AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _		COM	E SURVEY PLETED C	
		00520	B. WING			03/01/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
MAPLEW	OOD CARE CENTER	2	ERREN AVENU VOOD, MN 55'				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21620	Continued From pa	age 23	21620				
	stored in the first flounit)-1 medication of been dated when of Novolog and Lantu and Levemir for R1 RN D stated came another bottle of Na or dated when open insulins in the medi when opened. RN- the medication cart upon herself to che medications had be stated there was of looking at the medi medications.	/18, 6 of 6 bottles of insulin for TCU (transitional care cart were identified to have not opened. This included bottles of s for R162; a bottle of Novolog 61; a bottle of Novolog, which from the emergency kit; and ovolog which was not labeled ned. RN-D verified none of the ication cart had been dated D stated she had gone through a about a month ago and took if exch the medications in her expiration dates and to ensure een dated when opened. RN-D therwise no specific system for cation carts for expired	f I I I I I I I I I I I I I I I I I I I				
	Novolog insulin ind discarded 28 days insulin pen was to l according manufac guidance for Leven	ance for Lantus, Humalog and icated vials should be after opening. The Basaglar be discarded after 28 days sturer guidance. Manufacturer nir insulin indicated vials d 42 days after opening.					
	medication cart wa seven bottles of ins was not dated whe Basaglar insulin pe R160, which was n stated insulins were and verified the bot	o.m., the first floor TCU-2 s noted to contain one of sulin (Humalog for R159) which n opened. There was also one n in the medication cart for ot dated when opened. RN-B e to be dated when opened, ttle of Humalog and the n had not been dated when					

Minnesota Department of Hea STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED C 03/01/2018	
		00520				
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	2	ERREN AVENU VOOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLET DATE
21620	Continued From page 24		21620			
	medication cart was noted to contain a bottle of stock acidophilus which had expired on 6/17. LPN-C stated no one on her unit was currently taking the acidophilus.					
	On 3/1/18, at 2:59 p.m. the director of nursing (DON) stated the facility had no system in place for checking medication carts for expired medications. The DON stated the facility also did not have a specific policy to follow regarding checking medications for expiration dates or for labeling medications when opened. The DON stated the facility followed the contracted pharmacy's policy and procedures regarding expired medications and dating when opened.					
	2013 policy titled Si Medications, Biolog The policy indicated biological package follow manufacture respect to expiratio medications. The D record the date ope	a copy of the pharmacy's torage and Expiration of gicals, Syringes and Needles. d that once a medication or was opened the facility should r/supplier guidelines with on dates for opened DON said facility staff should ened on the medication nedications with a shortened				
	medications should when there was a r outdated/expired m destroyed by the fa pharmacy. The poli	cy also indicated that d be destroyed and reordered missing label, and indicated nedications should be icility or returned to the icy did not address how re to check medications for a.				
	administrator, direc	THOD OF CORRECTION: The ctor of nursing (DON) and cist could review and revise	e			

Minnesota Department of Health STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00520		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		COM	(X3) DATE SURVEY COMPLETED C 03/01/2018	
		B. WING					
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
IAPLEW	OOD CARE CENTER	2	ERREN AVENU VOOD, MN 55 [.]				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIO TAG CROSS-REFERENCED TO TH DEFICIENCY		ON SHOULD BE COMPL IE APPROPRIATE DATI		
21620	Continued From page 25		21620				
	medications. Nursi necessary to the in medications proper medications. The I the pharmacist, cor regular basis to en	dures for proper storage of ng staff could be educated as nportance of labeling rly and discarding expired DON or designee, along with uld audit medications on a sure compliance. R CORRECTION: Twenty-one					