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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: VHPG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00520

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245276**
2.STATE VENDOR OR MEDICAID NO.
(L2) **010343800**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 01/13/2014 (L34)

8. ACCREDITATION [illegible] (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **149** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
[ ] . Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 03/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 03/18/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 03/26/2014 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/24/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN = 24-5276

The facility was not in substantial compliance with Federal participation requirements at the time of the standard survey completed on 11/21/13. On 01/13/14, the Department of Health completed a Post Certification Revisit (PCR) by review of the plan of correction and on 12/20/13, the Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility achieved substantial compliance pursuant to the standard survey completed on 11/21/13, effective 12/31/2013. Refer to the CMS-2567B for both health and life safety code.

Effective 12/31/2013, the facility is certified for 149 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5276

March 17, 2014

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Dear Mr. Dolinsky:

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

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

Effective December 31, 2013, the above facility is certified for:

149 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 149 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 14, 2014

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: Project Number S5276024

Dear Mr. Dolinsky:

On December 11, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 21, 2013. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On January 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on December 20, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 21, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on November 21, 2013, effective December 31, 2013 and therefore remedies outlined in our letter to you dated December 11, 2013, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit. Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 651-201-3793 Fax: 651-201-3790

Enclosure

cc: Licensing and Certification File

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245276	A. Building B. Wing	1/13/2014

Name of Facility	Street Address, City, State, Zip Code
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0278** Reg. # **483.20(q) - (j)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/31/2013**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/31/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0327** Reg. # **483.25(i)** LSC	Correction Completed **12/31/2013**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **12/31/2013**	ID Prefix **F0464** Reg. # **483.70(q)** LSC	Correction Completed **12/31/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	03/17/2014	16022	01/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/21/2013			

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245276	01 - MAIN BUILDING 01	12/20/2013

Name of Facility	Street Address, City, State, Zip Code
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE MAPLEWOOD, MN 55109

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # **NFPA 101** LSC K0018	**11/22/2013**	ID Prefix Reg. # **NFPA 101** LSC K0029	**11/22/2013**	ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	03/17/2014	12424	12/20/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
11/21/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: VHPG

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/21/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **149** (L18)

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

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Robyn Woolley, HFE NE II — 12/19/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 01/17/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
03001 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

CCN=245276

At the time of the standard survey completed November 21,2013, the facility was not in substantial compliance and the most serious deficiencies were found 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 attached CMS-2567 whereby corrections are required. In addition, at the time of the November 21, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5276079 that was found to be unsubstantiated.The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6973

December 11, 2013

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

RE: Project Numbers S5276024 and H5276079

Dear Mr. Dolinsky:

On November 21, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the November 21, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number H5276079. 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 attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the November 21, 2013 standard survey the Minnesota Department of Health completed an investigation of complaint number that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

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

Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 31, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, an onsite revisit of your facility may be conducted to validate that

substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 21, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human

Services that your provider agreement be terminated by May 21, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

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

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	11/21/2013

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

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F 000	INITIAL COMMENTS A standard recertification survey was conducted and a complaint investigation had also been completed at the time of the standard survey. An investigation of complaint H5276079 had not been substantiated during this survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 12/19/13 SER	This Credible Allegation of Compliance has been prepared and timely submitted. Submission of the Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiency were correctly cited, and is also not to be construed as an admission against interest of the facility, its Administrator or any employee, agent or other individuals who draft or may be discussed in the Credible Allegation of Compliance. In addition, preparation and submission of the Credible Allegation of Compliance does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance within ten days of the receipt of the statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance with this time frame should in no way be considered or construed as agreement with the allegation of non-compliance or admissions by the facility.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is			

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

Executive Director 12-18-13

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

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F 278	Continued From page 1 subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the resident Minimum Data Set (MDS) assessment accurately reflected the resident's condition for 1 of 3 residents (R75) reviewed for assessment accuracy. Findings include: R75's Admission Record indicated an admission date of 9/27/13 and diagnosis of a knee replacement. The admission MDS dated 10/10/13, indicated R75 had been assessed for pressure ulcer risk and was not at risk for the development of pressure ulcers. R75's Braden and Skin Risk Data Collection form dated 9/27/13 included R75 was at "Severe Risk" of developing pressure ulcers. When interviewed on 11/21/13, at 11:45 a.m. registered nurse (RN)-A stated the MDS was inaccurately coded and that R75 was at risk for the development of pressure ulcers at the time of the assessment. RN-A had coded it incorrectly because R75 had been mobile and participating	F 278	F 278 It is the policy of Volunteers of America Maplewood Care Center to ensure that assessments accurately reflect the residents status. Resident # 75 was discharge home. The MDS that was inaccurate was modified to reflect correct data and resubmitted. If any other MDS are found to be inaccurate on quarterly review, re- assessement and modification of MDS will be completed. Policies and procedures were reviewed regarding assessments and MDS coding protocols. MDS staff to attend updated ANAAC training this month. Random audits will be conducted monthly for three months to ensure accurate coding of residents condition. Results of this monitoring will be reported to the facility QA committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. ~~1-6-14~~ 12/31/13 call to DON 12/19/13. completion date changed to 12/31/13	

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F 278	Continued From page 2 in therapy. Although R75 had been mobile, participating in therapy and the 9/27/13 Braden and Skin Risk Data Collection form indicated severe risk, the MDS was coded as not a risk for the development of pressure ulcers.			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to include the location of the dialysis access site in the temporary care plan plan 1 of 1 resident (R292) reviewed for dialysis care. Findings include: R292's temporary admission care plan dated 11/14/13, read, "Dialysis patient." The care plan described the times and location of dialysis for this resident, but not address the resident's dialysis access site or how to care for it. When interviewed on 11/21/13, at 9:00 a.m. licensed practical nurse (LPN)-B was unable to find information on where R292's dialysis access site was, or how to care for the site. She stated that this information is generally on the treatment administration record and she would put that information on the treatment administration record.	F 281	F 281 It is the policy of Volunteers of America Maplewood Care Center to provide services that meet professional standards of quality. Resident # 292 was found without dialysis access site on care plan. It was immediately added. Care plans of residents receiving dialysis were reviewed and revised if indicated, to reflect professional standards of care. Polices and procedures were reviewed and revised to ensure facility was meeting professional standards of quality . Nursing staff were educated on these policies and procedures regarding standards of care. Random audits will be done initially and monthly for three months on new dialysis residents to ensure facility is meeting standards of quality. The results of this monitoring will be reported to the facility QA Committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. 12/31/13 Completion date for certification purposes only. 1-6-14	

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F 281	Continued From page 3 When reviewed on 11/21/13, at 1 p.m. page 2 of the treatment administration record for R292, contained an entry that read, "Inspect right upper chest dialysis access site every shift and chart results in PCC [point click care] every shift for Dialysis Port-Order Date-11/21/13 0938 [9:38 a.m.]." LPN-B was interviewed and stated she had added this entry to the treatment administration record after her conversation with a surveyor earlier that day. When interviewed on 11/21/13, at 2:30 p.m. registered nurse (RN)-B stated that the dialysis access site information is normally put on the treatment administration record or the care plan, but it had been missed for R292. The facility's Care Plan Policy and Procedure, dated September 2006, read, "It is the policy of Volunteers of America to provide a temporary care plan within 24 hours of admission..."		RECEIVED DEC 19 2013 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow resident care plans for 2 of 2 residents (R190 and R105) reviewed who were at risk for dehydration and who were to have fluids encouraged.			

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F 282	Continued From page 4 Findings include: R190 was observed without water at bedside, even though the care plan indicated water should be available to R190 at bedside. R190's care plan dated 9/19/13, directed staff that R190 was at risk for dehydration due to Alzheimer's disease, diuretic use, chronic kidney disease, depression, and varied intakes. Staff were directed to provide and encourage extra fluids at all meals, activities, and at bedside as allowed. R190's quarterly Minimum Data Set (MDS) dated 10/8/13, included a diagnosis of Alzheimer's disease, had severe cognitive impairment, required extensive assistance with eating and drinking, and received a daily diuretic (water pill). When interviewed on 11/18/13, at 6:17 p.m. R190 stated she did not have water at bedside, "I don't know what I would do if I was thirsty." No water or any fluids were noted in R190's room. R190 was observed again on 11/20/13, at 7:35 a.m. with no water or fluids in her room. R190 was observed at breakfast on 11/20/13, at 9:45 a.m. The dietary card indicated R190 should have milk, juice, and coffee at breakfast. R190's breakfast tray did not contain any milk. R190 was giving approximately 90 ml (milliliters) of fluid with	F 282	F 282 It is the policy of Volunteers of America Maplewood Care Center to provide services in accordance with the residents written plan of care. Residents # 190 and # 105 written plans of care have been reviewed and revised. In this occurrence, bedside water was added to the MC unit daily routine to assist with encouraging fluids for residents acc to individual care plans. Resident care plans will be reviewed and revised as indicated with quarterly reviews. Any revisions will be communicated to direct care staff. Polices and procedures were reviewed regarding resident care plans. Nursing staff were educated on these policies and procedures regarding following the written plan of care. Random audits and observations of services will be done monthly for three months to ensure effectiveness of these actions. The results of this monitoring will be reported to the facility QA Committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. ~~12-6-14~~ 12/31/13	

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F 282	Continued From page 5 her medications at 10:13 a.m. When interviewed on 11/21/13, at 2:30 p.m. the dietitian (D)-A and dietitian (D)-B indicated there was no policy prohibiting water at bedside and saw no reason why R190 could not have water at the bedside. The registered nurse manager (RN)-C who was present during the interview agreed. It is the facility's policy to keep fluids at bedside so they are available to residents. R105 was observed without water at bedside, even though the care plan indicated water should be available to R105 at bedside. R105's care plan, dated 9/26/13, included a dietary fluid volume deficit which put the resident at risk for dehydration. The plan directed staff to provide and encourage extra fluids at all meals, during medication pass, during activities, and at bedside as allowed per physician. R105's quarterly MDS dated 10/8/13, included a diagnosis of a stroke and required limited assistance from staff for eating and drinking. R105 was interviewed on 11/18/13, at 5:36 p.m. and no fluids were observed at the bedside. When asked, R105 said, "They don't always have water." Nursing assistant (NA)-A was in the room providing assistance to another resident and when asked about water at the bedside he responded, "Sometimes they have water at the bedside." NA-A went to get R105 a water pitcher. When observed on 11/19/13, at various times throughout the day shift from 8:15 a.m. until 2:00			

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F 282	Continued From page 6 p.m., no water was observed at the bedside. On 11/20/13, observation between 7:15 a.m. and 9:15 a.m. no water was observed at the bedside and the resident remained in bed. At 9:15 a.m. R105 was asked whether he was hungry or thirsty because he had not been observed out of bed for breakfast. He responded that he was not hungry but he would like something to drink. R105's lips appeared dry but were not cracked. On 10/20/13, at 9:55 a.m. interview with NA-B revealed that R105 refused to get up for breakfast, however, morning cares were provided at 6:30 a.m. and at that time R105 drank some chocolate milk and water. At 10:00 a.m. NA-B again offered to get him up but he refused. Additional fluids were not offered. On 11/21/13, at 8:29 a.m. R105 was observed in bed being fed by NA-C and he drank 240 ml of juice, 240 ml of milk, and 150 ml of water. When interviewed on 11/21/13, at 10:10 a.m. NA-C stated nothing more had been offered to R105 after breakfast. When interviewed on 11/21/13, at 2:30 p.m. the dietitian (D)-A and dietitian (D)-B indicated there was no policy prohibiting water at bedside and saw no reason why R105 could not have water at the bedside. The registered nurse manager (RN)-C who was present during the interview agreed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 7 Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to include the location and care of the dialysis access site in the plan of care for 1 of 1 resident (R292) reviewed for dialysis care. Findings include: R292's temporary admission care plan dated 11/14/13, read, "Dialysis patient." The care plan also described the times and location of dialysis for this resident, but not include the resident's dialysis access site or how to care for it. When interviewed on 11/21/13, at 9:00 a.m. licensed practical nurse (LPN)-B was asked if there was a place in the record that identified the dialysis access site for R292 and the directions for care of this site. She looked through the treatment administration record and the medication administration record and could not locate this information. She stated that this information is generally on the treatment administration record and she would put that information on the treatment administration record.	F 309	F 309 It is the policy of Volunteers of America Maplewood Care Center to provide care and services for the highest well being of the residents. Resident # 292 was found without dialysis access site on care plan. It was immediately added. Care plans of residents receiving dialysis were reviewed and revised if indicated, to reflect care and services for highest well being. Polices and procedures were reviewed and revised to ensure facility was meeting care/services for highest well being.of residents. Nursing staff were educated on these policies and procedures regarding care and services. Random audits will be done initially and monthly for three months on new dialysis residents to ensure facility is meeting standards of quality. The results of this monitoring will be reported to the facility QA Committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. ~~1-6-14~~ 12/31/13	

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F 309	Continued From page 8 When reviewed on 11/21/13, at 1 p.m. page 2 of R292's treatment administration record for R292 contained and entry that read, "Inspect right upper chest dialysis access site every shift and chart results in PCC every shift for Dialysis Port-Order Date-11/21/13 0938 [9:38 a.m." LPN-B was interviewed and stated that she had added this entry to the treatment administration record after her conversation with a surveyor earlier that day. When interviewed on 11/21/13, at 2:30 p.m. RN-B stated that the dialysis access site information is normally put on the treatment administration record or the care plan. It had been missed for R292. The facility's Care Plan Policy and Procedure, dated September 2006, read, "It is the policy of Volunteers of America to provide a temporary care plan within 24 hours of admission..."			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the			

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F 314	Continued From page 9 facility failed to accurately assess and implement interventions to prevent a pressure ulcer from developing and failed to accurately assess a pressure ulcer after development, for 1 of 3 residents (R75) who was reviewed for pressure ulcers. Findings include: R75's Admission Record form included an admission date of 9/27/13, and diagnoses including a right total knee arthroplasty (replacement of joint), morbid obesity, and osteoarthrosis. R75's Minimum Data Set (MDS) dated 10/10/13, included he was cognitively intact, required extensive assistance for bed mobility and transfers. The MDS further indicated R75 was not at risk for developing pressure ulcers and did not have a current pressure ulcer. R75's Braden and Skin Risk Collection, dated 9/27/13, included, "A score of 8.0 that makes a risk level of Severe Risk." When interviewed on 11/21/13, at 11:45 a.m. registered nurse (RN)-A verified the 9/27/13, assessment clearly indicated R75 was at high risk for developing a pressure ulcer, but had not coded the MDS that way because, "I thought the resident was mobile, and participating in therapy, so thought that he was not that high of a risk."	F 314	F 314 It is the policy of Volunteers of America Maplewood Care Center to ensure that a resident who enters the facility without pressure sores, does not develop pressures unless the individual's clinical condition demonstrates that they were unavoidable, and that a resident that does have pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Resident # 75 was discharged home. Policies and procedures were reviewed for pressure sore protocols with minor revisions. Nurses re-educated on said protocols and proper documentation of such. Random audits will be done by Infection Control Specialist and/or designee for residents with pressure sores to ensure that protocols are followed, appropriate interventions are in place to promote healing and to prevent infection or new sores from developing. Results of this monitoring will be reported to the facility QA meeting monthly for three months. Upon this review, system changes, revisions, and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. ~~1-6-14~~ 12/31/13	

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F 314	Continued From page 10 R75's body audit dated 9/27/13, (admission) revealed R75 had a surgical incision on the right knee and a scar on the left knee. Section D entitled "heels" was checked as being clear. No pressure ulcers were noted on the 9/27/13, assessment. R75's body audit, dated 10/5/13, revealed R75 had an area on the right heel, measuring 3.0 centimeters (cm) x 1.5 cm x 0 cm, and it was a stage one (intact skin with non blanchable redness of a localized area usually over a bony prominence). However, review of the progress note corresponding to the body audit revealed, " An open area measuring 3.0 cm X 1.5 cm with a 0.8 cm x 0.8 cm scab in the center, there was a scant amount of serosanginous drainage on linen. NP [nurse practitioner] was called and gave order for Alleyvn and the keep pressure off heels and inform MD [medical doctor] on Monday." When interviewed on 11/21/13, at 9:45 a.m. licensed practical nurse (LPN)-B stated the progress note dated 10/5/13 should have indicated the pressure ulcer was unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough and/or eschar in the wound bed), rather than a stage one. The nurse practitioner (NP) was notified and an order was received to cover it with an Allevyn (dressing to absorb drainage and protect the area). LPN-B stated R75 was very strong willed, refused to take his TED socks (anti-embolism socks) off, refused the continuous passive motion machine (CPM) (device used by patients following knee			

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F 314	Continued From page 11 replacement to provide passive range of motion for the knee), and refused an air mattress. R75's progress notes indicated a refusal of the CPM on 10/1/13 and 10/2/13. Review of physician progress notes indicated the following : 10/7/13 "His left heel was examined. There was an extensive decubitus which is about 2 cm with yellowish eschar noted at the base with some foul odor and some drainage which is also very foul-smelling." The assessment/plan indicated, " heel decubitus. At present, I am going to order some Allevyn, switch him to an AP [air pressure] mattress and also order some Bactroban [ointment used to prevent infection] topically. I think he has some infection going in there. Continue with his wound care also. Requested him to switch his positions frequently and ordered AP mattress." 10/9/13 " His heel has an open area which is currently being dressed with Allevyn." 10/14/13 "His heel was examined and he does have a decub [decubitus] at the incision of his calcaneal tendon on his right heel but there is some granulation tissue noted. No eschar. No significant drainage. He is actually doing very nicely, looks nicely healing up." 10/16/13" He has the presence of a decub at the site of his insertion of his Achilles on the right side. There is an open area but there is minimal necrotic drainage noted from there and overall it seems to be improving nicely. No concerns for infection anymore." 10/21/13 "His heel has a chronic decub which was examined and it seems to be closing down. There is still some purulent drainage noted."			

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	245276	A. BUILDING _____ B. WING _____	11/21/2013

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F 314	Continued From page 12 R75's care plan dated 10/18/13, indicated a stage two pressure ulcer on the right heel, and the resident was at risk for pressure ulcers. There were no specific interventions listed prior to the open area, as there was only a generic temporary care plan. Although the template directed staff to check R75's heels, the main interventions pertained to the knee replacement. Interventions to relieve pressure were implemented after the ulcer developed. R75 was discharged home on 10/22/13. The discharge progress note did not contain any information regarding R75s's right heel.			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide fluids and adequately monitor fluid intake for 2 of 2 residents (R105, R190) in the sample who were at risk for dehydration. Findings include: R190 was assessed to be at risk for dehydration, but the facility failed to encourage fluids as directed by the care plan, and failed to evaluate if			

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F 327	Continued From page 13 fluids actually being consumed were adequate for R190. R190's quarterly Minimum Data Set (MDS) dated 10/8/13, included a diagnosis of Alzheimer's disease, had severe cognitive impairment, required extensive assistance with eating and drinking, and received a daily diuretic (water pill). R190's quarterly nutritional assessment by the dietician completed 9/23/13, indicated R190 was at risk for dehydration due to Alzheimer's disease, diuretic use, chronic kidney disease and varied intake. The assessment estimated the daily fluid requirement was 2072 cc (cubic centimeters/equal to milliliters) a day. The plan was to give extra fluids at meals, at medication passes, activities and at the bedside as allowed. R190's care plan dated 9/19/13, indicated she was at risk for dehydration due to Alzheimer's disease, diuretic use, chronic kidney disease, depression, and varied intakes. Staff were directed to provide and encourage extra fluids at all meals, activities, and at bedside as allowed. When interviewed on 11/18/13, at 6:17 p.m. R190 stated she did not have water at bedside, "I don't know what I would do if I was thirsty." No water or any fluids were noted in R190's room. R190 was observed again on 11/20/13, at 7:35 a.m. with no water or fluids in her room.	F 327	F 327 It is the policy of Volunteers of America Maplewood Care Center to provide each resident with sufficient fluid intake to maintain proper hydration. Resident #105 and #190 will be reassessed for hydration needs. At time of survey labs were done to note adequate hydration. Hydration documentation was reviewed for accuracy. Residents at risk for dehydration will be reviewed with scheduled assessment to ensure hydration needs are accurate and being met Policies and procedures were reviewed for hydration protocols and documentation. System implemented for potentially affected residents to ensure bedside water availability. Nursing department was educated on said protocols and appropriate documentation of all fluid intake, including fluids given between meals. Random audits of adequate fluid intakes on residents at risk for dehydration, will be done monthly for three months. Results of this monitoring will be reported to the QA committee. Upon this review, revisions and /or staff education will be implemented if needed. DON and/or designee will be responsible maintaining compliance. Completion date for certification purposes only.	~~1-6-14~~ 12/31/13

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F 327	Continued From page 14 R190 was observed at breakfast on 11/20/13, at 9:45 a.m. The dietary card indicated R190 should have milk, juice, and coffee at breakfast. R190's breakfast tray did not contain any milk. R190 was giving approximately 90 ml (milliliters) of fluid with her medications at 10:13 a.m. R190's Fluid Consumption at Meals dated 10/23/13 through 11/21/13, revealed that the resident consumed between 300 and 1290 cc at meals. The Snack/Hydration report dated 10/23/13 through 11/21/13, indicated how much fluid was consumed other than for meal time. It included, bedside water pitcher, overnights, activities and revealed on 12 days the resident consumed zero. On the remainder of the days the resident consumed 100-860 cc. This was less than the assessed need of 2072 cc. When interviewed on 11/21/13 at 2:30 p.m. the dietitian (D)-A and dietitian (D)-B indicated there was no policy prohibiting water at bedside and saw no reason why R190 could not have water at the bedside. D-B revealed that the daily fluid requirements were arrived at by utilizing a calculation with the residents weight. The daily fluid requirement would be what the resident was expected to consume to maintain hydration. The registered nurse manager (RN)-C who was present during the interview agreed. RN-C also indicated that without documentation of intake there was no way to know if R190 was consuming what she should be. R105 was observed without water at bedside, and			

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F 327	Continued From page 15 the facility failed to determine if actual consumed fluids were adequate for R105. R105's quarterly MDS dated 10/8/13, included a diagnosis of a stroke and required limited assistance from staff for eating and drinking. R105's care plan, dated 9/26/13, included a dietary fluid volume deficit which put the resident at risk for dehydration. The plan directed staff to provide and encourage extra fluids at all meals, during medication pass, during activities, and at bedside as allowed per physician. R105 was interviewed on 11/18/201,3 at 5:36 p.m. and no fluids were observed at the bedside. When asked, R105 said, "They don't always have water." Nursing assistant (NA)-A was in the room providing assistance to another resident and when asked about water at the bedside he responded, "Sometimes they have water at the bedside." NA-A went to get R105 a water pitcher. When observed on 11/19/13 at various times throughout the day shift from 8:15 a.m. until 2:00 p.m., no water was observed at the bedside. On 11/20/13 observation between 7:15 a.m. and 9:15 a.m. no water was observed at the bedside and the resident remained in bed. At 9:15 a.m. R105 was asked whether he was hungry or thirsty because he had not been observed out of bed for breakfast. He responded that he was not hungry but he would like something to drink. R105's lips appeared dry but were not cracked. On 10/20/13 at 9:55 a.m. interview with NA-B			

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F 327	Continued From page 16			

revealed that R105 refused to get up for breakfast, however morning cares were provided at 6:30 a.m. and at that time he did drink some chocolate milk and water. At 10:00 a.m. NA-B again offered to get him up but he refused. Additional fluids were not offered at that time. Interview with NA-B on 11/21/13 at 10:10 a.m. revealed nothing more had been offered to the resident after breakfast.

On 11/21/13 at 8:29 a.m., R105 was observed in bed being fed by NA-C and he drank 240 cc of juice, 240 cc of milk, and 150 cc of water.

R105's dietary assessment dated 9/22/13 indicated R105 was at risk for dehydration due to constipation, depression, dementia, and psychosis. The assessment estimated the daily fluid requirement was 2713 cc a day based on the resident's weight. The plan was to give extra fluids at meals, at medication passes, activities and at the bedside as allowed.

R105's Fluid Consumption at Meals dated 10/23/13 through 11/20/13, revealed that the resident consumed between 240 and 1120 cc at meals. The Snack/Hydration report dated 10/23/13 through 11/21/13, indicated how much fluid was consumed other than for meal time. It included, bedside pitcher, overnights, and activities and revealed on 4 days the resident consumed zero. On the remainder of the days the resident consumed 100-390 cc. Well below the assessed as needed 2713 cc per day.

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F 327	Continued From page 17 When interviewed on 11/21/13, at 2:30 p.m. the dietitian (D)-A and dietitian (D)-B indicated there was no policy prohibiting water at bedside and saw no reason why R105 could not have water at the bedside. D-B revealed that the daily fluid requirements were arrived at by utilizing a calculation with the residents weight. The daily fluid requirement would be what the resident was expected to consume to maintain hydration. RN-C, who was present during the interview, agreed. RN-C also agreed that without documentation of intake there was no way to know if R105 was consuming what he should be. The policy and procedure titled Hydration and dated 2006, indicated it is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration. Sufficient fluid means the amount of fluid needed to prevent dehydration and maintain health status. The document further revealed the amount needed was specific for each resident. Fluids would be offered during meals, between meals, at medication pass, and at the bedside unless contraindicated. The policy indicated fresh water would be delivered to residents as needed.			
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any			

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F 329	Continued From page 18 combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to monitor the resident's blood pressure after a change in an antihypertensive medication for 1 of 5 residents (R61) who were reviewed for unnecessary medications. Findings include: R61's physician orders dated 10/21/13, included Lisinopril (medication given to lower blood pressure) 20 mg (milligrams) . The order was written as "Decrease Lisinopril 20 mg. Give 20 mg by mouth in the morning for HTN (hypertension) hold if SBP (systolic blood pressure) < (less than) 110 , DBP (diastolic blood pressure) <60. " Review of the Medication Admission Record (MAR) for October 2013, and November 2013 revealed the medication was given every day since 10/22/13. No blood	F 329	F 329 It is the policy of Volunteers of America Maplewood Care Center to prevent unnecessary drug use without adequate monitoring. Resident # 61 orders were reviewed and appropriate BP monitoring was added to the residents MAR to ensure nurse monitoring and follow through for correct BP parameters and medication use. Residents having parameters for monitoring and medication use were reviewed for appropriate monitoring and documentation. Policies and procedures were reviewed for regulatory compliance. Nursing staff re-educated on necessity of monitoring and documentation when parameters noted in MD/NP orders for HTN medication. Random audits will be conducted monthly for three months to ensure given parameters are being monitored and documented per MD/NP order. Results of this monitoring will be reported to the facility QA committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only.	~~1614~~ 12/31/13

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F 329	Continued From page 19 pressure monitoring was noted before the medication was given. When interviewed on 11/20/13, at 10:45 a.m. Licensed Practical Nurse (LPN)-A stated when a physician or nurse practitioner writes a new order, the Health Unit Coordinator (HUC) will transcribe the order from the record to the MAR. The nurse is responsible to check the order and make sure it is completed (on the MAR or treatment sheet). LPN-A stated R61's blood pressure should have been checked every morning before the medication was given, but it was not. The physician examined the R61 on 10/21/13. Review of the physician note from 10/21/13 revealed the following : " 2. Hypertension with hypotension [low blood pressure] issues. I am going to decrease her Lisinopril to 20 mg, hold her med if systolic's less than 110, diastolic less than 60."			
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide adequate space for dining in 1 of 4 dining rooms which affected 3 residents (R70,			

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F 464	Continued From page 20 R142, R143) but had the potential to affect 19 of the 122 residents that resided in the facility. Findings include: The dining room on 2 North was overly crowded. Observations for the evening meal on 10/18/13 at 5:00 p.m. revealed the 2 North dining room had seating capacity for 19 residents. In the back, against the wall were 2 tables with 4 residents at each table. Six of the residents were in wheelchairs, one had a walker and one ambulated. One resident against the side wall in a wheelchair butted up to the wall and one resident at the other side wall, who ambulated, butted up against the wall. The 2 residents in the center, one in a wheelchair the other utilizing a walker, butted up to each other. There was no room to get around the sides or in between the 2 tables. The two residents (R70, R142) in wheelchairs seated in the back against the wall, could not easily get out of the dining room as they wished. The two residents in the back waited for others to clear out before they could leave. R142 was overheard being told that she had to wait for others to finish their meal because the other residents did not wish to be moved when they were still eating. R142 waited patiently as did R70 who also had finished but could not exit the back of the table. Breakfast observation on 11/19/13, at 8:45 a.m. revealed the same over-crowding issues as observed on the evening meal on 11/18/13. Observation of breakfast on 11/20/13, at 8:00 a.m. R142 was overheard complaining about being in the back and unable to get out. Staff	F 464	F 464 It is the policy of Volunteers of America Maplewood Care Center to ensure that residents have sufficient space to accommodate dining activities. Resident # 70, # 142, # 143 were reassigned tables of their choice. The 2 North dining room was reorganized to accommodate easier access for residents, food cart was moved to inside space of dining room to create more open space for coming and going to assist in our "open" dining program. If all residents are choosing to dine at the same time, the 2nd dining room space is utilized. Polices and procedures regarding dining room space and services were reviewed and revised if indicated. Nursing staff were educated on these policies and procedures to ensure a safe and pleasant dining experience for the residents. Random audits and observations of the 2N dining room will be conducted weekly for three months. The results of this monitoring will be reported to the facility QA Committee monthly for three months. Upon this review, revisions and/or staff education will be implemented if indicated. Director of Nursing Services and/or designee will be responsible for maintaining compliance. Completion date for certification purposes only. ~~1-6-14~~ 12/31/13	

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F 464	Continued From page 21 offered her more to drink as she patiently waited. At 8:10 a.m. R143 was observed coming out of the dining room after consuming only a piece of toast and juice. She was overheard complaining to dietary and nursing staff present how everyone keeps bumping into her. She stated, "It is too crowded." The licensed social worker (LSW)-A responded, "Sometimes it does get crowded." At 8:31 a.m. R143 returned to the area for her medications. She was asked if she had eaten and R143 responded, "No, I did not." She responded, "Who wants to go back in that room (pointing to the dining room) with everyone bumping into you?" She agreed to go into the smaller dining room next door which was not being utilized for breakfast. On 11/20/13, at 8:45 a.m. dietician (D)-A was interviewed and indicated the 2nd small dining room (DR) was not used at breakfast as people come and go. He did agree that the dining room does seem to be crowded and agreed that when residents are in the back it is difficult to get them out. RN-D agreed the dining room was too crowded, making it difficult to get the residents out, especially from the back. On 11/20/13, at 9:50 a.m. there were still 2-3 residents in the DR eating breakfast and registered nurses (RN)-C an RN-E were in the DR looking at table space. They agreed, with all of the wheelchairs, it was too crowded.			

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	245276	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	11/21/2013

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Maplewood Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. FIRE SAFETY PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	It is the policy of Volunteers of America Maplewood Care Center to maintain the building in accordance to NFPA 101 Life Safety Code Standards. POC ok JB 12-19-13	

DC: 12-31-13

EXIT: 11-21-13

RECEIVED
DEC 19 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Doug Dolan	Executive Director	12-18-13

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

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MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE MAPLEWOOD, MN 55109**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building was determined to be of Type II(222) construction. It has a full basement and is fully fire sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 157 beds and had a census of 123 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:			
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2013**

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

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K 018	Continued From page 2 are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents, in these rooms only. Findings include: On facility tour between 09:00 AM and 02:00 PM on 11/21/2013, it was observed that the corridor door to the corridor door of Nursing Supplies Storage Room across from room 103 has a latch that does not operate, keeping the door from properly latching. This deficiency was verified by facility Director of Enviromental Services (TB).	K 018	K018 Door latch was replaced door noted during inspection on 11/22/13. Director of Environmental Services and/or designee will be responsible for maintaining compliance.	11-22-13
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/21/2013**

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K 029	Continued From page 3 the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect staff within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 11/21/2013, it was observed that the door to the corridor of the lower level Storage Room is not equipped with a self closing device to automatically keep the door closed. This deficiency was verified by facility Director of Enviromental Services (TB).	K 029	K029 Door closer was installed on door noted during inspection on 11/22/13. Director of Environmental Services and/or designee will be responsible for maintaining compliance.	11-22-13

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7012 3050 0001 9094 6973

December 11, 2013

Mr. Doug Dolinsky, Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, Minnesota 55109

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5276024 and H5276079

Dear Mr. Dolinsky:

The above facility was surveyed on November 18, 2013 through November 21, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5276079 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

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

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 me.

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,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124
Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File