DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 16, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 14, 2020, we notified you a remedy was imposed. On December 14, 2020 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of November 27, 2020.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective November 13, 2020 be discontinued as of November 27, 2020. (42 CFR 488.417 (b))

However, as we notified you in our letter of October 14, 2020, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 13, 2020. This does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 16, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: Reinspection Results
Event ID: S53O12

Dear Administrator:

On December 14, 2020 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 6, 2020. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
November 23, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: October 2, 2020

Dear Administrator:

On October 14, 2020, we informed you of imposed enforcement remedies.

On November 6, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective November 13, 2020, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective November 13, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective November 13, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of October 14, 2020, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 13, 2020. However, due to the extended survey the new NATCEP loss date is November 13, 2020.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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).

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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

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

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 April 2, 2021 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.

Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at:
https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at:
https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	C 11/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On November 5 and 6, 2020, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found NOT to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED: H5276183C and H5276184C, with a deficiency cited at F580. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial	F 000		
F 580 SS=G	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial	F 580		

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

Electronically Signed | 11/25/2020

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 580	Continued From page 1 status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 580	F580	

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F 580	Continued From page 2 review, the facility failed to notify physician and responsible party of refusal of medications for 2 of 3 residents (R1, R2) reviewed for significant change in condition. R1 sustained actual harm after missing 19 of 25 doses of Haldol and was hospitalized for agitation. Findings include: R1's admission Minimum Data Set (MDS) dated 10/13/20, identified R1 had indicated it was "Very Important" to have family or a close friend to be involved in discussions about his cares. In addition, the admission MDS dated 10/13/20, identified R1 was cognitively intact, was not depressed and was not experiencing hallucinations, delusions or behaviors including, R1 was not refusing medications. R1's MDS indicated R1's guardian did not participate in the assessment process. R1's psychoactive medication care plan dated 10/7/20, identified R1 received antipsychotic medication for schizoaffective disorder bipolar type (a mental health disorder including hallucinations or delusions, mania and major depression) and instructed staff to monitor and document target behaviors/symptoms and evaluate for causes and contributing factors. R1's care plan dated 10/9/20, indicated R1 was oriented to person, place and time and desired facility staff to involve/family/responsible party in decision making. Care plan did not identify R1 had a guardian. Facility Order Listing report dated 11/2/20, indicated R1 had an order dated 10/7/20, for Haloperidol (Haldol) with instructions to give 15 milligrams (mg) by mouth at bedtime for	F 580	1. R 1 has discharged. R2 has received his psychotherapeutic medications. 2. Under the direction of the Director of Nursing all other residents who receive psychotherapeutic medications were reviewed to ensure they were given as ordered and provider and family notified of any issues. 3. The Director of Nursing has reviewed the facility policy for Medication Administration and Change of Condition. Nurse involved in resident #2 has been reeducated on medication administration and competencies completed. Education on assisting with medications, psychotropic medication use in long term care, medication administration, avoiding common errors and VOA change of condition (which includes notification to provider and family) was provided to licensed nursing staff starting on 11/6/2020. 4. Observational audits on residents receiving medications and provider and family notification will be conducted on all residents daily x 1 week, three times weekly x 2 weeks, weekly for 2 months. Results will be reviewed by QAPI and frequency determined after that review. 5. DON or designee responsible for compliance. Date of alleged compliance 11/27/20	

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schizoaffective disorder bipolar type.

R1's October 2020, Medication Administration Record (MAR) printed 11/5/20, identified R1 refused 19 of 25 doses of Haldol between 10/7/20, and 10/31/20.

Incident report dated 11/2/20, identified R1 had been refusing Haldol since admission on 10/7/20, and had only taken it twice in the previous month. Report indicated R1 had been hospitalized on 11/1/20, due to behaviors. Incident report indicated no notifications

R1's Clinical Resident Profile printed 11/6/20, indicated R1 had a guardian.

Review of Order Appointing Successor Guardian dated 5/11/20, indicated R1 was a protected person and that "The Ward [R1] remains an incapacitated person in need of assistance. The Ward lacks sufficient understanding to make or communicate responsible decisions." Guardianship order did not contain a specific order requiring R1 to take medications.

Late Entry Progress Note (PN) dated 11/1/20, indicated that at approximately 8 a.m., R1 became increasingly more agitated when licensed practical nurse (LPN)-A was unable to locate a specific lotion and was not able to be redirected. When LPN-A brought R1's medication, R1 refused medications and yelled at LPN-A to get "that slop" referring to the breakfast tray away. R1 became more agitated when LPN-A asked if she could get something different. The progress note indicated R1 stated, "Get away from me you f***ing bitch". R1 then stood up from recliner and lunged at LPN-A stating, "I'm going to

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kill you". Progress note indicated 911 was called and R1 was transferred to the hospital.

Review of progress notes (PN) from 10/7/20 until 11/2/20, revealed an increase in refusal of Haldol, delusions and escalating behaviors without clear communication of changes to medical provider or guardian.
Progress note dated 10/13/20, indicated R1 had refused Haldol and been up all night waiting for a car to arrive from Germany.
R1's PN dated 10/15/20, indicated R1 stated he had not slept well for the last few nights, because his platoon leader has told him to watch for this car to be delivered from Germany. R1 was checking the parking lot frequently for the car.
R1's PN dated 10/16/20, indicated R1 stated it was causing tremors.
R1's PN, dated 10/17/20, indicated R1 refused his evening medications. Registered nurse (RN)-A wrote a note regarding medication refusal in the facility communication book for the nurse practitioner.
R1's PN dated 10/19/20, indicated social worker (SW)-B spoke with R1's guardian regarding mail R1 had received. R1's guardian gave permission for R1 to have his expired ID card. The PN lacked documentation that SW-B informed R1's guardian that he was refusing medications or stating he had a car coming from Germany.
R1's Care Conference Summary dated 10/27/20, indicated, nursing staff had discussed R1's medications, and indicated there were no nursing concerns. R1's refusal of medications was not addressed. Guardian was not notified of missed medications or behaviors.
R1's PN, dated 10/28/20, indicated the SW-A spoke with R1's Veterans Administration social worker, guardian and foster home staff, regarding

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upcoming discharge back to foster home. There was no indication the SW-A, told them of R1's refusal Haldol or increasing behaviors.
R1's PN, dated 10/30/20, indicated R1 refused all evening medications, throwing them on the floor and stepping on them. There was no documentation of notifying medical provider or guardian of R1's actions.
R1's PN, dated 10/31/20, at 1:33 p.m. the on call nurse practitioner (NP-A) was informed resident had refused his morning medications and was hanging out by the door. The progress note did not indicate if NP-A was informed of total number of missed doses and what medications were missed. NP-A instructed the nurse to reoffer the medications after R1 had eaten.
R1's PN, dated 10/31/20 at 6:06 p.m. indicated R1 ordered RN-A out of his room, refusing his medications and blood sugar checks. The progress note also indicated R1 was constantly pacing.

TCU (transitional care unit) Health East Communication Log (communication book for TCU staff to leave messages for NP-B) entry dated 10/17/20, indicated R1 had refused all medications except insulin and lactaid for two day shifts stating they were making him crazy and tremor. Nurse Practitioner-B wrote back to the TCU nursing staff, "Not our Pt [patient]".

TCU Health East Communication Log entry dated 10/19/20, regarding R1 indicated, staff had explained to R1 he needed to take medications and requested Haldol be discontinued or change to as needed because R1 did not like how it made him feel. NP-B wrote back to the TCU nursing staff, "Not our Pt"

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During interview on 11/5/20, at 1:55 p.m. the director of nurses (DON) stated the staff had left a message in NP-B book twice instead of in NP-C's book. The DON stated NP-B just crossed out the information and wrote not our patient. During a follow up interview at 2:31 p.m., the DON stated the communication books were to be used for non life threatening issues. The DON stated staff assumed information put in the book was taken care of, but that there had been no system in place to ensure follow up had occurred.

During interview on 11/5/20, at 3:03 pm RN-B, evening supervisor, stated residents have right to refuse medications. RN-B stated after three refusals, staff were to inform the doctor. If the medication was a high risk medication or resident was displaying a change in behaviors, the doctor should be immediately notified. RN-B stated he had never used the communication book, and would not use it for medication refusals.

During interview on 11/5/20, at 3:11 p.m. RN-C stated she had noticed a significant change in R1. She was not his normal nurse but he liked to stop and talk with her. RN-C stated she had overheard R1 was refusing meds. RN-C stated she told one of the night nurses that R1 seemed to be getting more and more delirious. RN-C stated if a patient refused their medication, she would call the provider or write it in the communication book. RN-C verified she did not inform R1's guardian or physician of changes in behaviors.

During interview on 11/6/20, at 9:17 a.m. VA care coordinator stated R1 was still at Regions Hospital and they were pursuing a court order for committal and a Jarvis (a court order allowing the giving of antipsychotic medications to a patient

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without their consent). She verified she had not been informed of missed medications or behaviors until the day after he was admitted to the hospital

During interview on 11/6/20, at 9:27 a.m. VA social worker (VA SW) stated the facility social worker (SW)-A initially stated R1 missed two days of medications. The VA SW stated, when the VA care coordinator looked into R1's care, she found out R1 had missed most of his Haldol during his stay. VA SW stated R1 has not had any issues in the two and a half years she had known him and had not required a Jarvis order during that time.

On 11/9/20 at 9:33 a.m., NP-C returned phone call and verified facility had not told her R1 had been refusing Haldol for the majority of his stay. NP-C was surprised to learn R1 had refused more than 10 dose. RN-C stated no one at facility told her. NP-C stated she saw R1 once on 10/15/20, and at that time, she was not aware of missed medications or behaviors. NP-C stated she would have expected to be notified in person or by phone of a patient on Haldol refusing medication, because that would have been a significant medication concern that would cause the patient to suffer a mental collapse. NP-C verified NP-B was not R1's medical provider.

During interview on 11/6/20, at 9:38 a.m. R1's guardian stated R1 was in Regions Hospital, trying to be stabilized. R1's guardian said, "This was a big setback for [R1], "it took them 20 years to get him stable and one month at Maplewood to destabilize him." R1's guardian indicated no one told her R1 was refusing medication. Guardian stated she expected to be called the first time R1 refused medications. R1's guardian stated she

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	245276	A. BUILDING _____ B. WING _____	C 11/06/2020

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 580	Continued From page 8	F 580		

was not notified he was hospitalized until the next day. Guardian stated R1 was not able to make his own decisions.

R2

R2's significant change MDS dated 9/16/20, indicated diagnoses of dementia, and major depression with psychotic features. The MDS indicated R2 was unaware of season, staff faces, location of room or that he was in a nursing home. R2 has no indicators of depression but refused cares four to six days during the seven-day observation period. R2 required assistance with all ADLS including eating. MDS indicated R2 was on hospice.

R2's sleep care plan dated 1/2/20, instructed staff to encourage activities during day. R2's psychotropic medication care plan dated 1/2/20, instructed staff to evaluate medical cause for changes in behavior, mood or anxiety level prior to use of or dose change for psychoactive medication, monitor for adverse effects of medication and report symptoms to medical provider. R2's mood care plan dated 9/11/20, indicated R2 was experiencing alteration in feelings of well being related to depression and R2 had expressed having thoughts of being better off dead. R2's care plan indicated he was on hospice.

R2, was observed on 11/5/20, at 11:54 a.m. to be sitting in the day room, awake, appearing to be watching television.

An Incident report dated 11/2/20, indicated R2 had missed antidepressant and antipsychotic medications seven times in the month of October

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due to R2 being asleep. Staff notified nurse practitioner and family of the incident on 11/3/20 at 9:00 a.m.

R2's October 2020, Medication Administration Record (MAR) indicated R2 had an order for olanzapine 2.5 mg one time a day for severe major depressive disorder with psychotic features, dated 8/27/20. R2 also had an order for Venlafaxine HCL ER extended release 150 mg one time a day for major depressive disorder. Review of the October MAR indicated R2 did not receive his daily olanzapine or Venlafaxine HCL ER on 10/6, 10/12, 10/13 10/15, 10/18, 10/27, and 10/29/2020 because he was asleep.

During interview on 11/5/20, RN-D stated R2 was very hard to awaken. RN-D stated if R2 was sleeping she did not give him any medications. If R2 awoke more than an hour after the scheduled time for the medication, she did not offer it. RN-D stated she felt it would not be right to give a sedative to someone who was sleeping so soundly. RN-D stated she did not inform nurse practitioner, physician, hospice or family that she held R2's medications because he was sleeping.

During interview on 11/5/20, at 2:23 p.m. the DON stated R2's medications were once a day medications, they could have been given later that day. The DON stated stopping those medications suddenly could have caused problems for the patient. The DON stated once issue was identified during audit notifications were completed. Verified the nurse had not notified anyone. The DON stated R2 was examined and nurse practitioner stated he suffered no harm.

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F 580	Continued From page 10 During interview on 11/9/20, at 1:20 p.m. NP-B stated she expected to be informed if a patient was not receiving medications due to not being able to awakened multiple days in a row.	F 580		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
November 23, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: S53O11

Dear Administrator:

The above facility was surveyed on November 5, 2020 through November 6, 2020 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact:

Susanne Reuss, Unit Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Office: (651) 201-3793

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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On November 1 and 2, 2020, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000		

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

Electronically Signed | 11/25/20

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2 000	Continued From page 1 The following complaints were found to be SUBSTANTIATED: H5276183C and H5276184C with a licensing order issued at S0265. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.	2 000		
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the	2 265		11/27/20

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2 265	Continued From page 2 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify physician and responsible party of refusal of medications for 2 of 3 residents (R1, R2) reviewed for significant change in condition. R1 sustained actual harm after missing 19 of 25 doses of Haldol and was hospitalized for agitation. Findings include: R1's admission Minimum Data Set (MDS) dated 10/13/20, identified R1 had indicated it was "Very Important" to have family or a close friend to be involved in discussions about his cares. In addition, the admission MDS dated 10/13/20, identified R1 was cognitively intact, was not depressed and was not experiencing hallucinations, delusions or behaviors including, R1 was not refusing medications. R1's MDS indicated R1's guardian did not participate in the assessment process. R1's psychoactive medication care plan dated 10/7/20, identified R1 received antipsychotic medication for schizoaffective disorder bipolar type (a mental health disorder including hallucinations or delusions, mania and major depression) and instructed staff to monitor and document target behaviors/symptoms and evaluate for causes and contributing factors. R1's care plan dated 10/9/20, indicated R1 was oriented to person, place and time and desired facility staff to involve/family/responsible party in	2 265	Corrected	

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2 265	Continued From page 3 decision making. Care plan did not identify R1 had a guardian. Facility Order Listing report dated 11/2/20, indicated R1 had an order dated 10/7/20, for Haloperidol (Haldol) with instructions to give 15 milligrams (mg) by mouth at bedtime for schizoaffective disorder bipolar type. R1's October 2020, Medication Administration Record (MAR) printed 11/5/20, identified R1 refused 19 of 25 doses of Haldol between 10/7/20, and 10/31/20. Incident report dated 11/2/20, identified R1 had been refusing Haldol since admission on 10/7/20, and had only taken it twice in the previous month. Report indicated R1 had been hospitalized on 11/1/20, due to behaviors. Incident report indicated no notifications R1's Clinical Resident Profile printed 11/6/20, indicated R1 had a guardian. Review of Order Appointing Successor Guardian dated 5/11/20, indicated R1 was a protected person and that "The Ward [R1] remains an incapacitated person in need of assistance. The Ward lacks sufficient understanding to make or communicate responsible decisions." Guardianship order did not contain a specific order requiring R1 to take medications. Late Entry Progress Note (PN) dated 11/1/20, indicated that at approximately 8 a.m., R1 became increasingly more agitated when licensed practical nurse (LPN)-A was unable to locate a specific lotion and was not able to be redirected. When LPN-A brought R1's medication, R1 refused medications and yelled at	2 265		

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2 265	Continued From page 4 LPN-A to get "that slop" referring to the breakfast tray away. R1 became more agitated when LPN-A asked if she could get something different. The progress note indicated R1 stated, "Get away from me you f***ing bitch." R1 then stood up from recliner and lunged at LPN-A stating, "I'm going to kill you". Progress note indicated 911 was called and R1 was transferred to the hospital. Review of progress notes (PN) from 10/7/20 until 11/2/20, revealed an increase in refusal of Haldol, delusions and escalating behaviors without clear communication of changes to medical provider or guardian. Progress note dated 10/13/20, indicated R1 had refused Haldol and been up all night waiting for a car to arrive from Germany. R1's PN dated 10/15/20, indicated R1 stated he had not slept well for the last few nights, because his platoon leader has told him to watch for this car to be delivered from Germany. R1 was checking the parking lot frequently for the car. R1's PN dated 10/16/20, indicated R1 stated it was causing tremors. R1's PN, dated 10/17/20, indicated R1 refused his evening medications. Registered nurse (RN)-A wrote a note regarding medication refusal in the facility communication book for the nurse practitioner. R1's PN dated 10/19/20, indicated social worker (SW)-B spoke with R1's guardian regarding mail R1 had received. R1's guardian gave permission for R1 to have his expired ID card. The PN lacked documentation that SW-B informed R1's guardian that he was refusing medications or stating he had a car coming from Germany. R1's Care Conference Summary dated 10/27/20, indicated, nursing staff had discussed R1's medications, and indicated there were no nursing	2 265		

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2 265	Continued From page 5	2 265		

concerns. R1's refusal of medications was not addressed. Guardian was not notified of missed medications or behaviors.
R1's PN, dated 10/28/20, indicated the SW-A spoke with R1's Veterans Administration social worker, guardian and foster home staff, regarding upcoming discharge back to foster home. There was no indication the SW-A, told them of R1's refusal Haldol or increasing behaviors.
R1's PN, dated 10/30/20, indicated R1 refused all evening medications, throwing them on the floor and stepping on them. There was no documentation of notifying medical provider or guardian of R1's actions.
R1's PN, dated 10/31/20, at 1:33 p.m. the on call nurse practitioner (NP-A) was informed resident had refused his morning medications and was hanging out by the door. The progress note did not indicate if NP-A was informed of total number of missed doses and what medications were missed. NP-A instructed the nurse to re-offer the medications after R1 had eaten.
R1's PN, dated 10/31/20 at 6:06 p.m. indicated R1 ordered RN-A out of his room, refusing his medications and blood sugar checks. The progress note also indicated R1 was constantly pacing.

TCU (transitional care unit) Health East Communication Log (communication book for TCU staff to leave messages for NP-B) entry dated 10/17/20, indicated R1 had refused all medications except insulin and lactaid for two day shifts stating they were making him crazy and tremor. Nurse Practitioner-B wrote back to the TCU nursing staff, "Not our Pt [patient]".

TCU Health East Communication Log entry dated 10/19/20, regarding R1 indicated, staff had explained to R1 he needed to take medications

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2 265	Continued From page 6	2 265		

and requested Haldol be discontinued or change to as needed because R1 did not like how it made him feel. NP-B wrote back to the TCU nursing staff, "Not our Pt"

During interview on 11/5/20, at 1:55 p.m. the director of nurses (DON) stated the staff had left a message in NP-B book twice instead of in NP-C's book. The DON stated NP-B just crossed out the information and wrote not our patient. During a follow up interview at 2:31 p.m., the DON stated the communication books were to be used for non life threatening issues. The DON stated staff assumed information put in the book was taken care of, but that there had been no system in place to ensure follow up had occurred.

During interview on 11/5/20, at 3:03 pm RN-B, evening supervisor, stated residents have right to refuse medications. RN-B stated after three refusals, staff were to inform the doctor. If the medication was a high risk medication or resident was displaying a change in behaviors, the doctor should be immediately notified. RN-B stated he had never used the communication book, and would not use it for medication refusals.

During interview on 11/5/20, at 3:11 p.m. RN-C stated she had noticed a significant change in R1. She was not his normal nurse but he liked to stop and talk with her. RN-C stated she had overheard R1 was refusing meds. RN-C stated she told one of the night nurses that R1 seemed to be getting more and more delirious. RN-C stated if a patient refused their medication, she would call the provider or write it in the communication book. RN-C verified she did not inform R1's guardian or physician of changes in behaviors.

During interview on 11/6/20, at 9:17 a.m. VA care

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2 265	Continued From page 7	2 265		

coordinator stated R1 was still at Regions Hospital and they were pursuing a court order for committal and a Jarvis (a court order allowing the giving of antipsychotic medications to a patient without their consent). She verified she had not been informed of missed medications or behaviors until the day after he was admitted to the hospital

During interview on 11/6/20, at 9:27 a.m. VA social worker (VA SW) stated the facility social worker (SW)-A initially stated R1 missed two days of medications. The VA SW stated, when the VA care coordinator looked into R1's care, she found out R1 had missed most of his Haldol during his stay. VA SW stated R1 has not had any issues in the two and a half years she had known him and had not required a Jarvis order during that time.

On 11/9/20 at 9:33 a.m., NP-C returned phone call and verified facility had not told her R1 had been refusing Haldol for the majority of his stay. NP-C was surprised to learn R1 had refused more than 10 dose. RN-C stated no one at facility told her. NP-C stated she saw R1 once on 10/15/20, and at that time, she was not aware of missed medications or behaviors. NP-C stated she would have expected to be notified in person or by phone of a patient on Haldol refusing medication, because that would have been a significant medication concern that would cause the patient to suffer a mental collapse. NP-C verified NP-B was not R1's medical provider.

During interview on 11/6/20, at 9:38 a.m. R1's guardian stated R1 was in Regions Hospital, trying to be stabilized. R1's guardian said, "This was a big setback for [R1], "it took them 20 years to get him stable and one month at Maplewood to destabilize him." R1's guardian indicated no one

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	00520	A. BUILDING: _____ B. WING _____	C 11/06/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 265	Continued From page 8	2 265		

told her R1 was refusing medication. Guardian stated she expected to be called the first time R1 refused medications. R1's guardian stated she was not notified he was hospitalized until the next day. Guardian stated R1 was not able to make his own decisions.

R2

R2's significant change MDS dated 9/16/20, indicated diagnoses of dementia, and major depression with psychotic features. The MDS indicated R2 was unaware of season, staff faces, location of room or that he was in a nursing home. R2 has no indicators of depression but refused cares four to six days during the seven-day observation period. R2 required assistance with all ADLS including eating. MDS indicated R2 was on hospice.

R2's sleep care plan dated 1/2/20, instructed staff to encourage activities during day. R2's psychotropic medication care plan dated 1/2/20, instructed staff to evaluate medical cause for changes in behavior, mood or anxiety level prior to use of or dose change for psychoactive medication, monitor for adverse effects of medication and report symptoms to medical provider. R2's mood care plan dated 9/11/20, indicated R2 was experiencing alteration in feelings of well being related to depression and R2 had expressed having thoughts of being better off dead. R2's care plan indicated he was on hospice.

R2, was observed on 11/5/20, at 11:54 a.m. to be sitting in the day room, awake, appearing to be watching television.

An Incident report dated 11/2/20, indicated R2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 9	2 265		

had missed antidepressant and antipsychotic medications seven times in the month of October due to R2 being asleep. Staff notified nurse practitioner and family of the incident on 11/3/20 at 9:00 a.m.

R2's October 2020, Medication Administration Record (MAR) indicated R2 had an order for olanzapine 2.5 mg one time a day for severe major depressive disorder with psychotic features, dated 8/27/20. R2 also had an order for Venlafaxine HCL ER extended release 150 mg one time a day for major depressive disorder. Review of the October MAR indicated R2 did not receive his daily olanzapine or Venlafaxine HCL ER on 10/6, 10/12, 10/13 10/15, 10/18, 10/27, and 10/29/2020 because he was asleep.

During interview on 11/5/20, RN-D stated R2 was very hard to awaken. RN-D stated if R2 was sleeping she did not give him any medications. If R2 awoke more than an hour after the scheduled time for the medication, she did not offer it. RN-D stated she felt it would not be right to give a sedative to someone who was sleeping so soundly. RN-D stated she did not inform nurse practitioner, physician, hospice or family that she held R2's medications because he was sleeping.

During interview on 11/5/20, at 2:23 p.m. the DON stated R2's medications were once a day medications, they could have been given later that day. The DON stated stopping those medications suddenly could have caused problems for the patient. The DON stated once issue was identified during audit notifications were completed. Verified the nurse had not notified anyone. The DON stated R2 was examined and nurse practitioner stated he suffered no harm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 10 During interview on 11/9/20, at 1:20 p.m. NP-B stated she expected to be informed if a patient was not receiving medications due to not being able to awakened multiple days in a row. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to notification of responsible party and medical provider for missed medications and educate staff on these requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		