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

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: Reinspection Results
Event ID: QUNG12

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 18, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 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 18, 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 constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), 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.

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 11/18/2020

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 11/18/20 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 UNSUBSTANTIATED: H5276185C and H5276188C. The following complaint was found to be SUBSTANTIATED: H5276187C, with with no deficiencies cited. The following complaint was found to be SUBSTANTIATED: H5276186C, 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 compliance with the regulations has been attained in accordance with your verification.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes.	F 580		12/9/20

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

Electronically Signed | 12/04/2020

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 (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 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)	F 580		

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F 580	Continued From page 2 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 interview and document review, the facility failed to report a significant change of condition to the physician (MD), emergency medical services (EMS), and the resident's representative in a timely manner for 1 of 4 residents (R2) reviewed for a change in condition. Findings include: R2's quarterly minimum data set (MDS), dated 8/24/20, indicated R2 had moderate cognitive impairment and required 1 person physical assist for most activities of daily living (ADLs). R2's diagnoses included COVID-19, essential (primary) hypertension, presence of cardia pacemaker, and chronic kidney disease stage 3A. When interviewed on 11/18/20, at 11:31 a.m. Nursing assistant (NA)-A reported on the morning of 11/9/20 she had gone into R2's room to check on his roommate and noted R2 was asleep around 6:15 a.m. or 6:30 a.m. At around 7:30 a.m. NA-A went to check on R2 and noticed the bathroom light was on and R2 was sitting on the toilet, attempting to change his incontinence products, with which he is usually independent and looked confused, unsteady and was "talking garbled". NA-A assisted R2 in dressing, then went	F 580	F0580 It is the policy of Maplewood Care Center to follow all Federal, State, and local guidelines, laws, regulations and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility administrator, employees, agents, or other individuals. The response to the alleged deficient practice cited in this statement of deficiencies does not constitute agreement with citations. The preparation, submission and implementation of this plan of correction will serve as our credible allegation of compliance. 1. R1 has discharged. 2. All residents who have a change in condition have a potential to be affected. All residents' charts were reviewed during a whole house chart audit with no change of condition findings noted. 3. Whole house charts have been reviewed and any change of condition was followed up with the appropriate notification. The change in conditions/notification policy and procedure was reviewed and revised as	

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F 580	Continued From page 3 and asked RN-A if she had been in with R2 yet and informed RN-A "there is something not right with him." RN-A went in and assessed R2 "right away" but there was no nurse manager on the floor to report this to. NA-A reported she believed RN-B usually came in to work around 8:00 a.m. however RN-B was not in yet on that day. NA-A indicated as soon as RN-B came in, RN-A went in and reported it to RN-B. NA-A reported her next interaction with R2 occurred when she went into R2's room to help him get ready to go to the hospital and R2's family was on a live video call on R2's tablet that was sitting in his lap. R2's daughter directed NA-A to make sure to send the tablet to the hospital with R2. When interviewed on 11/18/20, at 11:52 a.m. RN-A indicated she had started completing her morning blood sugars on residents and took the blood sugar for R2's roommate at about 6:00 a.m. or 6:30 a.m. and noted that R2 was still sleeping at that time. RN-A then went to receive report from night shift and began her cares. At about 7:30 a.m. nursing assistant (NA)-A came to inform RN-A that she tried to help R2 with some care and he couldn't get up. RN-A informed NA-A that once she was finished punching medications, she would come check on R2. RN-A assessed R2, called his name, asked him to grip RN-A's hand and he could not grip hard. RN-A asked R2 to smile and he could not smile well and then asked if he knew his name or where he was. He had slurred speech and was confused. RN-A took R2's vitals and checked on him several more times and then told RN-B when she arrived. RN-B instructed RN-A to call the NP. RN-A was unable to reach the NP and left a voicemail and continued to check on R2 "every like 15 or 10 minutes" while communicating with RN-B. RN-B	F 580	appropriate. Education on change of condition, appropriate notification, and signs and symptoms of stroke was provided to licensed nursing staff and completed by December 9, 2020. 4. All residents identified with a change in condition will be audited for proper notification 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 December 9, 2020.	

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F 580	Continued From page 4	F 580		

then went to assess R2 herself, then went to call the NP again. By the time RN-A came back to check on R2 again, he had called his daughter and son-in-law via a FaceTime call. The family asked RN-A how R2 had been over the past 2 days. RN-A informed to the best of her knowledge R2 was ok, but RN-A had just come in that morning and had not worked the weekend. Per the report RN-A received from the night shift, R2 was "fine." Per RN-A the family decided to call 911. RN-B came into R2's room right after and said she got ahold of the NP and the facility was also calling 911. RN-A verified the expectation when there is a change in condition involved completing an assessment, notifying the nurse practitioner (NP) or physician (MD) and if an emergency to call 911. RN-A confirmed the NP was not called or notified of R2's change in condition until RN-B got into work after 9:00 a.m.

When interviewed on 11/18/20, at 12:01 p.m. RN-B informed on the morning of 11/9/20 she had come in at 9:00 a.m. and at about 9:15 a.m. RN-A approached RN-B and informed that R2 "had something going on." RN-B instructed RN-A to call the NP right away, then went in to see R2 immediately. When RN-B entered the room, R2 was already on video chat with his family. RN-B confirmed R2's speech was "not right" and stated she did not do an in-depth strength test as R2's family wanted 911 called. RN-B went to DON and informed the DON they would call 911 and placed the call to 911 to get R2 sent out. RN-B confirmed RN-A had not called RN-B or the NP prior to RN-B coming in at 9:00 a.m. RN-B indicated she thought RN-A's first contact with R2 was around 9:15 a.m. when RN-B was notified. RN-B confirmed while waiting for the facility to take action, R2's family had also called 911. RN-B

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F 580	Continued From page 5	F 580		

indicated R2's family was "upset, maybe more stressed or worried" and "they were wondering why 911 had not already been called, but that was my first encounter with R2." RN-B verbalized her expectations for staff, who notice a change in condition for a resident, would be to call the provider right away and then me or other management. Certain critical situations the time is more important." RN-B indicated there should have been an "SBAR (Situation -Background-Assessment-Recommendation) form" completed with a detailed timeline and information on the incident. The facility was unable to produce this document. When asked why RN-A's first note was from 1:14 p.m. that day, RN-B was unsure and stated, "they should be putting the notes in as soon as things happen, or at least putting it in as a late entry so we know timelines, that is critical in at least some cases." RN-B confirmed she was the one who called 911 and gave them report. RN-B confirmed the facility "couldn't really establish a last known well time" for R2.

When interviewed on 11/18/20, at 12:56 p.m. family member (FM)-A verbalized R2 had called the family via FaceTime on his iPad around 9:00 a.m. and as soon as the video feed starting coming through, "we instantly knew he was having a stroke." FM-A indicated the family immediately called the facility and were told somebody would be in to check on R2. The family remained on FaceTime with R2 and did not see staff enter the room to check on R2 and they called the facility again. The facility informed the family staff had already checked on R2 and they were trying to call R2's doctor. Per FM-A, while on FaceTime, R2's face was drooping, a staff came in and spoke with family and stated they thought

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F 580	Continued From page 6	F 580		

R2 "was just sad." R2's family then stated they were going to call 911. When FM-A made the call to Ramsey County EMS, they were informed another call had just come in after theirs from the facility.

When interviewed on 11/18/20, at 2:08 p.m. the DON verbalized her expectation when there is a change in condition and stated, "Aids should notify the RN and the RN is capable to call the NP. If the RN noticed a change, they notify the RN manager right away and then the RN manager would come in to do an assessment and call the NP. If the RN manager is not on site at the time the RN noticed a change, the RN should call the NP or on-call manager themselves."

R1's document review of interdisciplinary progress notes (IPN) dated 11/9/20, at 9:52 a.m. created by registered nurse (RN)-B indicated, "Call placed to emergency contact #1 to update regarding resident being sent to hospital."

R1's IPN dated 11/9/20, at 10:09 a.m. created by RN-B indicated, "Writer updated [emergency contact #1] that his dad had been taken to St John's hospital to be assessed and evaluated. [emergency contact #1] has no questions at this time."

R1's IPN dated 11/9/20, at 1:14 p.m. created by RN-A indicated, "Writer became aware that resident could not utter words clearly this morning after getting up and seemed weak. Writer assessed resident, took vitals to give report to clinical manager who called in ambulance for him."

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Review of the Prehospital Care Report Summary from Maplewood Emergency Medical Services (EMS), dated 11/9/20, indicated the 911 call was received at 9:33 a.m. and stated "Family of the patient are the calling party." EMS report further indicated the staff at the care facility advised that the patient seemed more confused this morning. They also note that the patient has been weaker today. The family relates that the patient is normally alert, oriented, without slurred speech or general weakness. They advise that they are able to tell the patient is not his baseline. Staff relate that one of the staff members did a check last night and noted that the patient was at his baseline; however, they are unable to relate what time exactly the patient was last normal. EMS treated and transported a 92 year old male who has a possible CVA (stoke). The patient is transported lights and siren due to CVA symptoms. EMS report then stated, "No stroke code is called because there is not a clear last seen normal time. Extended stroke is requested due to onset of symptoms being within 24 hours according to staff."

Review of physician notes from M Health Fairview St. Josephs, dated 11/9/20, indicated, "TPA not given contraindication bedtime." (Tissue plasminogen activator "TPA" is a thrombolytic a "clot-busting" drug to break up blood clots)

Review of physician notes from M Health Fairview St. Josephs, dated 11/10/20, indicated, "Patient not a candidate for TPA given the time course."

Review of pharmacy notes from M Health Fairview St. Josephs, date 11/10/20, indicated, "TPA was not given because of Time from onset contraindications."

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Review of neurology notes from M Health Fairview Neurology, dated 11/10/20, indicated R2 had a diagnosis of acute ischemic stroke with left-sided facial weakness, slurred speech, Carotid stenosis, severe on the left and moderate on right. Neurology notes further indicated, "No TPA given due to time factor."

Review of neurology notes from M Health Fairview St. Josephs, encounter date 11/11/20, indicated, "He was not a candidate for TPA due to time of onset contraindication."

Per Centers for Disease Control and Prevention (CDC) document titled Stroke Signs and Symptoms reviewed 8/28/20, indicated, Acting F.A.S.T. can help stroke patients get the treatments they desperately need. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms. Stroke patients may not be eligible for these if they don't arrive at the hospital in time. Note the time when any symptoms first appear. This information helps health care providers determine the best treatment for each person. If you think someone may be having a stroke, act F.A.S.T. and do the following simple test:
F-Face: Ask the person to smile. Does one side of the face droop?
A-Arms: Ask the person to raise both arms. Does one arm drift downward?
S-Speech: Ask the person to repeat a simple phrase. Is the speech slurred or strange?
T-Time: If you see any of these signs, call 9-1-1 right away.

Per Centers for Disease Control and Prevention

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(CDC) document titled Stroke Treatment, reviewed 11/14/19, "If you get to the hospital within 3 hours of the first symptoms of an ischemic stroke, you may get a type of medicine called a thrombolytic (a "clot-busting" drug) to break up blood clots. Tissue plasminogen activator (tPA) is a thrombolytic. tPA improves the chances of recovering from a stroke. Studies show that patients with ischemic strokes who receive tPA are more likely to recover fully or have less disability than patients who do not receive the drug. 2, 3 Patients treated with tPA are also less likely to need long-term care in a nursing home. 4 Unfortunately, many stroke victims don't get to the hospital in time for tPA treatment. This is why it's so important to recognize the signs and symptoms of stroke right away and call 9-1-1."

Review of facility policy titled Notification of Changes, revised 12/16, indicated immediate notification of the resident; consult with the resident's physician, notification of the resident representative is to be done in the following situations:
"a significant change in the resident's physical, mental, or psychosocial status including a deterioration in the health, mental, cognition, medication change, or psychosocial status in either life-threatening conditions or clinical complications."

Review of facility policy titled Change of Condition Protocol, reviewed 2/19, indicated the following steps should be completed upon noticing a change in condition:
1) staff complete Stop N Watch or Verbal Notification Nurse identifies a COC
2) Complete Assessment using E Interact

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F 580	Continued From page 10 COC in PCC or complete a paper Interact SBAR and scan in the paper interact SBAR into Point Click Care 3) Follow E Interact or paper Interact Care Path 4) Notification to provider and designated resident representative 5) Update care plan 6) If transfer is required, complete E Interact Transfer in PCC or paper Interact Transfer Form is completed and scanned into point click care	F 580		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 3, 2020

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: QUNG11

Dear Administrator:

The above facility was surveyed on November 18, 2020 through November 18, 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 11/18/20, 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		

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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H5276185C and H5276188C. The following complaint was found to be SUBSTANTIATED: H5276187C, with with no deficiencies cited. The following complaint was found to be SUBSTANTIATED: H5276186C, with a 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	2 265		12/9/20

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2 265	Continued From page 2 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 resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to report a significant change of condition to the physician (MD), emergency medical services (EMS), and the resident's representative in a timely manner for 1 of 4 residents (R2) reviewed for a change in condition. Findings include: R2's quarterly minimum data set (MDS), dated 8/24/20, indicated R2 had moderate cognitive impairment and required 1 person physical assist for most activities of daily living (ADLs). R2's diagnoses included COVID-19, essential (primary) hypertension, presence of cardia pacemaker, and chronic kidney disease stage 3A. When interviewed on 11/18/20, at 11:31 a.m. Nursing assistant (NA)-A reported on the morning of 11/9/20 she had gone into R2's room to check on his roommate and noted R2 was asleep around 6:15 a.m. or 6:30 a.m. At around 7:30	2 265	Corrected	

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a.m. NA-A went to check on R2 and noticed the bathroom light was on and R2 was sitting on the toilet, attempting to change his incontinence products, with which he is usually independent and looked confused, unsteady and was "talking garbled". NA-A assisted R2 in dressing, then went and asked RN-A if she had been in with R2 yet and informed RN-A "there is something not right with him." RN-A went in and assessed R2 "right away" but there was no nurse manager on the floor to report this to. NA-A reported she believed RN-B usually came in to work around 8:00 a.m. however RN-B was not in yet on that day. NA-A indicated as soon as RN-B came in, RN-A went in and reported it to RN-B. NA-A reported her next interaction with R2 occurred when she went into R2's room to help him get ready to go to the hospital and R2's family was on a live video call on R2's tablet that was sitting in his lap. R2's daughter directed NA-A to make sure to send the tablet to the hospital with R2.

When interviewed on 11/18/20, at 11:52 a.m. RN-A indicated she had started completing her morning blood sugars on residents and took the blood sugar for R2's roommate at about 6:00 a.m. or 6:30 a.m. and noted that R2 was still sleeping at that time. RN-A then went to receive report from night shift and began her cares. At about 7:30 a.m. nursing assistant (NA)-A came to inform RN-A that she tried to help R2 with some care and he couldn't get up. RN-A informed NA-A that once she was finished punching medications, she would come check on R2. RN-A assessed R2, called his name, asked him to grip RN-A's hand and he could not grip hard. RN-A asked R2 to smile and he could not smile well and then asked if he knew his name or where he was. He had slurred speech and was confused. RN-A took R2's vitals and checked on him several more

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times and then told RN-B when she arrived. RN-B instructed RN-A to call the NP. RN-A was unable to reach the NP and left a voicemail and continued to check on R2 "every like 15 or 10 minutes" while communicating with RN-B. RN-B then went to assess R2 herself, then went to call the NP again. By the time RN-A came back to check on R2 again, he had called his daughter and son-in-law via a FaceTime call. The family asked RN-A how R2 had been over the past 2 days. RN-A informed to the best of her knowledge R2 was ok, but RN-A had just come in that morning and had not worked the weekend. Per the report RN-A received from the night shift, R2 was "fine." Per RN-A the family decided to call 911. RN-B came into R2's room right after and said she got ahold of the NP and the facility was also calling 911. RN-A verified the expectation when there is a change in condition involved completing an assessment, notifying the nurse practitioner (NP) or physician (MD) and if an emergency to call 911. RN-A confirmed the NP was not called or notified of R2's change in condition until RN-B got into work after 9:00 a.m.

When interviewed on 11/18/20, at 12:01 p.m. RN-B informed on the morning of 11/9/20 she had come in at 9:00 a.m. and at about 9:15 a.m. RN-A approached RN-B and informed that R2 "had something going on." RN-B instructed RN-A to call the NP right away, then went in to see R2 immediately. When RN-B entered the room, R2 was already on video chat with his family. RN-B confirmed R2's speech was "not right" and stated she did not do an in-depth strength test as R2's family wanted 911 called. RN-B went to DON and informed the DON they would call 911 and placed the call to 911 to get R2 sent out. RN-B confirmed RN-A had not called RN-B or the NP prior to RN-B coming in at 9:00 a.m. RN-B indicated she

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2 265	Continued From page 5	2 265		

thought RN-A's first contact with R2 was around 9:15 a.m. when RN-B was notified. RN-B confirmed while waiting for the facility to take action, R2's family had also called 911. RN-B indicated R2's family was "upset, maybe more stressed or worried" and "they were wondering why 911 had not already been called, but that was my first encounter with R2." RN-B verbalized her expectations for staff, who notice a change in condition for a resident, would be to call the provider right away and then me or other management. Certain critical situations the time is more important." RN-B indicated there should have been an "SBAR (Situation -Background-Assessment-Recommendation) form" completed with a detailed timeline and information on the incident. The facility was unable to produce this document. When asked why RN-A's first note was from 1:14 p.m. that day, RN-B was unsure and stated, "they should be putting the notes in as soon as things happen, or at least putting it in as a late entry so we know timelines, that is critical in at least some cases." RN-B confirmed she was the one who called 911 and gave them report. RN-B confirmed the facility "couldn't really establish a last known well time" for R2.

When interviewed on 11/18/20, at 12:56 p.m. family member (FM)-A verbalized R2 had called the family via FaceTime on his iPad around 9:00 a.m. and as soon as the video feed starting coming through, "we instantly knew he was having a stroke." FM-A indicated the family immediately called the facility and were told somebody would be in to check on R2. The family remained on FaceTime with R2 and did not see staff enter the room to check on R2 and they called the facility again. The facility informed the family staff had already checked on R2 and they

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were trying to call R2's doctor. Per FM-A, while on FaceTime, R2's face was drooping, a staff came in and spoke with family and stated they thought R2 "was just sad." R2's family then stated they were going to call 911. When FM-A made the call to Ramsey County EMS, they were informed another call had just come in after theirs from the facility.

When interviewed on 11/18/20, at 2:08 p.m. the DON verbalized her expectation when there is a change in condition and stated, "Aids should notify the RN and the RN is capable to call the NP. If the RN noticed a change, they notify the RN manager right away and then the RN manager would come in to do an assessment and call the NP. If the RN manager is not on site at the time the RN noticed a change, the RN should call the NP or on-call manager themselves."

R1's document review of interdisciplinary progress notes (IPN) dated 11/9/20, at 9:52 a.m. created by registered nurse (RN)-B indicated, "Call placed to emergency contact #1 to update regarding resident being sent to hospital."

R1's IPN dated 11/9/20, at 10:09 a.m. created by RN-B indicated, "Writer updated [emergency contact #1] that his dad had been taken to St John's hospital to be assessed and evaluated. [emergency contact #1] has no questions at this time."

R1's IPN dated 11/9/20, at 1:14 p.m. created by RN-A indicated, "Writer became aware that resident could not utter words clearly this morning after getting up and seemed weak. Writer assessed resident, took vitals to give report to clinical manager who called in ambulance for

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2 265	Continued From page 7 him." Review of the Prehospital Care Report Summary from Maplewood Emergency Medical Services (EMS), dated 11/9/20, indicated the 911 call was received at 9:33 a.m. and stated "Family of the patient are the calling party." EMS report further indicated the staff at the care facility advised that the patient seemed more confused this morning. They also note that the patient has been weaker today. The family relates that the patient is normally alert, oriented, without slurred speech or general weakness. They advise that they are able to tell the patient is not his baseline. Staff relate that one of the staff members did a check last night and noted that the patient was at his baseline; however, they are unable to relate what time exactly the patient was last normal. EMS treated and transported a 92 year old male who has a possible CVA (stoke). The patient is transported lights and siren due to CVA symptoms. EMS report then stated, "No stroke code is called because there is not a clear last seen normal time. Extended stroke is requested due to onset of symptoms being within 24 hours according to staff." Review of physician notes from M Health Fairview St. Josephs, dated 11/9/20, indicated, "TPA not given contraindication bedtime." (Tissue plasminogen activator "TPA" is a thrombolytic a "clot-busting" drug to break up blood clots) Review of physician notes from M Health Fairview St. Josephs, dated 11/10/20, indicated, "Patient not a candidate for TPA given the time course." Review of pharmacy notes from M Health Fairview St. Josephs, date 11/10/20, indicated, "TPA was not given because of Time from onset	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00520	A. BUILDING: _____ B. WING _____	C 11/18/2020

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2 265	Continued From page 8 contraindications." Review of neurology notes from M Health Fairview Neurology, dated 11/10/20, indicated R2 had a diagnosis of acute ischemic stroke with left-sided facial weakness, slurred speech, Carotid stenosis, severe on the left and moderate on right. Neurology notes further indicated, "No TPA given due to time factor." Review of neurology notes from M Health Fairview St. Josephs, encounter date 11/11/20, indicated, "He was not a candidate for TPA due to time of onset contraindication." Per Centers for Disease Control and Prevention (CDC) document titled Stroke Signs and Symptoms reviewed 8/28/20, indicated, Acting F.A.S.T. can help stroke patients get the treatments they desperately need. The stroke treatments that work best are available only if the stroke is recognized and diagnosed within 3 hours of the first symptoms. Stroke patients may not be eligible for these if they don't arrive at the hospital in time. Note the time when any symptoms first appear. This information helps health care providers determine the best treatment for each person. If you think someone may be having a stroke, act F.A.S.T. and do the following simple test: F-Face: Ask the person to smile. Does one side of the face droop? A-Arms: Ask the person to raise both arms. Does one arm drift downward? S-Speech: Ask the person to repeat a simple phrase. Is the speech slurred or strange? T-Time: If you see any of these signs, call 9-1-1 right away. Per Centers for Disease Control and Prevention	2 265		

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2 265	Continued From page 9 (CDC) document titled Stroke Treatment, reviewed 11/14/19, "If you get to the hospital within 3 hours of the first symptoms of an ischemic stroke, you may get a type of medicine called a thrombolytic (a "clot-busting" drug) to break up blood clots. Tissue plasminogen activator (tPA) is a thrombolytic. tPA improves the chances of recovering from a stroke. Studies show that patients with ischemic strokes who receive tPA are more likely to recover fully or have less disability than patients who do not receive the drug. 2, 3 Patients treated with tPA are also less likely to need long-term care in a nursing home. 4 Unfortunately, many stroke victims don't get to the hospital in time for tPA treatment. This is why it's so important to recognize the signs and symptoms of stroke right away and call 9-1-1." Review of facility policy titled Notification of Changes, revised 12/16, indicated immediate notification of the resident; consult with the resident's physician, notification of the resident representative is to be done in the following situations: "a significant change in the resident's physical, mental, or psychosocial status including a deterioration in the health, mental, cognition, medication change, or psychosocial status in either life-threatening conditions or clinical complications." Review of facility policy titled Change of Condition Protocol, reviewed 2/19, indicated the following steps should be completed upon noticing a change in condition: 1) staff complete Stop N Watch or Verbal Notification Nurse identifies a COC 2) Complete Assessment using E Interact COC in PCC or complete a paper Interact SBAR	2 265		

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2 265	Continued From page 10 and scan in the paper interact SBAR into Point Click Care 3) Follow E Interact or paper Interact Care Path 4) Notification to provider and designated resident representative 5) Update care plan 6) If transfer is required, complete E Interact Transfer in PCC or paper Interact Transfer Form is completed and scanned into point click care SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop/revise and implement policies and procedures related to notifying physician and pertinent persons of significant changes in residents conditions, educate staff and monitor to assure these requirements are met. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	2 265		