DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 30, 2021

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: July 28, 2021

Dear Administrator:

On August 18, 2021, we notified you a remedy was imposed. On September 22, 2021 the Minnesota Department 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 August 31, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective October 28, 2021 did not go into effect. (42 CFR 488.417 (b))

However, as we notified you in our letter of August 18, 2021, 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 August 3, 2021. 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 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
August 17, 2021

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

RE: CCN: 245276
Cycle Start Date: July 28, 2021

Dear Administrator:

On July 28, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable 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.

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.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jamie Perell, Unit Supervisor
Metro B 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 28, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by January 28, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

INFORMAL DISPUTE RESOLUTION (IDR) / 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 electronic 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.

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

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 07/28/2021

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 7/28/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5276213C (MN75102), with a deficiency cited at F686. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		8/31/21

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

Electronically Signed | 08/19/2021

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 686	Continued From page 1 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide wound care as ordered by the physician to promote healing of pressure ulcers for 2 of 2 residents (R1, R2) who had stage four pressure ulcers. Findings include: R1's Face Sheet dated 7/21/21, indicated R1's diagnoses included paraplegia, stage four sacral pressure ulcer, unstageable pressure ulcer to the left heel, and stage two pressure ulcer to the right heel. R1's significant change Minimum Data Set (MDS) dated 6/7/21, indicated R1 had a moderate cognitive impairment. R1 required extensive assistance with bed mobility, dressing, and personal hygiene. R1 was noted to have one stage two pressure ulcer, one stage four pressure ulcer, and two stage three pressure ulcers which were not present upon admission. Treatments included applications of ointments/medications, surgical wound care, and pressure ulcer care. R1's physician orders dated 7/21/21, indicated: - Staff were to cleanse R1's sacral pressure ulcer and pack it with gauze soaked in a Dakins solution (used to prevent and treat infections). Staff were then to cover the packed wound with a non-boarded Mepilex (absorbent dressing) followed by covering the wound with a bordered 8 centimeter (cm) by 8 cm. Mepilex dressing. The dressing was to be changed twice daily.	F 686	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. POC F686 1. Nurse manager completed immediate education to RN-A and observed RN-A providing wound dressings per physician order to R1 and R2. R1 and R2 were assessed after the dressing change. Based on assessment findings, no changes to dressing change were needed for R1 and R2. 2. On 7/28/21, nurse manager reviewed all dressing changes by RN-A to ensure they were done correctly per physician orders. All residents with wounds were reviewed that the appropriate treatments per physician's orders and documentation was completed. 3. The prevention and treatment of skin	

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F 686	Continued From page 2 - Staff were to cleanse R1's right heel wound and apply a Vaseline gauze (non-adherent mesh gauze) and cover it with a 4 inch (in) by 4 in. gauze pad. Staff were then to wrap the wound with Kerlix (woven gauze) and change the dressing daily. - Staff were to apply skin prep (a liquid which forms a protective film to reduce friction) twice daily to R1's left heel. A progress note dated 7/22/21, at 2:50 p.m. indicated R1's right heel wound had copious amounts of purulent drainage with blood noted on an old dressing. The wound measured 5 cm. x 5 cm. and was macerated (soft). R1's sacral/coccyx wound had copious amounts of purulent drainage with active bleeding and measured length 11.5 cm. x 7.5 cm. x 5 cm. deep. During observation on 7/28/21, at 9:19 a.m. registered nurse (RN)-A entered R1's room to perform would care. Regional educator (RE) inquired if RN-A had all the supplies she needed. RN-A replied she did. RN-A removed a dressing from R1's sacral pressure ulcer and cleansed the wound with Derma Cleanser. The wound was observed to be a stage four pressure wound with tunneling. There was no drainage, with a red wound bed and muscle or tendon showing. The wound measured: - Tunnel - 4.5 cm. - Length 9.5 cm. - Width 11.0 cm. - Depth 7.2 cm. The wound was then packed with dry gauze. At this time, the surveyor intervened and asked RN-A to review R1's wound orders. RN-A then removed the dry gauze from R1's sacral pressure	F 686	break down policy and procedure including documentation was reviewed. Education will be provided to licensed nurses on Wound Care and documentation by 8/31/21.Wound care checklist has been added to the nurse agency orientation. 4. Wound audits will be completed by DON or designee 3x per week for 2 weeks, 2x week for 2 weeks, 1x week for 8 weeks. The trends will be reported at QAPI and the need for continued audits will be determined. 5. The Director of Nursing will be responsible for compliance. Date of Compliance 8/31/2021	

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F 686	Continued From page 3	F 686		

ulcer, reviewed a document on a clipboard, and verbalized she was unaware she first needed to soak the gauze. RN-A again repacked the wound with a dry gauze and covered the area with a sterile island dressing.

RN-A then removed the dressing from R1's right heel wounds. The wounds were observed to have odorless gray-colored and serosanguinous (clear liquid mixed with blood) drainage.
The wound measurements were:
- Back of heel wound measured: Length 6.0 cm. x Width 5.4 cm. x 0
- Bottom of heel wound measured: Length 8.0 cm. x Width 3.2 cm. x 0
Skin prep was applied to the wound and RN-A reached for a Mepilex dressing. The wound was then cleaned with Derma Cleanser after surveyor inquiry. RN-A again reached for a Mepilex dressing and the surveyor inquired if a Mepilex dressing was the same as Vaseline gauze. RN-A removed her gloves and exited R1's room at this time. RN-A returned to the room and verbalized the order read to use a Mepilex dressing and a 4 in. x 4 in. gauze pad. RN-A was asked if Mepilex was the same as Vaseline gauze and she responded she had a petroleum (Vaseline) dressing. RN-A applied the petroleum dressing to R1's right heel and wrapped it with Kerlix. RN-A did not apply the 4 in. x 4 in. gauze as identified by the physician order. RN-A then removed the dressing from R1's left heel wound and cleansed the area. RN-A applied skin prep, Mepilex, and Kerlix to the wound.

When interviewed on 7/28/21, at 10:32 a.m. RN-A stated when she did not understand the orders, she would ask for help from another nurse or nurse manager. RN-A did not know what would

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F 686	Continued From page 4	F 686		

occur if a wound was packed with dry gauze but felt it would keep a wound dry. RN-A stated she did not apply a 4 in. by 4 in. gauze to R1's right heel because it was too big, however, acknowledged there was less protection for wound and drainage could cause the wound to worsen. RN-A stated she would change R1's wound dressings once she learned they were performed incorrectly, however, was not observed to return to R1's room.

When interviewed on 7/28/21, at 12:07 p.m. RN-D stated if a large wound was packed with dry gauze, it would remove new tissue, cause bleeding, and open a wound further when removed.

When interviewed on 7/28/21, at 12:29 p.m. licensed practical nurse (LPN)-A stated if a pressure ulcer was packed with dry gauze, it would be hard to remove and cause bleeding.

When interviewed on 7/28/21, at 12:42 p.m. RN-B stated wound care orders were found on a resident's treatment administration record (TAR) and nurses should write down treatment orders prior to entering a room. RN-B stated dry gauze could adhere to a wound and cause unintentional debridement (removal of tissue). RN-B stated she expected nurses to follow wound care orders.

When interviewed on 7/28/21, at 2:24 p.m. the facility wound nurse, RN-E stated nurses were expected to follow wound care orders. RN-E stated dry gauze would adhere to a wound and could cause damage.

When interviewed on 7/28/21, at 2:24 p.m. RN-E and the director of nursing (DON) stated RN-A

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F 686	Continued From page 5	F 686		

was reeducated on wound care.

An interview was requested with R1's physician, however, contact was unable to be established.

R2's Admission Record printed 7/28/21, indicated R2's diagnoses included arteriosclerosis (narrowing of blood vessels, right foot ulceration, peripheral vascular disease, and diabetes.

R2's quarterly Minimum Data Set (MDS) dated 7/9/21, indicated R2 had severely impaired cognition and required extensive assistance with bed mobility, transfers, and personal hygiene. R2 had a stage four pressure ulcer which was present upon admission and had treatment which included application of ointments/medications other than to feet and pressure ulcer care. There were no occurrences of R2 rejecting care.

R2's July 2021 Treatment Administration Record (TAR) indicated starting 7/1/21, staff were to cleanse a wound to the heel of R1's right foot with normal saline. Staff were then to apply skin prep (protective film) to intact skin and allow the area to dry. Santyl (ointment) was then to be applied over the wound bed and covered with a gauze island dressing. The dressing was to be changed daily on dayshift. The above order was discontinued on 7/15/21. Effective on 7/15/21, staff were to cleanse R1's right heel wound with normal saline and apply skin prep to intact skin and allow to dry. Calcium alginate (absorbs fluid) was to be applied to the wound bed and covered with a gauze island dressing. The dressing was to be changed daily on dayshift.

Review of R2's July 2021 TAR revealed from 7/1/21, through 7/27/21, wound care was not

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F 686	Continued From page 6 documented on 7/5/21, 7/9/21, 7/19/21, and 7/23/21. Review of R2's medical record lacked indication wound care was refused on the above dates. During interview on 7/27/21, at 11:51 a.m. licensed practical nurse (LPN)-A stated if a resident refused care staff were expected to reapproach three times. If a resident continued to refuse care staff were expected to write a progress note to describe what was tried and why the resident refused. During an interview on 7/28/21, at 11:12 a.m. LPN-A stated R2 had daily wound care ordered which was scheduled for dayshift. If she was unable to complete wound care, she would write a progress note indicating the task was not completed and report the information to the next shift. When wound care was completed, she documented on the TAR with a check mark and her initials. If the TAR was blank, that would mean wound care was not completed. During interview on 7/28/21, at 11:26 a.m. registered nurse (RN)-B stated if a task on the TAR was not initialed or checked it was considered not completed. RN-B stated if wound care was unable to be completed during dayshift, staff were expected to report to the evening nurse to ensure completion. Wound care was expected to be done as ordered. During interview on 7/27/21, at 2:07 p.m. the director of nursing (DON) stated she was aware wound care was missed on 7/5/21, 7/9/21, 7/19/21, and 7/23/21. An explanation as to why wound care was documented was not provided.	F 686		

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F 686	Continued From page 7 The DON stated she took the matter very seriously and identified nurses' who did not complete wound care. Education would be completed with the involved nurses prior to their next scheduled shifts. R2 declined to be interviewed or to have her wound observed during the investigation. "Policy and Procedure for the Prevention and Treatment of Skin Breakdown" (revised in 2018) specified implement wound care guidelines, which are a part of the physician's orders.	F 686		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 17, 2021

Administrator
Maplewood Care Center
1900 Sherren Avenue
Maplewood, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: 7WPY11

Dear Administrator:

The above facility was surveyed on July 28, 2021 through July 28, 2021 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:

Jamie Perell, Unit Supervisor
Metro B 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: jamie.perell@state.mn.us
Office: (651) 245-8094

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

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 07/28/2021

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
2 000	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 7/28/21, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction 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 complaint was found to be SUBSTANTIATED: H5276213C (MN75102) with a licensing order issued at 0900. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. 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/ib14_1.html> The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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. 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		

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2 900	Continued From page 2	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide wound care as ordered by the physician to promote healing of pressure ulcers for 2 of 2 residents (R1, R2) who had stage four pressure ulcers. Findings include: R1's Face Sheet dated 7/21/21, indicated R1's diagnoses included paraplegia, stage four sacral pressure ulcer, unstageable pressure ulcer to the left heel, and stage two pressure ulcer to the right heel. R1's significant change Minimum Data Set (MDS) dated 6/7/21, indicated R1 had a moderate	2 900	Corrected	8/31/21

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2 900	Continued From page 3 cognitive impairment. R1 required extensive assistance with bed mobility, dressing, and personal hygiene. R1 was noted to have one stage two pressure ulcer, one stage four pressure ulcer, and two stage three pressure ulcers which were not present upon admission. Treatments included applications of ointments/medications, surgical wound care, and pressure ulcer care. R1's physician orders dated 7/21/21, indicated: - Staff were to cleanse R1's sacral pressure ulcer and pack it with gauze soaked in a Dakins solution (used to prevent and treat infections). Staff were then to cover the packed wound with a non-boarded Mepilex (absorbent dressing) followed by covering the wound with a bordered 8 centimeter (cm) by 8 cm. Mepilex dressing. The dressing was to be changed twice daily. - Staff were to cleanse R1's right heel wound and apply a Vaseline gauze (non-adherent mesh gauze) and cover it with a 4 inch (in) by 4 in. gauze pad. Staff were then to wrap the wound with Kerlix (woven gauze) and change the dressing daily. - Staff were to apply skin prep (a liquid which forms a protective film to reduce friction) twice daily to R1's left heel. A progress note dated 7/22/21, at 2:50 p.m. indicated R1's right heel wound had copious amounts of purulent drainage with blood noted on an old dressing. The wound measured 5 cm. x 5 cm. and was macerated (soft). R1's sacral/coccyx wound had copious amounts of purulent drainage with active bleeding and measured length 11.5 cm. x 7.5 cm. x 5 cm. deep. During observation on 7/28/21, at 9:19 a.m. registered nurse (RN)-A entered R1's room to	2 900		

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2 900	Continued From page 4	2 900		

perform would care. Regional educator (RE) inquired if RN-A had all the supplies she needed. RN-A replied she did. RN-A removed a dressing from R1's sacral pressure ulcer and cleansed the wound with Derma Cleanser. The wound was observed to be a stage four pressure wound with tunneling. There was no drainage, with a red wound bed and muscle or tendon showing. The wound measured:
- Tunnel - 4.5 cm.
- Length 9.5 cm.
- Width 11.0 cm.
- Depth 7.2 cm.
The wound was then packed with dry gauze. At this time, the surveyor intervened and asked RN-A to review R1's wound orders. RN-A then removed the dry gauze from R1's sacral pressure ulcer, reviewed a document on a clipboard, and verbalized she was unaware she first needed to soak the gauze. RN-A again repacked the wound with a dry gauze and covered the area with a sterile island dressing.

RN-A then removed the dressing from R1's right heel wounds. The wounds were observed to have odorless gray-colored and serosanguinous (clear liquid mixed with blood) drainage.
The wound measurements were:
- Back of heel wound measured: Length 6.0 cm. x Width 5.4 cm. x 0
- Bottom of heel wound measured: Length 8.0 cm. x Width 3.2 cm. x 0
Skin prep was applied to the wound and RN-A reached for a Mepilex dressing. The wound was then cleaned with Derma Cleanser after surveyor inquiry. RN-A again reached for a Mepilex dressing and the surveyor inquired if a Mepilex dressing was the same as Vaseline gauze. RN-A removed her gloves and exited R1's room at this time. RN-A returned to the room and verbalized

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2 900	Continued From page 5 the order read to use a Mepilex dressing and a 4 in. x 4 in. gauze pad. RN-A was asked if Mepilex was the same as Vaseline gauze and she responded she had a petroleum (Vaseline) dressing. RN-A applied the petroleum dressing to R1's right heel and wrapped it with Kerlix. RN-A did not apply the 4 in. x 4 in. gauze as identified by the physician order. RN-A then removed the dressing from R1's left heel wound and cleansed the area. RN-A applied skin prep, Mepilex, and Kerlix to the wound. When interviewed on 7/28/21, at 10:32 a.m. RN-A stated when she did not understand the orders, she would ask for help from another nurse or nurse manager. RN-A did not know what would occur if a wound was packed with dry gauze but felt it would keep a wound dry. RN-A stated she did not apply a 4 in. by 4 in. gauze to R1's right heel because it was too big, however, acknowledged there was less protection for wound and drainage could cause the wound to worsen. RN-A stated she would change R1's wound dressings once she learned they were performed incorrectly, however, was not observed to return to R1's room. When interviewed on 7/28/21, at 12:07 p.m. RN-D stated if a large wound was packed with dry gauze, it would remove new tissue, cause bleeding, and open a wound further when removed. When interviewed on 7/28/21, at 12:29 p.m. licensed practical nurse (LPN)-A stated if a pressure ulcer was packed with dry gauze, it would be hard to remove and cause bleeding. When interviewed on 7/28/21, at 12:42 p.m. RN-B stated wound care orders were found on a	2 900		

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2 900	Continued From page 6	2 900		

resident's treatment administration record (TAR) and nurses should write down treatment orders prior to entering a room. RN-B stated dry gauze could adhere to a wound and cause unintentional debridement (removal of tissue). RN-B stated she expected nurses to follow wound care orders.

When interviewed on 7/28/21, at 2:24 p.m. the facility wound nurse, RN-E stated nurses were expected to follow wound care orders. RN-E stated dry gauze would adhere to a wound and could cause damage.

When interviewed on 7/28/21, at 2:24 p.m. RN-E and the director of nursing (DON) stated RN-A was reeducated on wound care.

An interview was requested with R1's physician, however, contact was unable to be established.

R2's Admission Record printed 7/28/21, indicated R2's diagnoses included arteriosclerosis (narrowing of blood vessels, right foot ulceration, peripheral vascular disease, and diabetes.

R2's quarterly Minimum Data Set (MDS) dated 7/9/21, indicated R2 had severely impaired cognition and required extensive assistance with bed mobility, transfers, and personal hygiene. R2 had a stage four pressure ulcer which was present upon admission and had treatment which included application of ointments/medications other than to feet and pressure ulcer care. There were no occurrences of R2 rejecting care.

R2's July 2021 Treatment Administration Record (TAR) indicated starting 7/1/21, staff were to cleanse a wound to the heel of R1's right foot with normal saline. Staff were then to apply skin prep (protective film) to intact skin and allow the area

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2 900	Continued From page 7 to dry. Santyl (ointment) was then to be applied over the wound bed and covered with a gauze island dressing. The dressing was to be changed daily on dayshift. The above order was discontinued on 7/15/21. Effective on 7/15/21, staff were to cleanse R1's right heel wound with normal saline and apply skin prep to intact skin and allow to dry. Calcium alginate (absorbs fluid) was to be applied to the wound bed and covered with a gauze island dressing. The dressing was to be changed daily on dayshift. Review of R2's July 2021 TAR revealed from 7/1/21, through 7/27/21, wound care was not documented on 7/5/21, 7/9/21, 7/19/21, and 7/23/21. Review of R2's medical record lacked indication wound care was refused on the above dates. During interview on 7/27/21, at 11:51 a.m. licensed practical nurse (LPN)-A stated if a resident refused care staff were expected to reapproach three times. If a resident continued to refuse care staff were expected to write a progress note to describe what was tried and why the resident refused. During an interview on 7/28/21, at 11:12 a.m. LPN-A stated R2 had daily wound care ordered which was scheduled for dayshift. If she was unable to complete wound care, she would write a progress note indicating the task was not completed and report the information to the next shift. When wound care was completed, she documented on the TAR with a check mark and her initials. If the TAR was blank, that would mean wound care was not completed. During interview on 7/28/21, at 11:26 a.m.	2 900		

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2 900	Continued From page 8 registered nurse (RN)-B stated if a task on the TAR was not initialed or checked it was considered not completed. RN-B stated if wound care was unable to be completed during dayshift, staff were expected to report to the evening nurse to ensure completion. Wound care was expected to be done as ordered. During interview on 7/27/21, at 2:07 p.m. the director of nursing (DON) stated she was aware wound care was missed on 7/5/21, 7/9/21, 7/19/21, and 7/23/21. An explanation as to why wound care was documented was not provided. The DON stated she took the matter very seriously and identified nurses' who did not complete wound care. Education would be completed with the involved nurses prior to their next scheduled shifts. R2 declined to be interviewed or to have her wound observed during the investigation. "Policy and Procedure for the Prevention and Treatment of Skin Breakdown" (revised in 2018) specified implement wound care guidelines, which are a part of the physician's orders. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one	2 900		

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2 900	Continued From page 9 (21) days.	2 900		