

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



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: 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:

Maplewood Care Center August 17, 2021 Page 2

- 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).

Maplewood Care Center August 17, 2021 Page 3

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

PRINTED: 08/24/2021 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER   STREET ADDRESS, CITY, STATE, ZIP CODE   1900 SHERREN AVENUE   MAPLEWOOD, MN 55109	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		' IDENTIFICATION NUMBER. '		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
STREET ADDRESS. CITY. STATE, ZIP CODE   1900 SHERREN AVENUE   19			245276		B. WING				
PRÉFIX TAG    CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PRÉFIX TAG   CROSS-REFERÊNCED TO THE APPROPRIATE   COMPLET TAG					1900 SHERREN AVENUE	CODE	<u>  077</u>	20/2021	
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 686 Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)  §4483.25(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 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	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD	BE	(X5) COMPLETION DATE	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE (X6) DATE		§483.25(b)(1) Pres Based on the comp resident, the facility (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that (ii) A resident with p	sure ulcers.  prehensive assessment of a remust ensure thateses care, consistent with ards of practice, to prevent d does not develop pressure adividual's clinical condition they were unavoidable; and pressure ulcers receives						

Electronically Signed 08/19/2021

by deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			E SURVEY IPLETED	
		245276	B. WING			C <b>07/28/2021</b>	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	20/2021	
				1900 SHERREN AVENUE			
MAPLEV	VOOD CARE CENTER	}		MAPLEWOOD, MN 55109			
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F 686	with professional si promote healing, promote healing, promote healing, promote with the promote of this REQUIREMED by:  Based on observareview, the facility fordered by the physpressure ulcers for had stage four pressure ulcers for had stage four pressure ulcer, unsleft heel, and stage heel.  R1's Face Sheet dadiagnoses included pressure ulcer, unsleft heel, and stage heel.  R1's significant chadated 6/7/21, indicated 6/7/21, indicated 6/7/21, indicated in the personal hygiene. If stage two pressure ulcer, and two stage were not present upincluded application surgical wound car.  R1's physician orders of the prosonal hygiene of the stage two pressure ulcer, and two stage were not present upincluded application surgical wound car.  R1's physician orders of the prosonal hygiene of the prosonal hygiene. If stage two pressure ulcer, and two stage were not present upincluded application surgical wound car.  R1's physician orders of the prosonal hygiene of the prosonal hygiene. If stage two pressure ulcer, and two stage were not present upincluded application surgical wound car.	revent infection and prevent veloping.  NT is not met as evidenced tion, interview, and document ailed to provide wound care as sician to promote healing of 2 of 2 residents (R1, R2) who	F 6	It is the policy of Maplewood C to follow all Federal, State, and guidelines, laws, regulations an This plan of correction is not to construed as an admission of c practice by the facility administremployees, agents, or other incomplete the practice cited in this statement deficiencies does not constitute agreement with citations. The public submission and implementation plan of correction will serve as credible allegation of compliant POC F686  1. Nurse manager completed education to RN-A and observe providing wound dressings per order to R1 and R2. R1 and R2 assessed after the dressing changes to dressing change we for R1 and R2.  2. On 7/28/21, nurse manage all dressing changes by RN-A to they were done correctly per phyorders. All residents with wound reviewed that the appropriate to per physician's orders and doc was completed.  3. The prevention and treatments.	local d statutes. be eficient rator, lividuals. ficient of reparation, n of this our se. immediate d RN-A physician were reange. no ere needed reviewed o ensure		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
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F 686	- Staff were to clea apply a Vaseline gagauze) and cover in gauze pad. Staff which with Kerlix (woven dressing daily Staff were to applied forms a protective daily to R1's left here.  A progress note daindicated R1's right amounts of puruler an old dressing. The cm. and was made sacral/coccyx would purulent drainage with measured length 1 deep.  During observation registered nurse (Find perform would care inquired if RN-A hard RN-A replied she of from R1's sacral proposed from R1's sacral proposed from R1's sacral proposed from R1's common decided and multiple wound measured: - Tunnel - 4.5 cm Length 9.5 cm Width 11.0 cm Depth 7.2 cm. The wound was the this time, the surver RN-A to review R1's construction.	nse R1's right heel wound and auze (non-adherent mesh t with a 4 inch (in) by 4 in. ere then to wrap the wound gauze) and change the ly skin prep (a liquid which film to reduce friction) twice rel.  Itted 7/22/21, at 2:50 p.m. theel wound had copious at drainage with blood noted on the wound measured 5 cm. x 5	F 686	break down policy and procedure including documentation was revi Education will be provided to licer nurses on Wound Care and documentation by 8/31/21. Wound checklist has been added to the ragency orientation.  4. Wound audits will be complet DON or designee 3x per week for weeks, 2x week for 2 weeks, 1x v 8 weeks. The trends will be report QAPI and the need for continued will be determined.  5. The Director of Nursing will be responsible for compliance.  Date of Compliance 8/31/2021	ewed. Insed Id care Inurse Ited by In 2 Ited at Ited at Ited at Ited at	

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	verbalized she was soak the gauze. Riwith a dry gauze ar sterile island dress.  RN-A then remove heel wounds. The vodorless gray-color liquid mixed with bl. The wound measure. Back of heel wounds. Width 5.4 cm. x 0.2 Bottom of heel words. X Width 3.2 cm. Skin prep was applied reached for a Mepithen cleaned with Einquiry. RN-A againd dressing and the standard her glove time. RN-A returned the order read to us in. x 4 in. gauze pawas the same as V responded she had dressing. RN-A app. R1's right heel and did not apply the 4 by the physician orderssing from R1's the area. RN-A app. Kerlix to the wound. When interviewed stated when she dishe would ask for her started would be started would ask for her started would be started	ocument on a clipboard, and a unaware she first needed to N-A again repacked the wound not covered the area with a ing.  If the dressing from R1's right wounds were observed to have red and serosanguinous (clear ood) drainage.  If the dressing from R1's right wounds were observed to have red and serosanguinous (clear ood) drainage.  If the dressing from R1's right wounds were:  If the dressing from R1's right wounds were:  If the dressing from R1's right wound was on the saured: Length 8.0 cm.  If the dressing from R1's rom and RN-A lex dressing. The wound was of the wound and RN-A lex dressing. The wound was of the perform and verbalized are a Mepilex dressing and a 4 down of the petroleum (Vaseline) of the petroleum dressing to wrapped it with Kerlix. RN-A in. x 4 in. gauze as identified der. RN-A then removed the left heel wound and cleansed of the petroleum dressing to lied skin prep, Mepilex, and	F 68	36 · · · · · · · · · · · · · · · · · · ·		

	FATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245276	B. WING		0.	C <b>7/28/2021</b>	
	PROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZI 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		1/20/2021	
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F 686	occur if a wound wa felt it would keep a did not apply a 4 in. heel because it was acknowledged therwound and drainag worsen. RN-A state wound dressings of performed incorrect observed to return. When interviewed of RN-D stated if a largauze, it would rembleeding, and open removed.  When interviewed of licensed practical in pressure ulcer was would be hard to reword to entering a recould adhere to a widebridement (remo expected nurses to When interviewed of facility wound nurse expected to follow wistated dry gauze we could cause damage.	as packed with dry gauze but wound dry. RN-A stated she by 4 in. gauze to R1's right stoo big, however, e was less protection for e could cause the wound to de she would change R1's nee she learned they were tly, however, was not to R1's room.  On 7/28/21, at 12:07 p.m. ge wound was packed with dry love new tissue, cause a wound further when  On 7/28/21, at 12:29 p.m. urse (LPN)-A stated if a packed with dry gauze, it move and cause bleeding.  On 7/28/21, at 12:42 p.m. It care orders were found on a t administration record (TAR) write down treatment orders oom. RN-B stated dry gauze yound and cause unintentional val of tissue). RN-B stated she follow wound care orders. RN-E ould adhere to a wound and	F6	586			

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	was reeducated on An interview was rehowever, contact w R2's Admission Ree R2's diagnoses incl (narrowing of blood peripheral vascular R2's quarterly Minin 7/9/21, indicated R2 cognition and requilibed mobility, transfehad a stage four prepresent upon admisincluded application other than to feet all were no occurrence R2's July 2021 Trea (TAR) indicated staceleanse a wound to normal saline. Staff (protective film) to ito dry. Santyl (ointmover the wound bedisland dressing. The daily on dayshift. The discontinued on 7/1 staff were to cleans normal saline and a and allow to dry. Ca was to be applied to with a gauze island be changed daily or	wound care.  equested with R1's physician, as unable to be established.  cord printed 7/28/21, indicated uded arteriosclerosis vessels, right foot ulceration, disease, and diabetes.  mum Data Set (MDS) dated 2 had severely impaired red extensive assistance with ers, and personal hygiene. R2 essure ulcer which was assion and had treatment which of ointments/medications and pressure ulcer care. There as of R2 rejecting care.  Attment Administration Record ring 7/1/21, staff were to the heel of R1's right foot with were then to apply skin prepontact skin and allow the area ment) was then to be applied and covered with a gauze are dressing was to be changed the above order was 5/21. Effective on 7/15/21, are R1's right heel wound with apply skin prep to intact skin alcium alginate (absorbs fluid) to the wound bed and covered dressing. The dressing was to	F 6	886			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	documented on 7/5 7/23/21.  Review of R2's me wound care was re  During interview or licensed practical resident refused careapproach three tirefuse care staff wo progress note to dethe resident refuse  During an interview LPN-A stated R2 h which was schedul unable to complete a progress note indicompleted and repshift. When wound documented on the her initials. If the Tomean wound care or limitials. If the Tomean wound care was unable to staff were expected to ensure completing to be done as order or director of nursing wound care was m 7/19/21, and 7/23/2	dical record lacked indication fused on the above dates.  1. 7/27/21, at 11:51 a.m. hurse (LPN)-A stated if a are staff were expected to imes. If a resident continued to ere expected to write a escribe what was tried and why d.  1. on 7/28/21, at 11:12 a.m. ad daily wound care ordered ed for dayshift. If she was a wound care, she would write dicating the task was not ort the information to the next care was completed, she at TAR with a check mark and AR was blank, that would was not completed.  1. 7/28/21, at 11:26 a.m. and AR was blank, that would was not completed.  1. 7/28/21, at 11:26 a.m. and	F 68			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245276	B. WING			C / <b>28/2021</b>	
	NAME OF PROVIDER OR SUPPLIER  MAPLEWOOD CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 1900 SHERREN AVENUE MAPLEWOOD, MN 55109		20,2021	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 686	The DON stated sh seriously and identi complete wound ca completed with the next scheduled shift R2 declined to be in wound observed du "Policy and Procedu Treatment of Skin Especified implement	e took the matter very fied nurses' who did not re. Education would be involved nurses prior to their	F 6	86			



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at

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.

Maplewood Care Center August 17, 2021 Page 2

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.

· Pu-6

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

Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
		00520	B. WING		07/2	8/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		RREN AVEN	<del></del>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surve found that the defic herein are not corrected shall	Minnesota Statute, section ction order has been issued y. If, upon reinspection, it is iency or deficiencies cited ected, a fine for each violation be assessed in accordance ines promulgated by rule of artment of Health.				
	corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	nether a violation has been compliance with all a rule provided at the tagule number indicated below. In several items, failure to the items will be considered Lack of compliance upon any item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department witl	hearing on any assessments n non-compliance with these it a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	your facility by survey Department of Heal found NOT in comp Licensure. Please in of correction you ha	TS: blaint survey was conducted at eyors from the Minnesota lth (MDH). Your facility was bliance with the MN State and the conditional reviewed these orders and the enthey will be completed.				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

08/19/21 **Electronically Signed** 

STATE FORM 6899 7WPY11 If continuation sheet 1 of 10

TITLE

(X6) DATE

Minnesota Department of Health

-	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
					C	
		00520	B. WING		07/2	8/2021
	PROVIDER OR SUPPLIER  VOOD CARE CENTER	1900 SHE	RREN AVEN			
	T		OOD, MN 5			T.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	SUBSTANTIATED: a licensing order iss The Minnesota Dep documenting the St Orders using Feder have been assigned statutes/rules for Nit tag number appears "ID Prefix Tag." The compliance is listed of Deficiencies" colic Comply" portion of column also include violation of the state "This Rule is not me the surveyor's find Method of Correction Correction. You have agreed to receipt of State lice the Minnesota Depa Informational Bullet <a href="https://www.health on/infobulletins/ib14">https://www.health on/infobulletins/ib14</a> orders are delineate Department of Hea you electronically, is necessary for State enter the word "CO available for text. You electronic State lice heading completion be corrected prior to the Minnesota Depa is enrolled in ePOC	partment of Health is tate Licensing Correction ral software. Tag numbers of to Minnesota state cursing Homes. The assigned is in the far-left column entitled to e state statute/rule out of the in the "Summary Statement cumn and replaces the "To the correction order. This test the findings which are in the statute after the statement, are the Suggested on and Time Period for a participate in the electronic insure orders consistent with				

Minnesota Department of Health STATE FORM

7WPY11 If continuation sheet 2 of 10

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
					С	
		00520	B. WING	B. WING 07		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER		RREN AVEN	· <del>-</del>		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETE DATE
2 900	Continued From pa	ge 2	2 900			
2 900	MN Rule 4658.0525 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			8/31/21
	comprehensive resi of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without pressure so pressure sores unle condition demonstra	o enters the nursing home ores does not develop ess the individual's clinical ates, and a physician they were unavoidable; and				
	receives necessary	ho has pressure sores y treatment and services to event infection, and prevent yeloping.				
	by: Based on observati review, the facility fa ordered by the phys	ent is not met as evidenced on, interview, and document ailed to provide wound care as sician to promote healing of 2 of 2 residents (R1, R2) who sure ulcers.		Corrected		
	Findings include:					
	diagnoses included pressure ulcer, uns	ated 7/21/21, indicated R1's paraplegia, stage four sacral tageable pressure ulcer to the two pressure ulcer to the right				
		nge Minimum Data Set (MDS) ted R1 had a moderate				

Minnesota Department of Health STATE FORM

A. BUILDING: COMPLETED  COMPLETED  COMPLETED  COMPLETED  COMPLETED  O7/28/202	C	
00520 B. WING 07/28/202		
	28/2021	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
MAPLEWOOD CARE CENTER  1900 SHERREN AVENUE  MAPLEWOOD, MN 55109		
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	(X5) COMPLETE DATE	
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 light 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 blood noted on an easured 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		

Minnesota Department of Health

STATE FORM 6899 7WPY11 If continuation sheet 4 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00520	B. WING			C <b>28/2021</b>
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
MAPLEV	VOOD CARE CENTER		RREN AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	perform would care inquired if RN-A had RN-A replied she di from R1's sacral prowound with Derma observed to be a st tunneling. There was wound bed and mu wound measured:  - Tunnel - 4.5 cm.  - Length 9.5 cm.  - Width 11.0 cm.  - Depth 7.2 cm.  The wound was the this time, the survey RN-A to review R1's removed the dry gaulcer, reviewed a deverbalized she was soak the gauze. RN with a dry gauze an sterile island dressi  RN-A then removed heel wounds. The wounds. The wood orless gray-color liquid mixed with bluthe wound measur. Back of heel wourx Width 5.4 cm. x 0.  - Bottom of heel words. Width 3.2 cm.  Skin prep was applineached for a Mepil then cleaned with Einquiry. RN-A again dressing and the sudressing was the saremoved her gloves removed her gloves	Regional educator (RE) dall the supplies she needed. d. RN-A removed a dressing essure ulcer and cleansed the Cleanser. The wound was age four pressure wound with as no drainage, with a red scle or tendon showing. The en packed with dry gauze. At yor intervened and asked s wound orders. RN-A then uze from R1's sacral pressure ocument on a clipboard, and unaware she first needed to I-A again repacked the wound d covered the area with a ng.  If the dressing from R1's right wounds were observed to have ed and serosanguinous (clear bod) drainage. Ements were: and measured: Length 6.0 cm.	2 900			

Minnesota Department of Health

STATE FORM 6899 7WPY11 If continuation sheet 5 of 10

Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
JEHN IS HOLDEN.			A. BUILDING:			
00520		B. WING		C <b>07/28/2021</b>		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	WOOD CARE CENTER	}	RREN AVEN OOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	the order read to us in. x 4 in. gauze parwas the same as V responded she had dressing. RN-A app R1's right heel and did not apply the 4 by the physician orderssing from R1's the area. RN-A app Kerlix to the wound.  When interviewed stated when she dishe would ask for hourse manager. RN occur if a wound was felt it would keep a did not apply a 4 in heel because it was acknowledged ther wound and drainag worsen. RN-A state wound dressings of performed incorrect observed to return.  When interviewed of RN-D stated if a largauze, it would rem bleeding, and open removed.  When interviewed of licensed practical in pressure ulcer was would be hard to rew.	se a Mepilex dressing and a 4 d. RN-A was asked if Mepilex aseline gauze and she a petroleum (Vaseline) blied the petroleum dressing to wrapped it with Kerlix. RN-A in. x 4 in. gauze as identified der. RN-A then removed the left heel wound and cleansed blied skin prep, Mepilex, and l.  on 7/28/21, at 10:32 a.m. RN-A d not understand the orders, nelp from another nurse or N-A did not know what would as packed with dry gauze but wound dry. RN-A stated she by 4 in. gauze to R1's right stoo big, however, e was less protection for the could cause the wound to ed she would change R1's nice she learned they were tly, however, was not				

Minnesota Department of Health

STATE FORM 6899 7WPY11 If continuation sheet 6 of 10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00520	B. WING			2 <mark>8/2021</mark>
MAPI EWOOD CARE CENTER 1900 SHE			DRESS, CITY, S RREN AVEN OOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	resident's treatment and nurses should prior to entering a recould adhere to a widebridement (removexpected nurses to)  When interviewed of facility wound nurse expected to follow with stated dry gauze we could cause damage.  When interviewed of and the director of the was reeducated on.  An interview was rehowever, contact with the director of the was reeducated on.  R2's Admission Rec R2's diagnoses included in a stage four propersion and required mobility, transformed a stage four propersent upon admissincluded application other than to feet at were no occurrence.  R2's July 2021 Treat (TAR) indicated state cleanse a wound to normal saline. Staff	t administration record (TAR) write down treatment orders oom. RN-B stated dry gauze round and cause unintentional val of tissue). RN-B stated she follow wound care orders.  on 7/28/21, at 2:24 p.m. the e, RN-E stated nurses were wound care orders. RN-E ould adhere to a wound and ge.  on 7/28/21, at 2:24 p.m. RN-E our 7/28/21, at 2:24 p.m. RN-E nursing (DON) stated RN-A	2 900			

Minnesota Department of Health

STATE FORM 6899 7WPY11 If continuation sheet 7 of 10

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.		С		
		00520	B. WING		_	28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLEV	VOOD CARE CENTER	₹	RREN AVEN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	to dry. Santyl (ointrover the wound begind island dressing. The daily on dayshift. The discontinued on 7/1 staff were to cleans normal saline and a and allow to dry. Cawas to be applied the with a gauze island be changed daily on the Review of R2's July 7/1/21, through 7/2 documented on 7/5 7/23/21.  Review of R2's mewound care was removed by the resident refused care approach three to the resident refuse care staff was progress note to determine the resident refused to determine the resident refuse approach three to the resident refused to determine the resident refused to determine an interview LPN-A stated R2 has which was schedulunable to complete and repositift. When wound documented on the her initials. If the Tamean wound care was resident refused to complete and repositift. When wound documented on the her initials. If the Tamean wound care was resident refused.	ment) was then to be applied d and covered with a gauze be dressing was to be changed the above order was 15/21. Effective on 7/15/21, see R1's right heel wound with apply skin prep to intact skin alcium alginate (absorbs fluid) to the wound bed and covered dressing. The dressing was to n dayshift.  1/2021 TAR revealed from 7/21, wound care was not 5/21, 7/9/21, 7/19/21, and dical record lacked indication fused on the above dates.  1/27/21, at 11:51 a.m. hurse (LPN)-A stated if a are staff were expected to mes. If a resident continued to ere expected to write a escribe what was tried and why				

Minnesota Department of Health STATE FORM

TE FORM 7WPY11 If continuation sheet 8 of 10

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		A. BOILDING.		С		
		00520	B. WING			28/2021
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
MAPLE	WOOD CARE CENTER	₹	RREN AVEN OOD, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 900	registered nurse (FTAR was not initially considered not concare was unable to staff were expected to ensure complete to be done as orded.  During interview or director of nursing wound care was modern and the DON stated shad seriously and ident complete wound care wound observed do "Policy and Proced Treatment of Skin I specified implement which are a part of SUGGESTED MET The director of nursuall residents at risk they are receiving the treatment/services from developing and pressure ulcers. The designee, could condelivery of care; to services are implement of the pressure ulcer developing and pressure ulcer developing are pressure ulcers. The designee, could condelivery of care; to services are implement of the pressure ulcer developing and pressure ulcer developing are pressure ulcers. The designee, could condelivery of care; to services are implement of the pressure ulcer developing and pressure ulcer developing are pressure ulcers.	RN)-B stated if a task on the ed or checked it was appleted. RN-B stated if wound a be completed during dayshift, d to report to the evening nurse on. Wound care was expected red.  1. 7/27/21, at 2:07 p.m. the (DON) stated she was aware issed on 7/5/21, 7/9/21, 21. An explanation as to why ocumented was not provided ne took the matter very ified nurses' who did not are. Education would be involved nurses prior to their fts.  Interviewed or to have her uring the investigation.  It wound care guidelines, the physician's orders.  THOD OF CORRECTION: sing or designee, could review for pressure ulcers to assure the necessary to prevent pressure ulcers and to promote healing of the director of nursing or nduct random audits of the ensure appropriate care and mented; to reduce the risk for	2 900			

6899

Minnesota Department of Health STATE FORM

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
00520		B. WING			C <b>07/28/2021</b>			
					01/2	.0/2U2 I		
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE				
MAPLEWOOD CARE CENTER  1900 SHERREN AVENUE  MAPLEWOOD, MN 55109								
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETE		
PRÉFIX TAG	(EACH DEFICIENCY REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE OPRIATE	COMPLETE DATE		
2 900	Continued From pa	ge 9	2 900					
	(21) days.							

Minnesota Department of Health