DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 23, 2026

Administrator
MAPLEWOOD REHABILITATION CENTER
1900 SHERREN AVENUE EAST
MAPLEWOOD, MN 55109

RE: CCN: 245276

Cycle Start Date: December 4, 2025

Dear Administrator:

On February 4, 2026, we notified you a remedy was imposed. On February 18, 2026, the Minnesota Departments of Health and Public Safety 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 February 6, 2026.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective March 4, 2026 did not go into effect. (42 CFR 488.417 (b))

In our letter of February 4, 2026, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 4, 2026 due to denial of payment for new admissions. Since your facility attained substantial compliance on February 6, 2026, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Location may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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February 23, 2026

Administrator
MAPLEWOOD REHABILITATION CENTER
1900 SHERREN AVENUE EAST
MAPLEWOOD, MN 55109

Re: Reinspection Results
Event ID: 1DC2C7-H2 and 1E214F-H2

Dear Administrator:

On January 27, 2026 and February 18, 2026 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 December 4, 2025 and January 27, 2026. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

DEPARTMENT OF HEALTH

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February 4, 2026

Administrator
MAPLEWOOD REHABILITATION CENTER
1900 SHERREN AVENUE EAST
MAPLEWOOD, MN 55109

RE: CCN: 245276
Cycle Start Date: December 2, 2025

Dear Administrator:

On December 22, 2025, we informed you that we may impose enforcement remedies.

On January 27, 2026, the Minnesota Department of Health completed a survey and it has been determined that your facility is not 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.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS location for imposition. The CMS location concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective March 2, 2026.

The CMS location will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective March 2, 2026. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective March 2, 2026.

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.

The CMS location may determine to impose other remedies such as a Civil Money Penalty.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $13,343, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by March 2, 2026, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, MAPLEWOOD REHABILITATION CENTER will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 2, 2026. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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. 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.

DEPARTMENT CONTACT

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

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 June 2, 2026 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 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
202-795-7490

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 Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to tamika.brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR)

In accordance with 42 CFR 488.331 and Minnesota Statute 144A.10 subd 15, 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:
https://forms.web.health.state.mn.us/form/NHDisputeResolution
This request must be sent within the same ten calendar days you have for submitting an ePoC for the cited deficiencies. 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.

A copy of the Department's informal dispute resolution policies is posted on the MDH Information Bulletin website at:

https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with 42 CFR § 488.431 and Minnesota Statute 144A.10 subd 16, when a CMP subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. 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:

https://forms.web.health.state.mn.us/form/NHDisputeResolution

A facility may not use both IDR and independent IDR for the same deficiency citation(s) arising from the same survey unless the IDR process was completed prior to the imposition of the CMP. This request must be sent within ten calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

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February 4, 2026

Administrator
MAPLEWOOD REHABILITATION CENTER
1900 SHERREN AVENUE EAST
MAPLEWOOD, MN 55109

Re: State Nursing Home Licensing Orders
Event ID: 1E214F-H1

Dear Administrator:

The above facility survey was completed on January 27, 2026 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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:

Lisa Krebs, Regional Supervisor, Federal Rapid Response
Health Regulation Division
Minnesota Department of Health
Rochester District Office
3425 40th Avenue NW, Suite 115
Rochester, MN 55901
Email: Lisa.Krebs@state.mn.us
Office (507) 206-2728

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 feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing
Compliance Analyst | Federal Enforcement
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Office: 651-201-4112

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD REHABILITATION CENTER	1900 SHERREN AVENUE EAST , MAPLEWOOD, Minnesota, 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
F0000	INITIAL COMMENTS On 1/26/26 and 1/27/26, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52764303C (2723355) with a deficiency issued at F656. 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.	F0000		
F0656 SS = D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided	F0656	Immediate corrective action: R1 and R2 have been discharged from the facility. R3's care plan was reviewed and had anticoagulant use added to her care plan. Corrective action as it applies to others: The facility conducted a whole house audit to identify any residents who were on anticoagulant or antiplatelet medications. Care plans were reviewed for identified residents and updated as needed with anticoagulant/antiplatelet use. Side effect monitoring orders were reviewed and updated as needed. Education provided to nursing leadership regarding care planning of anticoagulant and antiplatelet medications. Care plan policy was reviewed with nursing leadership regarding care plan expectations. Recurrence will be prevented by: Director of nursing or designee will complete weekly audits on 5 residents who	02/06/2026

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 reverse for further 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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MAPLEWOOD REHABILITATION CENTER	1900 SHERREN AVENUE EAST , MAPLEWOOD, Minnesota, 55109

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F0656 SS = D	Continued from page 1 due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure that care plans were developed and implemented to address the use of blood-thinning medications for 3 of 3 residents (R1, R2 and R3) reviewed. R1 R1's face sheet, printed 1/26/26, identified diagnoses of cerebral vascular accident (stroke) and dysphagia. R1's admission Minimum Data Set (MDS) dated 1/12/26 identified moderate cognitive impairment, the need for a feeding tube, and receipt of antiplatelet medications.	F0656	Continued from page 1 are newly on anticoagulant or antiplatelet medications to ensure care plan includes medication use and side effect monitoring is in place x 4 weeks. Audits will be reviewed at QAPI to determine the need to increase, decrease, or discontinue.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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F0656 SS = D	Continued from page 2 R1's physician's orders dated 1/6/26 identified the resident was to receive clopidogrel 75 mg via G-tube every morning and aspirin 325 mg via J-tube daily with a meal. According to the FDA-approved Plavix (clopidogrel) labeling, clopidogrel is an antiplatelet medication. The FDA-approved labeling warns that "Plavix can cause bleeding which can be serious and can sometimes lead to death." The FDA-approved Plavix Medication Guide identifies signs and symptoms of bleeding, including "blood in your urine (pink, red or brown urine)" and "red or black stools (looks like tar)." According to the FDA-approved aspirin 325 mg labeling (Drug Facts), aspirin is an antiplatelet medication. The labeling warns that "This product contains an NSAID, which may cause severe stomach bleeding," and identifies signs of stomach bleeding, including "vomit blood" and "bloody or black stools." Although Review of R1's January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident's blood-thinning medications, review of R1's comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident's use of blood-thinning medications. The care plan did not identify the R1 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with antiplatelet therapy. Review of R1's Kardex, printed 1/27/26, did not identify the use of blood-thinning medications. R1's care guide was requested and not received. R2 R2's face sheet, printed 1/27/26, identified a diagnosis of atrial fibrillation. R2's admission MDS dated 10/15/25 identified moderate cognitive impairment and receipt of anticoagulant	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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F0656 SS = D	Continued from page 3 medications. R2's physician's orders dated 1/6/26 identified the resident was to receive apixaban 5 mg twice daily. According to the FDA-approved Eliquis (apixaban) label (Prescribing Information), Eliquis is an anticoagulant medication. The FDA-approved labeling states "ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." The labeling further identifies signs and symptoms of blood loss. Although Review of R2's January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident's blood-thinning medications, Review of R2's comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident's use of blood-thinning medications. The care plan did not identify R2 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with anticoagulant therapy. Review of R2's Kardex, printed 1/27/26, did not identify the resident's use of blood-thinning medications. R2's care guide was requested and not received. R3 R3's face sheet, printed 1/27/26, identified a diagnosis of infection and inflammatory reaction due to unspecified internal joint prosthesis of the left knee. R3's admission MDS dated 10/20/25 identified no cognitive impairment and receipt of anticoagulant medications. R3's physician's orders dated 12/30/25 identified the resident was to receive enoxaparin sodium injection 40 mg (0.4 mL) subcutaneously daily.	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

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F0656 SS = D	Continued from page 4 According to the FDA-approved Lovenox (enoxaparin) label (Prescribing Information), Lovenox is an anticoagulant medication and “should be used with extreme caution in conditions with increased risk of hemorrhage.” Although Review of R3’s January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident’s blood-thinning medications, review of R3’s comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident’s use of blood-thinning medications. The care plan did not identify R3 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with anticoagulant therapy. Review of R3’s Kardex, printed 1/27/26, and review of R3’s undated care guide did not identify the resident’s use of blood-thinning medications. During an interview on 1/27/26 at 12:54 p.m., R3 was observed lying in bed and stated she receives a daily blood-thinner injection in her abdomen to help prevent blood clots. R3 reported she experiences bruising to her abdomen related to the injections but nowhere else. During an interview on 1/27/26 at 1:37 p.m., Nursing Assistant (NA)-A stated she would want to know if a resident was receiving blood-thinning medications so she could immediately notify the nurse of any signs of bleeding. NA-A reported that she relies on care guides and the resident Kardex to direct resident care; however, she stated these tools did not identify residents receiving blood-thinning medications. NA-A further stated she would need to obtain this information directly from the nurse. During an interview on 1/27/26 at 1:34 p.m., Licensed Practical Nurse (LPN)-A indicated that residents receiving blood-thinning medications should have this risk addressed in their care plans. LPN-A further stated the nurse manager was responsible for ensuring this documentation was completed. During an interview on 1/27/26 at 12:11 p.m., clinical care coordinator (CCC)-A stated she was the nurse manager of the Transitional Care Unit. (TCU). CCC-A	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLEWOOD REHABILITATION CENTER	1900 SHERREN AVENUE EAST , MAPLEWOOD, Minnesota, 55109

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F0656 SS = D	Continued from page 5 verified R1, R2 and R3 had received blood thinning medications that put them at increased risk for bleeding. CCC-A further stated she was unaware that residents receiving blood-thinning medications were required to have this risk addressed in their care plans to monitor for bleeding. During an interview on 1/27/26 at 1:16 p.m., the Director of Nursing (DON) verified R1, R2 and R3 received blood thinning medications. DON was unable to explain the need to include residents receiving blood-thinning medications in the comprehensive care plan and stated that monitoring once weekly would be sufficient. The DON was unable to articulate that residents receiving high-risk medications, including anticoagulants and antiplatelets, require individualized care plan interventions to ensure risks, monitoring, and interventions are communicated to all staff involved in the residents' care, placing residents at risk for unrecognized bleeding. The facility policy, "Care Planning," revised 11/2024, lacked specific guidance requiring the identification and care planning of high-risk medications and medication administration routes. As a result, the policy did not ensure that foreseeable risks, such as bleeding related to blood-thinning medications, were addressed through individualized care plan interventions.	F0656		

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20000	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 1/26/26 and 1/27/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order was issued. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	20000		

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

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20000	Continued from page 1 The following complaint was reviewed: H52764303C (2723355) with a licensing order issued at 0555. 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. 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.	20000		
20555	Comprehensive Plan of Care; Development CFR(s): MN Rule 4658.0405 Subp. 1 Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for	20555	corrected	02/06/2026

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20555	Continued from page 2 the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This LICENSURE REQUIREMENT is NOT MET as evidenced by: Based on observation, interview and document review, the facility failed to ensure that care plans were developed and implemented to address the use of blood-thinning medications for 3 of 3 residents (R1, R2 and R3) reviewed Findings include R1 R1's face sheet, printed 1/26/26, identified diagnoses of cerebral vascular accident (stroke) and dysphagia. R1's admission Minimum Data Set (MDS) dated 1/12/26 identified moderate cognitive impairment, the need for a feeding tube, and receipt of antiplatelet medications. R1's physician's orders dated 1/6/26 identified the resident was to receive clopidogrel 75 mg via G-tube every morning and aspirin 325 mg via J-tube daily with a meal. According to the FDA-approved Plavix (clopidogrel) labeling, clopidogrel is an antiplatelet medication. The FDA-approved labeling warns that "Plavix can cause bleeding which can be serious and can sometimes lead to death." The FDA-approved Plavix Medication Guide identifies signs and symptoms of bleeding, including "blood in your urine (pink, red or brown urine)" and "red or black stools (looks like tar)." According to the FDA-approved aspirin 325 mg labeling (Drug Facts), aspirin is an antiplatelet medication. The labeling warns that "This product contains an NSAID, which may cause severe stomach bleeding," and identifies signs of stomach bleeding, including "vomit blood" and "bloody or black stools." Although Review of R1's January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident's blood-thinning medications, review of R1's comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident's use of	20555		

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20555	Continued from page 3 blood-thinning medications. The care plan did not identify the R1 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with antiplatelet therapy. Review of R1's Kardex, printed 1/27/26, did not identify the use of blood-thinning medications. R1's care guide was requested and not received. R2 R2's face sheet, printed 1/27/26, identified a diagnosis of atrial fibrillation. R2's admission MDS dated 10/15/25 identified moderate cognitive impairment and receipt of anticoagulant medications. R2's physician's orders dated 1/6/26 identified the resident was to receive apixaban 5 mg twice daily. According to the FDA-approved Eliquis (apixaban) label (Prescribing Information), Eliquis is an anticoagulant medication. The FDA-approved labeling states "ELIQUIS increases the risk of bleeding and can cause serious, potentially fatal, bleeding." The labeling further identifies signs and symptoms of blood loss. Although Review of R2's January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident's blood-thinning medications, Review of R2's comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident's use of blood-thinning medications. The care plan did not identify R2 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with anticoagulant therapy. Review of R2's Kardex, printed 1/27/26, did not identify the resident's use of blood-thinning medications. R2's care guide was requested and not received. R3 R3's face sheet, printed 1/27/26, identified a	20555		

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20555	Continued from page 4 diagnosis of infection and inflammatory reaction due to unspecified internal joint prosthesis of the left knee. R3's admission MDS dated 10/20/25 identified no cognitive impairment and receipt of anticoagulant medications. R3's physician's orders dated 12/30/25 identified the resident was to receive enoxaparin sodium injection 40 mg (0.4 mL) subcutaneously daily. According to the FDA-approved Lovenox (enoxaparin) label (Prescribing Information), Lovenox is an anticoagulant medication and "should be used with extreme caution in conditions with increased risk of hemorrhage." Although Review of R3's January 2026 Treatment Administration Record (TAR) revealed physician ordered monitoring intervention associated with the resident's blood-thinning medications, review of R3's comprehensive care plan (current at the time of the survey) revealed no identified problem, goal, or interventions related to the resident's use of blood-thinning medications. The care plan did not identify R3 as being at risk for bleeding and did not include interventions addressing management or mitigation of bleeding risk associated with anticoagulant therapy. Review of R3's Kardex, printed 1/27/26, and review of R3's undated care guide did not identify the resident's use of blood-thinning medications. During an interview on 1/27/26 at 12:54 p.m., R3 was observed lying in bed and stated she receives a daily blood-thinner injection in her abdomen to help prevent blood clots. R3 reported she experiences bruising to her abdomen related to the injections but nowhere else. During an interview on 1/27/26 at 1:37 p.m., Nursing Assistant (NA)-A stated she would want to know if a resident was receiving blood-thinning medications so she could immediately notify the nurse of any signs of bleeding. NA-A reported that she relies on care guides and the resident Kardex to direct resident care; however, she stated these tools did not identify residents receiving blood-thinning medications. NA-A further stated she would need to obtain this information directly from the nurse. During an interview on 1/27/26 at 1:34 p.m., Licensed Practical Nurse (LPN)-A indicated that residents receiving blood-thinning medications should have this	20555		

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20555	Continued from page 5 risk addressed in their care plans. LPN-A further stated the nurse manager was responsible for ensuring this documentation was completed. During an interview on 1/27/26 at 12:11 p.m., clinical care coordinator (CCC)-A stated she was the nurse manager of the Transitional Care Unit. (TCU). CCC-A verified R1, R2 and R3 had received blood thinning medications that put them at increased risk for bleeding. CCC-A further stated she was unaware that residents receiving blood-thinning medications were required to have this risk addressed in their care plans to monitor for bleeding. During an interview on 1/27/26 at 1:16 p.m., the Director of Nursing (DON) verified R1, R2 and R3 received blood thinning medications. DON was unable to explain the need to include residents receiving blood-thinning medications in the comprehensive care plan and stated that monitoring once weekly would be sufficient. The DON was unable to articulate that residents receiving high-risk medications, including anticoagulants and antiplatelets, require individualized care plan interventions to ensure risks, monitoring, and interventions are communicated to all staff involved in the residents' care, placing residents at risk for unrecognized bleeding. The facility policy, "Care Planning," revised 11/2024, lacked specific guidance requiring the identification and care planning of high-risk medications and medication administration routes. As a result, the policy did not ensure that foreseeable risks, such as bleeding related to blood-thinning medications, were addressed through individualized care plan interventions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee will create, review, and/or revise policies and procedures to ensure that individualized care plans are developed and implemented, including care plans that specifically address the use of blood-thinning medications, in order to meet the needs of each resident. The DON or designee will establish a system to educate staff on these care plans and will develop a monitoring system, such as measurable audits, to ensure that individual care plans—including those related to blood-thinning medications—are consistently used and followed. The results of these audits will be reviewed by the QAPI committee to determine compliance and identify the need for additional monitoring or corrective actions. The Administrator will be responsible for ensuring that	20555		

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20555	Continued from page 6 these actions are implemented and maintained. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	20555		