Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 14, 2026

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

RE: CCN: 245276
Cycle Start Date: September 30, 2026

Dear Administrator:

On September 30, 2026, a survey was completed at your facility by the Minnesota Department of Health 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 actual harm that was not immediate jeopardy (Level G). The Statement of Deficiencies (CMS-2567) is being electronically delivered. Because corrective action was taken prior to the survey, past non-compliance does not require a plan of correction (POC).

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 listed below to the CMS location.

- **Civil money penalty, (42 CFR 488.430 through 488.444).**

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

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.

Therefore, your agency may be prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective September 30, 2026. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

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 Operations Supervisor, 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

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)

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

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

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 09/30/2026

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 9/30/26, 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: H52764425C (3709428), H52764425C (3709009), and H52764425C (3708343); with a deficiency cited at F760 at PAST NON-COMPLIANCE. 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		
F0760 SS = G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and document review, the facility failed to give the right dose of a narcotic pain medication (Methadone) to the right resident for 1 of 2 residents (R1) reviewed for medication errors. The facility's failures caused harm when R1 was admitted to the hospital after she was administered 40 times more than the prescribed dose of Methadone. However, the facility implemented immediate corrective action on 9/28/26, prior to survey, so the deficient practice was issued at past non-compliance.	F0760	"Past Noncompliance - no plan of correction required"	

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 09/30/2026

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
F0760 SS = G	Continued from page 1 Findings include: R1’s face sheet identified diagnoses of chronic pain syndrome, acute respiratory failure with hypoxia, altered mental status, and anxiety disorder. R1’s admission Minimum Data Set (MDS) dated 7/1/26, identified R1 had cognitive deficits, was able to understand and be understood. R1 was dependent on staff for eating and activities of daily living. R1’s care plan dated 8/27/26, identified R1 had a risk for discomfort related to opioid use. Interventions dated 8/27/26, included: Administer pain medications as ordered. Monitor for side effects and document on effectiveness of prescribed medication. Monitor for potential medication side effects related to pain medication usage including constipation, nausea/vomiting, sedation, lethargy, anorexia, and increased confusion. R1’s physician order dated 8/8/26, identified an order for Methadone HCI tablet. Give 2.5 milligrams (mg) every 12 hours for pain. R1’s Medication Administration Record (MAR) for September 2026, identified R1’s Methadone dose was scheduled daily at 8:00 a.m. and 8:00 p.m. and signed out as given for each dose from September 1-28. Registered nurse (RN)-A signed out the medication as given on 9/28/26. R1’s ledger in the bound Narcotic Book count identified that the last dose of Methadone 2.5 mg provided to R1 was on 9/28/26 at 7:40 a.m. by the nurse working the day shift. R1’s Methadone count in the bound book matched the number of tablets in the prepackaged card for the last dose given at 7:40 a.m., with a count of 52 tablets remaining. However, in another resident’s ledger in the bound Narcotic Book, a Methadone dose of 10 milligrams/milliliter Methadone was given at 7:55 p.m. on 9/28/26, and signed out by RN-A. R1’s progress note dated 9/28/26 at 9:15 p.m., identified R1 had received the wrong patient’s Methadone, which was a different dose than R1 was prescribed. Upon assessment, R1’s vital signs were within normal limits and R1 did not appear to have a change in condition. Emergency medical services (EMS) were contacted, did not feel Narcan needed to be administered. EMS would not transport R1 to the	F0760		

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 09/30/2026

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
F0760 SS = G	Continued from page 2 hospital until hospice gave approval. Hospice and family updated and hospice gave approval. R1 left facility at 8:50 p.m. R1’s progress note dated 9/28/26, at 11:27 p.m., identified R1 was admitted to hospital. Facility filed a report with the State Agency regarding incident. R1’s Hospital records dated 9/30/26, identified R1 was hospitalized on 9/28/26, following an accidental methadone overdose due to administration error at facility. R1 was scheduled to receive Methadone 2.5 mg twice daily but received 100 mg dose resulting in altered mental status and unresponsive that required continuous Narcan drip due to opioid-induced respiratory depression. R1 required extended duration of Narcan infusion given long-acting Methadone. R1’s Narcan drip was discontinued on 9/30/26 at 11:30 a.m. During a phone interview on 9/30/26, at 12:46 p.m., RN-A stated this was her first time working at this facility and she provided medications to R1 on the morning of 9/28/26. RN-A stated when she was preparing R1’s medications for administration R1 had an order for Methadone. RN-A opened the locked narcotic box, saw a bottle of liquid Methadone and assumed it was R1’s. RN-A looked at the dose of medication label which directed to give 100 mg then gave the 100 mg dose to R1. RN-A stated she did not verify the order on the bottle against R1’s prescription in the electronic health record (EHR). RN-A stated shortly after she gave R1 her medications on 9/28/26, R1 called her into her room “because she didn’t feel ok” and complained of her stomach getting upset. RN-A stated she asked R1 if her stomach was upset from something she ate, took a set of vital signs, “which were normal”, everything seemed fine from the assessments so RN-A gave R1 water to drink. RN-A advised R1 to call in five minutes if she still did not feel good. R1 called RN-A back into the room in less than five minutes to report she felt lousy. RN-A took another set of “normal” vital signs and went to the medication cart to review the list of medications she had provided to R1 and questioned if the cause was from one of the medications. RN-A noted R1 had Methadone, that a side effect of an overdose of Methadone was upset stomach, and that was “when I noticed I gave the wrong dose”. RN-A returned to R1’s room and completed another set of vital signs, had another nurse sit with and monitor R1. RN-A notified the provider and called 9-1-1. RN-A stated she did not follow the six rights of medication administration when providing R1 the Methadone.	F0760		

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 09/30/2026

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
F0760 SS = G	Continued from page 3 During an interview on 9/30/26, at 12:17 p.m., Administrator and director of nursing (DON) were present. DON and Administrator came to facility after the incident occurred on 9/28/26, and immediately placed RN-A on suspension. They immediately began education on following the rights of medication administration with all nurses and trained medication aides (TMA) that were working. DON stated they educated staff as they came for each shift and continued to provide the education until all staff that pass medications had been trained. Administrator reviewed RN-A's license, background check, and verified through sister facilities that RN-A had not had any disciplinary actions or significant medication errors prior to 9/28/26. DON began an audit of the bound Narcotic books to ensure there was no potential for a system error. In addition, the liquid Methadone was placed in a lockbox within the narcotic locked box so it would be an extra step. DON completed audits on the six rights of medication administration with all nurses and TMA's and would be continuing to do weekly audits and report findings to quality assurance performance improvement committee. During DON's investigation RN-A reported she made the error because she "was going too fast"; after RN-A acknowledged where she had made the mistake, she followed the medication error policy. DON had kept in contact with the hospital and stated R1 was receiving Narcan intravenously (IV) and when R1 returned to baseline, R1 would return to facility. Administrator and DON both acknowledged that administration of 100 mg of Narcan when 2.5 mg was prescribed was a significant medication error. During a phone call on 9/30/26, at 2:59 p.m., pharmacist (PH)-A stated providing a resident with 100 mg of Methadone would be considered a significant medication error and could potentially be lethal to an opioid naïve adult. During a phone call on 9/30/26, at 1:34 p.m., medical doctor (MD)-A stated an overdose of Methadone could include respiratory depression, respiratory distress, cardiac arrest, and unfortunately death. MD-A stated this was a significant medication error. "It's a big mistake and unfortunate. We will do everything we can to prevent it in the future. Thank goodness R1 seems to be doing good." The following corrective actions were verified as implemented on 9/28/26, prior to the survey, through interview and record review: sent R1 to hospital, suspension of RN-A immediately, staff education on six rights of medication administration, audit of all bound Narcotic books and medication	F0760		

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 09/30/2026

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
F0760 SS = G	Continued from page 4 carts, audit of like residents, placed the liquid Methadone in a secondary individual lock box inside the locked box in the medication cart, and replacement of other residents Methadone. The facility Medication Administration General Guidelines dated 1/2026, identified the six rights of safe medication administration: right patient, right medication, right dose, right time, right route, and right documentation.	F0760		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 14, 2026

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

Re: Event ID: 3EC50E-H1

Dear Administrator:

The above facility survey was completed on September 30, 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/30/2026**

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
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 9/30/26, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was IN compliance with the MN State Licensure The following complaints were reviewed during the survey: H52764425C (3709428), H52764425C (3709009), and H52764425C (3708343). No orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal	20000		

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:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **09/30/2026**

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
20000	Continued from page 1 software. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	20000		