STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. Building B. Wing	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maplewood Rehabilitation Center	1900 Sherren Avenue East Maplewood, MN 55109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident's primary medical provider was notified of changes in condition for 1 of 1 resident (R1) who exhibited increased pain and extremity swelling after a fall, which required x-ray services, along with failure to ensure a physician order was acted upon for R1 after she returned from the emergency department (ED).Findings include: R1's quarterly Minimum Data Set (MDS), dated [DATE], identified severe cognitive impairment. R1's diagnoses included, but not limited to, diabetes, stroke, malnutrition, depression, bipolar disorder, chronic pain syndrome, insomnia, and vascular dementia. Additionally, R1 continued with hospice care. She was administered scheduled pain medication during the five days of the assessment period; however, no PRN medications and/or non-medication interventions for pain. R1 was unable to participate in the pain questionnaire and staff interview(s) indicated R1 lacked indicators of pain, or possible pain, during the assessment period. R1's May 2025 progress notes lacked pain related entries related to any R1 pain verbalizations and/or physical s/s of pain. R1's comprehensive care plan, identified, on 5/31/24, a pain care plan indicated R1's chronic pain and fibromyalgia (long-term condition causing widespread body pain, fatigue, etc.). Interventions directed staff to observe for signs of unmet pain and to report any increase in pain to MD/NP (medical doctor/nurse practitioner). A progress note, dated 6/12/25 at 9:48 p.m., identified R1 was found on the floor. R1 responded to staff she fell after they attempted to question her on fall details. An assessment was free of signs and/or symptoms (s/s) of injury, but she endorsed arm and back pain. Daughter, hospice, and on-call [facility] nurse were contacted. The note lacked evidence the medical provider was updated that evening. A Found on Floor Risk Management report, dated 6/12/25 at 7:45 p.m., identified the 6/12/25 progress note information, along with information R1's pain level was assessed at a 3 based on R1's negative vocalization (occasional moan or groan, low level of speech with a negative quality), her facial expression (sad, frightened, frown) and her body language (tensed, distressed pacing). The report indicated R1 was Agitated, forgetful, confused, did not always realize her limitations, and had dementia. The report lacked additional details to R1's agitation and/or any possibly associated behaviors. Additionally, the report lacked evidence the medical provider was updated. A hospice note, dated 6/12/25, indicated R1 was assessed by registered nurse (RN)-B in response to the fall. The assessment was free of fracture s/s. R1 was unable to verbalize pain. She laid in bed comfortably but appeared anxious and pulled at her clothing. Staff were instructed to utilize PRN pain medications. A progress note, dated 6/13/25, indicated the interdisciplinary team (IDT) meet and reviewed the fall. No injuries were identified. The nurse practitioner (NP) and the daughter were updated [time and/or route of the provider update was not identified]. R1's MARs, 5/1/25 through July 7/7/25 identified the following information:-Gabapentin in the evening for neurogenic pain each month.-Methadone 2.5mg twice a day: May (nine doses not administered due to her sleeping); June (18 doses not administered due to sleeping - seven instances prior to a 6/12/25 fall and 11 after); July (two doses not administered due to her sleeping).-Methadone 5mg (milligrams) at bedtime (HS) for chronic pain syndrome: May (with one dose not administered due to her sleeping); June (four doses not administered due to sleeping - one instance prior to the fall and three after); July (no missed administrations).-Tylenol 1000mg three times a day for pain: May (12 doses not administered due to her sleeping. Pain level monitoring indicated six shifts with documented pain, identified either a 2 or a 3 in intensity); June (27 doses not administered due to her sleeping and/or refusal - seven instances prior to the fall and 19 after. Pain level monitoring indicated no signs of pain prior to the fall and pain on four days with pain documented once as a 1, once as a 4, and twice as 6, after the fall); July (five doses not administered due to her sleeping and/or refusal. Pain level monitoring indicated three days with pain ranging from 4 to 5). -Hydromorphone PRN: May (no administrations); June (6/12/25 after the fall with a pain score of 8, and then on 6/20/25, 6/21/25, 6/23/25, 6/24/25 three times, 6/26/25, and 6/27/25 with pain ranging from a 4 to a 10); July (administered three times with pain ranging from 4 to 5).-Morphine sulfate PRN: May (no administrations); June (administered on 6/23/25 - 6/28/25, once each day with pain ranging from 6 to 8); July (administered twice with pain at a 4). -R1's June MAR/TAR lacked evidence fall monitoring was implemented after the fall to monitor for fall related concerns. A hospice Physician Order, dated 6/16/25, identified R1's every four-hour lorazepam was discontinued and a new order for three times a day dosing was initiated. R1's medical record lacked evidence her medical provider was updated on the lorazepam order and/or was collaborated with prior to, or after this adjustment. On 6/20/25, a progress note

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement individualized interventions to reduce the risk of falls for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm for R1 who sustained fractures after a fall from bed, and required emergency medical care. Findings include: R1's significant change Minimum Data Set (MDS) Falls CAA (Care Area Assessment) Worksheet, dated 11/6/24, identified R1 was diagnosed with vascular dementia, end stage chronic disease, diabetes, bipolar disorder, and pain syndrome. She required staff assistance and triggered falls related to daily scheduled antianxiety medications. She was free of falls in the past year. She was enrolled in hospice (end of life) care since 6/2022. R1 was non-ambulatory and was bed-bound. At times, R1 lacked verbal responses and was impacted by flexion contracture of the upper extremity. R1's quarterly MDS, dated [DATE], identified severe cognitive impairment. R1 required overall dependence on staff for her activities of daily living (ADLs) with substantial/maximal assistance for rolling from side to side while in bed. R1's diagnoses included, but not limited to, stroke, chronic pain syndrome, and moderate vascular dementia. Additionally, R1 continued with hospice and displayed episodes of bowel and bladder incontinence. R1 was free of falls in the previous three months. R1's admission Record, printed 7/7/25, identified the following additional diagnoses: obsessive-compulsive disorder (mental health condition with unwanted thoughts and repetitive behaviors), fibromyalgia (long-term condition causing widespread body pain, fatigue, etc.), and weakness. R1's comprehensive care plan, identified, on 5/31/24, R1 was determined to have an ADL deficit related to many of the above diagnoses along with back contractures that caused her to lean forward at times. One of the two goals was to remain free of falls/sliding out of bed to the floor. Interventions directed R1 to be laid down around 7:00 p.m. - 7:30 p.m. and if R1 was agitated, she was to be up in the broda chair (specialized chair to help support head, neck, spine) by the nurses' station for observation. R1's comprehensive care plan, identified, on 5/31/24, R1 had a history of falls with risk factors related to morbid obesity, right sided weakness secondary to her history of stroke, gout (form of arthritis), COPD (chronic obstructive pulmonary disease), chronic pain, incontinence, dementia and end state renal disease. [R1] becomes agitated and restless at times. R1's goal was to remain free of falls. On 6/12/25, interventions directed a few of the following: bariatric bed for comfort and to help prevent falls from bed, broda chair for comfort, and Place in staff view when restless. R1's comprehensive care plan, identified on 5/31/24, R1 had a potential for altered mood state due to bipolar disorder with depression and anxiety where she was anxious and/or hot at times and will take blankets off. Additionally, she had episodes of restlessness, asking repetitive questions, and/or yelling out for her brother when he is not there. Goal was for R1 to be less anxious after staff interventions. Interventions directed medications per physician orders, to provide reassurance and TLC (tender loving care), and to remind resident to use distraction strategies when worried such as deep breathing, watching TV, and to assist with re-dressing with encouragement to keep clothing on. R1's June 2025, Medication Administration Record (MAR), identified an order for lorazepam (anti-anxiety) medication every four hours with an evening dose scheduled at 6:00 p.m., along with every four hours as needed (PRN) dosing. The MAR identified no PRN dosing was administered. An Administration Details report printed 7/9/25, identified R1 was administered the scheduled 6:00 p.m. lorazepam at 5:05 p.m. R1's June 2025 Medication Administration Record (TAR), identified staff documentation each shift for Non-Pharmacological Pain Interventions. 6/12/25's, evening section identified a 0 correlating to No interventions needed. Additionally, another section instructed each shift for the nurse to offer pain medication and anti-anxiety medication throughout the shift as R1 would often not ask for these medications. Documentation for this identified a 0. A Found on Floor Risk Management report, dated 6/12/25 at 7:45 p.m., identified the 6/12/25, progress note information, along with information R1's pain level was assessed at a 3 based on R1's negative vocalization (occasional moan or groan, low level of speech with a negative quality), her facial expression (sad, frightened, frown) and her body language (tensed, distressed pacing). The report indicated R1 was Agitated, forgetful, confused, did not always realize her limitations, and had dementia. An immediate interaction initiated was to Check and change after dinner [supper]. A section labeled Predisposing Situation Factors (i.e. , rolled out of bed, reaching for something, exhibiting behaviors, toileting needs, responding to hunger/thirst needs, other, etc.,) lacked indication of any such identified factors. The report lacked additional details to R1's agitation and/or any possibly associated behaviors. Additionally, the report lacked identification of