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	01/27/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 [DATE] 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 (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 [DATE] 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 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.