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	12/04/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and document review, the facility failed to ensure the Quality Assurance and Performance Improvement (QAPI) program effectively sustained ongoing compliance related to repeat citations for past surveys regarding provider notification of changes, care plan revisions, arrangement of hearing appointments, oxygen administration, and infection control practices. This had the potential to affect all 101 residents residing in the facility. Findings include:Review of the facility Certification and Survey Provider Enhanced Reports (CASPER)-3 (assessment data was converted to quality measures [QM] to evaluate nursing home's performance) dated11/25/25, identified the following prior deficiencies by month and year. F580-Notify of Changes (Injury/Decline/Room, etc.) cited on prior survey 11/7/24. Cited at a scope and severity (S&S) of a D. F657-Care Plan Timing and Revision cited on prior surveys 10/2023 and 11/27/24. Cited both times at a scope and severity (S&S) of a D. F685-Treatment/Devices to Maintain Hearing/Vision cited on prior survey 11/7/24. Cited at a scope and severity (S&S) of a D. F695-Respiratory/Tracheostomy Care and Suctioning cited on prior survey 11/7/24. Cited at a scope and severity (S&S) of a D. F880-Infection Prevention & Control cited on prior survey 11/7/24. Cited at a scope and severity (S&S) of a E. See also F580. Based in interview and record review the facility failed to ensure notification was made to the provider and resident representative for concerns of toenail infection and refused podiatry appointments for 1 of 1 resident R83 who required podiatry services. Furthermore, the facility failed to promptly notify the resident's physician and/or practitioner of changes in resident condition for 2 of 2 residents (R53 and R55) reviewed for notification of changes. Specifically, the facility failed to notify the provider of episodes of diarrhea for 1 resident (R53) reviewed for constipation and failed to notify the provider of significant weight gain in accordance with physician-ordered parameters for 1 resident (R55). These deficient practices had the potential to delay medical evaluation and treatment.See also F657. Based on record review and interview, the facility failed to ensure resident-centered care plans were developed, implemented, and revised to accurately reflect residents' current needs for 3 of 3 residents reviewed (R55, R102, and R109). Specifically, the facility failed to include required interventions for edema management for 1 resident, failed to update the care plan to remove discontinued enhanced barrier precautions for 1 resident, and maintained conflicting information regarding the level of assistance required for eating for 1 resident. These deficient practices resulted in the potential for inconsistent care, unmet resident needs, and compromised resident safety and well-being.See also F685. Based on observation, interview, and document review, the facility failed to ensure audiology appointments were available for 1 of 1 resident (R67) who requested audiology services.Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided in accordance with physician orders and professional standards of practice for 1 of 1 residents reviewed (R109). Specifically, the facility administered oxygen therapy without a physician's order. This deficient practice resulted in the potential for improper oxygen administration, respiratory compromise, and harm to the resident.See also F880. Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were in place for maintaining a central line with dressing changes and use of enhanced (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
	245276	A. Building B. Wing	12/04/2025

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	barrier precautions (EBP) with personal protective equipment (PPE) for 1 of 2 residents (R36) reviewed who had a central line indwelling device.The facility's QAPI committee meeting minutes dated 11/11/25, lacked evidence of ongoing monitoring, tracking or audits to ensure continued compliance from the previous recertification survey. During interview on 12/4/25 at 3:33 p.m., regional operations director (RDO) stated expectation was for QAPI program to continue to ensure compliance through audits, spot checks and mock surveys.

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	12/04/2025

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure toenail care was completed for 1 of 1 resident (R83) who was dependent on staff assistance for activities of daily living (ADLs). Findings include:R83's quarterly Minimum Data Set (MDS) dated [DATE], indicated R83 had severe cognitive impairment and diagnoses of intellectual disabilities, seizure disorder, and personality disorder. R83 had no rejection of cares and was dependent on staff for lower body dressing, including socks and shoes. R83's Therapy ADL communication form dated 10/31/25, indicated R83 was dependent of staff for clothing management.R83's provider order dated 8/16/26. Indicated R83 required a nurse skin check weekly. R83's weekly skin inspection dated 10/27/25, indicated R83 had a shower and R83's toenails did not require trimming. R83's weekly skin inspection dated 11/1/25, indicated R83 had a bed bath and R83's toenails were trimmed.R83's weekly skin inspection dated 11/8/25, indicated R83 had a shower and R83's toenails did not require trimming.R83's weekly skin inspection dated 11/17/25, indicated R83 had a bed bath and R83's toenails were trimmed.R83's care plan revised 8/22/25, indicated R83 required interventions with ADL care. R83 required extensive assist of one person for lower body dressing and two persons assist with bathing. R83's emergency room provider progress note dated 11/25/25, indicated R83 had bad toenail infection and was started on Lamisil 250 milligram (MG) tablet (medication for fungal infection) daily for 28 days. The note further described R83's bilateral feet with significant thickening and discoloration of all the toenails with red non-blanching papules on bilateral feet. R83's diagnosed with fungal infection of the toenails. When interviewed on 12/2/25 at 8:05 a.m., nursing assistant (NA)-A stated nail care was completed on bath days. If the resident was diabetic, the nurse would do them. If there was any concern with toenails, the nurse would be notified.When interviewed on 12/2/25 at 9:06 a.m., registered nurse (RN)-A stated nail care was completed on shower days. The nurses were responsible to complete them if the resident was diabetic. Documentation was completed by the nurses in the weekly skin assessment. RN-A was not aware of any concerns with R83's toenails. When interviewed on 12/2/25 at 10:3 a.m., the assistant director of nursing (ADON) did not recall nail concerns for R83 and further stated if there were any concerns with toenails, podiatry would have seen him. ADON further stated nail care was documented on the weekly skin assessments and verified as indicated in the chart. Pictures of R83's nails were shown and ADON. ADON verified R83's toenails looked overgrown, yellow and thick and R83's toenails could not have been done recently as indicated in the documentation.When interviewed on 12/2/25 at 2:04 p.m., guardian-A stated R83 had discharged recently from the facility to a group home. When arriving at the group home it was noted R83's toenails were in terrible shape. They were all yellow and appeared some were almost falling off. R83 was sent into the emergency room for treatment, and it was determined R83 had a bad toenail infection and was started on some medication. Guardian-A further stated she was unaware of R83's toenail issue as the facility had never discussed it with her. When interviewed on 12/3/25 at 9:10 a.m., physician assistant (PA)-A stated she was the provider for R83 at the group home. PA-A stated the group home called and requested an urgent visit to assess the toenails when R83 had arrived. Unable to complete a visit, staff sent R83 to the ER for evaluation of his feet. R83 was aware of the treatment prescribed for R83 and was due to follow up with him next week. PA-A stated the description of the nails by the emergency room provider would lead her to believe the condition has been going on for a few months. When interviewed on 12/3/25 at 10:47 a.m., the Director of Nursing (DON) expected nails to be looked at and care completed if needed on bath days. Furthermore, any concerns with toenails should be brought to the ADON for evaluation and would contact the provider as needed. A facility policy titled Activities of Daily Living /Maintain Abilities dated 3/31/25, directed staff to provide services to maintain good grooming and personal hygiene to residents who are unable to carry out activities of daily living.

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	12/04/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interview, the facility failed to ensure residents received care and services to maintain or prevent decline in range of motion in accordance with their functional maintenance programs for 7 of 7 residents reviewed (R1, R4, R53, R55, R88, R108, and R109). Specifically, the facility failed to implement prescribed range of motion (ROM) exercises as outlined in residents' functional maintenance programs. In addition, the facility lacked a policy or procedure to ensure functional maintenance programs were implemented, communicated to direct care staff, and consistently monitored for completion. This deficient practice resulted in the potential for decreased mobility, increased contractures, pain, and decline in functional status. Findings include: R1's diagnoses included hemiplegia and hemiparesis (weakness on one side of the body) following a cerebral infarction (stroke) affecting left non-dominant side, muscle weakness, acute respiratory failure with hypoxia, gout, morbid (severe) obesity with alveolar hypoventilation (respiratory condition characterized by inadequate ventilation). R1's quarterly Minimum Data Set (MDS) dated [DATE], indicated R1 was cognitively intact. His functional limitations in ROM were upper and lower extremity impairment on one side and mobility device utilized was a wheelchair. R1's required moderate assistance with bed mobility, personal hygiene and upper body dressing. R1 required maximal assist with lower body dressing and putting on/taking off footwear. R1 was dependent for transfers, chair/bed-to-chair transfers and toileting. R1's physician orders included the following: physical therapy (PT) and occupational therapy (OT) to evaluate and treat, On 11/28/25, OT ordered R1 to receive active assistive range of motion (AAROM) on both upper extremities for shoulders, elbows, wrist and hands 10-15 reps one-two sets per the Functional Maintenance Program. R1's care plan dated 11/13/25, indicated self-care deficit. R1 was dependent on assistance from staff with ADL's. Interventions included functional maintenance program- assist with passive range of motion (PROM) to both hips, knees and ankles. R1 was dependent on two staff for boosting up in bed, required supervision with bed mobility, and transferred with assist of two and wheeled walker. R1's treatment administration record (TAR) dated November 2025, lacked functional maintenance documentation, and a schedule for it to be completed. During interview on 12/1/25 at 7:39 p.m., R1 stated he had limited ROM on left side due to a stroke, was not participating in PT or OT. The therapies were discontinued, he had a maintenance program from OT, staff was supposed to help but did not. Associated Clinic of Psychology (ACP) progress note dated 10/30/25, R1 reported being interested in using some hand weights to increase strength. During interview on 12/2/25 at 3:07 p.m., registered nurse (RN)-D reported the cares and treatments (continued on next page)

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	12/04/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for residents were documented in the care plan, care sheets, and treatment administration record (TAR) and tasks. To confirm the cares were being done, she observed and assisted staff in cares, provided additional education and support to the staff, RN-D did not perform ROM with residents. During observation on 12/3/25 at 9:18 a.m. NA-E completed cares for R1 according to care plan. However, no ROM was completed per the functional maintenance program. During interview on 12/3/25 at 9:51 a.m., nursing assistant (NA)-E stated updates to resident care needs was provided during stand-up report, care sheets and tasks. NA-E stated R1 did not receive range of motion cares. During interview on 12/4/25 at 1:20 p.m., Director of Nursing (DON)-A stated ROM was expected to be done as ordered. The facility had a corporate change about 2 years ago, the other system, when information was put in care plan it would automatically populate over to all other areas. However, we just found out that it was not, the functional maintenance program was not getting done. It was important to keep the resident's mobility and strength. The interdisciplinary team (IDT) was reviewing care plans, TAR, care sheets and tasks to confirm all areas were updated and accurate. The staff would be provided ROM education according to recommendations. R4R4's annual Minimum Data Set (MDS) dated [DATE], identified R4 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R4's diagnoses included multiple sclerosis, anemia, gastroesophageal reflux disease (GERD), non-Alzheimer's dementia, seizure disorder, malnutrition, depression, bipolar disorder, post-traumatic stress disorder (PTSD), dysphagia, and slow transit constipation. The MDS also indicated R4 had a feeding tube. Record review on 12/2/25 revealed R4 had an active functional maintenance program (FMP) dated 6/17/25 that included scheduled passive and active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions. Review of therapy documentation since the start of R4's FMP and nursing notes revealed no documentation indicating the range of motion exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R4. R53R53's significant change MDS dated [DATE], identified R53 had intact cognition and required assistance with some ADLs. R53's diagnoses included hemiplegia following cerebral infarction affecting the left non-dominant side, hypertension, GERD, renal failure, diabetes mellitus, arthritis, stroke, anxiety disorder, and adjustment disorder with mixed anxiety and depressed mood. The MDS indicated R53 was not experiencing constipation. Record review on 12/2/25 revealed R53 had an active functional maintenance program dated 11/13/25 that included scheduled active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions. Review of therapy documentation and nursing notes since the start of R53's FMP, revealed no documentation indicating the exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R53. (continued on next page)

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	12/04/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R55R55's quarterly MDS dated [DATE], identified R55 had intact cognition and required assistance with ADLs. R55's diagnoses included heart failure, hypertension, hyperlipidemia, schizophrenia, pulmonary embolism without acute cor pulmonale (enlarged right ventricle of the heart), hypoxemia (low oxygen saturation in the blood), thrombocytopenia (low platelet count in the blood), acute embolism (obstruction of a blood vessel) and thrombosis (blood clot) of deep veins of the left upper extremity, hypothyroidism, and dysthymic disorder (persistent depressive disorder). Record review on 12/2/25 revealed R55 had an active FMP dated 3/10/25 that included scheduled active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions. Review of therapy documentation and nursing notes since the start of R55's FMP revealed no documentation indicating the exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R55. R88R88's quarterly MDS dated [DATE], identified R88 had moderate cognitive impairment and required assistance with ADLs. R88's diagnoses included cancer, anemia, hypertension, renal failure, obstructive uropathy (blockage in the urinary system), diabetes mellitus, arthritis, non-Alzheimer's dementia, urinary retention, generalized edema, hydronephrosis (stops urine from flowing from the kidney to the bladder), benign prostatic hyperplasia (BPH), and presence of urogenital implants. The MDS indicated R88 had an indwelling urinary catheter and did not exhibit behaviors. Record review on 12/2/25 revealed R88 had an active FMP dated 2/19/25 that included scheduled active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions. Review of therapy documentation and nursing notes since the start of R88's FMP revealed no documentation indicating the exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R88. R108R108's quarterly MDS dated [DATE], identified R108 had moderate cognitive impairment and required assistance with ADLs. R108's diagnoses included stroke, hemiplegia following cerebral infarction affecting the right dominant side, anemia, hypertension, renal failure, wound infection, diabetes mellitus, hyperlipidemia, arthritis, aphasia (communication disorder), seizure disorder, anxiety disorder, depression, chronic obstructive pulmonary disease (COPD), furuncle (boil) of the buttock, immunodeficiency, and mood disorder due to a known physiological condition. Record review on 12/2/25 revealed R108 had an active FMP dated 6/2/25 that included scheduled passive and active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions, and an additional FMP dated 6/4/25 that included scheduled passive and active range of motion exercises to both hips, knees, and ankles, consisting of two sets of 10 repetitions. Review of therapy documentation and nursing notes since the start of R108's FMP revealed no documentation indicating the exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R108. R109R109's quarterly MDS dated [DATE], identified R109 had intact cognition and required assistance with ADLs. R109's diagnoses included hemiplegia following cerebral infarction affecting (continued on next page)

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	12/04/2025

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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the right dominant side, hypertension, diabetes mellitus, hyperlipidemia, malnutrition, bipolar disorder, dysphagia following cerebral infarction, unspecified protein-calorie malnutrition, and constipation. Record review on 12/2/25 revealed R109 had an active FMP dated 8/8/25 that included scheduled passive and active range of motion exercises to both shoulders, elbows, wrists, and hands, consisting of one to two sets of 10 to 15 repetitions. Review of therapy documentation and nursing notes since the start of R109's FMP revealed no documentation indicating the exercises were carried out as prescribed. Record review revealed no documentation of resident refusal, contraindications, or physician notification regarding the lack of ROM exercises for R109. During an interview on 12/3/25 at 1:23 p.m., nursing assistant (NA)-A stated there were no residents on the third floor with functional maintenance programs. NA-A stated residents who received therapy services completed range of motion exercises during therapy sessions and confirmed range of motion exercises were not completed by nursing staff. During an interview on 12/3/25 at 2:48 p.m., NA-F stated there were no range of motion exercises for any residents that needed to be completed by staff. During an interview on 12/4/25 at 11:45 a.m., the assistant director of nursing (ADON) confirmed residents' functional maintenance programs required ongoing ROM exercises and acknowledged there was no documentation indicating the exercises had been implemented consistently. The ADON stated nursing assistants should have been completing the exercises as ordered. The ADON explained when functional maintenance programs were added to residents' care plans, a required step to pull the program into point-of-care documentation had not been completed, resulting in staff being unaware of the programs. The ADON stated range of motion exercises were important to maintain resident strength and prevent loss of stamina. During an interview on 12/4/25 at 12:18 p.m., the Director of Nursing (DON) confirmed residents with functional maintenance programs were expected to receive ROM exercises as outlined by therapy and acknowledged the exercises were not implemented as ordered. The DON stated the programs were not pulled into point-of-care documentation, and therefore staff were not aware A facility policy for mobility was requested. The interim Administrator stated the facility did not have a generalized mobility policy.

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	12/04/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure a resident's right to privacy and dignity was maintained by ensuring personal medical equipment was not exposed to public view for 1 of 1 residents (R88) reviewed for resident rights. Specifically, the facility failed to ensure a urinary catheter drainage bag was positioned discreetly while the resident was laying in his bed with the door opened to the main hallway. This deficient practice had the potential to compromise the resident's dignity and privacy.Findings include:R88's quarterly Minimum Data Set (MDS) dated [DATE] identified R88 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R88's diagnoses included cancer (abnormal cell growth), anemia (low red blood cells), hypertension (high blood pressure), renal failure (impaired kidney function), obstructive uropathy (blocked urine flow), diabetes mellitus (impaired blood sugar regulation), arthritis (joint inflammation), non-Alzheimer's dementia (cognitive decline not due to Alzheimer's disease), urinary retention (inability to fully empty the bladder), generalized edema (fluid-related swelling), hydronephrosis (kidney swelling from urine backup), benign prostatic hyperplasia (BPH) (enlarged prostate causing urinary obstruction), and presence of urogenital implants (surgically placed urinary devices). The MDS also indicated R88 had an indwelling urinary catheter (continuous bladder drainage) and did not exhibit any behaviors.During observation on 12/2/25 at 9:13 a.m., R88 was observed lying in bed with the door open to the main hallway. R88 had an indwelling urinary catheter, and the catheter drainage bag, which was approximately half full of yellow-amber colored urine, was hanging uncovered on the side of the bed and was visible to other residents, visitors, and staff in the area. During observation on 12/3/25 at 2:22 p.m., R88 was lying in bed with the door open to the main hallway. R88's catheter drainage bag, which was approximately half full of yellow-amber colored urine, was hanging uncovered on the side of the bed and was visible to other residents, visitors, and staff in the area. During an interview on 12/3/25 at 1:42 p.m., nursing assistant (NA)-A stated R88 required assistance with all cares, including transferring the catheter bag from under his wheelchair to the side of his bed. NA-A stated the catheter bag should be covered and confirmed it was not. During an interview on 12/3/25 at 2:33 p.m., registered nurse (RN)-E stated catheter bags should be covered by placing them in a bag to protect the resident's privacy and dignity. RN-E stated staff must assist R88 with moving the catheter bag from under his wheelchair to the side of his bed. RN-E confirmed the catheter bag was hanging uncovered on the side of the bed and was visible to others. Why is it important to have the bag covered? Res dignity? I had indicated this above (bolded area) During an interview on 12/3/25 at 2:44 p.m., licensed practical nurse (LPN)-D stated catheter bags should be covered to respect resident privacy and dignity. LPN-D stated staff must assist R88 with moving the catheter bag from under his wheelchair to the side of his bed. LPN-D confirmed the catheter bag was hanging uncovered on the side of the bed and was visible to others. During an interview on 12/4/25 at 11:23 a.m., the assistant director of nursing (ADON) stated she would expect all catheter bags to be covered at all times to protect resident privacy and dignity. The ADON stated catheter bags should be covered whether positioned under a wheelchair or on the side of the bed. The ADON stated if a catheter bag was not covered and was visible to others, it would be a dignity concern. During an interview on 12/4/25 at 12:22 p.m., the director of nursing (DON) stated she would expect staff to cover residents' catheter bags at all times to maintain privacy and dignity. A facility policy related to catheter care and privacy was requested but was not provided.

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	12/04/2025

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure call lights were accessible to 1 of 1 resident (R74) reviewed for call light accessibility. Findings include:R74's annual Minimum Data Set (MDS) dated [DATE], indicated severe cognitive impairment, was able to express ideas and wants, used a wheelchair, was dependent on staff for dressing, hygiene, bathing, and transfers, and required substantial assistance with rolling in bed, sitting to lying in bed and lying to sitting on the side of the bed, and was always incontinent.R74's Falls care area assessment (CAA) dated 10/22/25, indicated R74 had no falls, however, was at risk for falls due to decreased mobility and strength and planned to continue with the care plan.R74's care sheet indicated in a pink banner that all nursing assistants were expected to assist with all call lights. R74's care plan dated 4/11/23, indicated R74 was alert and oriented to person.R74's care plan dated 4/10/23, indicated R74's goal was to have no injuries due to falling with a target date of 1/9/26. Interventions included to make sure the call light was within reach and encourage R74 to use it for assistance as needed and provide prompt response to all requests for assistance.During observation on 12/1/25 between 7:19 p.m. and 7:26 p.m., R74 was in bed sleeping. R74's call light was located on the floor and unidentified staff assisted R74's roommate to bed, walked by R74 and left the room and did not provide R74 with his call light.During observation on 12/3/25 at 7:33 a.m., R74 was in bed and his call light was located under R74's roommate's bed.During observation on 12/3/25 at 8:01 a.m., nursing assistant (NA)-C sanitized his hands in the hallway near the storage closet and looked in R74's room and continued walking past the room and did not pick up R74's call light.During observation on 12/3/25 at 8:05 a.m., NA-C looked inside R74's room and closed the door but did not give R74 his call light and continued down the hall.During interview and observation on 12/3/25 between 8:09 a.m. and 8:12 a.m., NA-C stated R74 required total care and could make his needs known and further stated he asked R74 about getting up, R74 told NA-C he did not want to get up and stated R74 should always have his call light so staff can assist with his needs. At 8:12 a.m., NA-C verified R74 did not have his call light and further stated the call light was supposed to have a clip and the clip would help in case R74 turned. During interview on 12/3/25 at 8:15 a.m., licensed practical nurse (LPN)-B stated R74 required total care and didn't think R74 moved and thought R74 used his call light and viewed R74's care plan and verified R74 was at risk for falls and had an intervention to ensure the call light was in reach and expected staff provide the call light in accordance with the care plan. LPN-B further stated everyone should have a clip for their call light, so they do not end up on the floor.During interview on 12/3/25 at 8:22 a.m., LPN-C stated normally all residents had a clip and did not know why R74 did not have a clip for the call light and would get a new one right away and expected the call light to be in reach and further stated the purpose of the clips is to keep the light secure on the bed. During interview on 12/3/25 at 2:27 p.m., the director of nursing (DON) stated they had call light clips and expected the clip to be closed in bed and that call lights should always be within reach.A policy, Call Light Policy, dated 5/16/23, indicated call cords, buttons, or other communication devices must be placed where they are within reach of each resident.

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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based in interview and record review the facility failed to ensure notification was made to the provider and resident representative for concerns of toenail infection and refused podiatry appointments for 1 of 1 resident R83 who required podiatry services. Furthermore, the facility failed to promptly notify the resident's physician and/or practitioner of changes in resident condition for 2 of 2 residents (R53 and R55) reviewed for notification of changes. Specifically, the facility failed to notify the provider of episodes of diarrhea for 1 resident (R53) reviewed for constipation and failed to notify the provider of significant weight gain in accordance with physician-ordered parameters for 1 resident (R55). These deficient practices had the potential to delay medical evaluation and treatment. Findings include: R83's quarterly Minimum Data Set (MDS) dated [DATE], indicated R83 had severe cognitive impairment and diagnoses of intellectual disabilities, seizure disorder, and personality disorder. R83 had no rejection of cares and was dependent on staff for lower body dressing, including socks and shoes. R83's Therapy ADL communication form dated 10/31/25, indicated R83 was dependent of staff for clothing management. R83's provider order dated 8/16/25. Indicated R83 required a nurse skin check weekly. R83's care plan revised 8/22/25, indicated R83 required interventions with ADL care. R83 required extensive assist of one person for lower body dressing and two persons assist with bathing. R83's podiatry progress note dated 8/6/25, indicated R83 was scheduled for treatment today, but R83 refused. R83's podiatry progress note dated 11/13/25, indicated R83 was scheduled for treatment today, but R83 refused. R83's provider discharge summary from the facility dated 11/21/25, lacked indication there was concern or problems with R83's feet or toenails. R83's emergency room provider progress note dated 11/25/25, indicated R83 had bad toenail infection and was started on Lamisil 250 milligram (MG) tablet (medication for fungal infection) daily for 28 days. The note further described R83's bilateral feet with significant thickening and discoloration of all the toenails with red non-blanching papules on bilateral feet. R83's diagnosed with fungal infection of the toenails. R83's electronic medical record (EMR) lacked indication R83's guardian was notified of the condition of R83's toenails or notified of the refused podiatry appointments. R83's EMR further lacked indication R83's provider was aware of the condition of the toenails. When interviewed on 12/2/25 at 8:05 a.m., nursing assistant (NA)-A stated nail care was completed on bath days. If the resident was diabetic, the nurse would do them. If there was any concern with (continued on next page)

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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	toenails, the nurse would be notified. When interviewed on 12/2/25 at 9:06 a.m., registered nurse (RN)-A stated nail care was completed on shower days. The nurses were responsible to complete if the resident was diabetic. If there were concerns, the resident's provider would be notified. If there was a guardian, they would also be notified. When interviewed on 12/2/25 at 10:3 a.m., the assistant director of nursing (ADON) did not recall toenail concerns for R83 and further stated if there were any concerns with toenails, podiatry would have seen him. If R83 refused to be seen, R83's guardian would be notified by either the social work or the nurse manager. ADON further stated there have been some concerns with the podiatry services that the facility was working on. At times residents would not be seen because they like to stay in bed and didn't get to the room where services were being provided. ADON further stated R83 liked familiar faces and would have agreed if approached by staff. ADON verified R83's refusal of podiatry services and would need to review the chart further to determine if R83's guardian was notified. When interviewed on 12/2/25 at 2:04 p.m., guardian-A stated R83 had discharged recently from the facility to a group home. When arriving at the group home it was noted R83's toenails were in terrible shape. They were all yellow and appeared some were almost falling off. R83 was sent into the emergency room for immediate treatment, and it was determined R83 had a bad toenail infection and was started on some medication. Guardian-A was not aware R83 had refused podiatry and further stated she was unaware of R83's toenail issue as the facility had never discussed it with her. When interviewed on 12/3/25 at 9:57 a.m., nurse practitioner (NP)-A had not been aware if R83's toenails. NP-A further stated she expected staff to notify her if there were concerns with R83's feet. When interviewed on 12/3/25 at 9:10 a.m., physician assistant (PA)-A stated she was the provider for R83 at the group home. PA-A stated the group home called and requested an urgent visit to assess the toenails when R83 had arrived. Unable to complete a visit, staff sent R83 to the ER for evaluation of his feet. PA-A was aware of the treatment prescribed for R83 and was due to follow up with him next week. PA-A stated the description of the nails by the emergency room provider would lead her to believe the condition has been going on for a few months. When interviewed on 12/3/25 at 10:47 a.m., the Director of Nursing (DON) expected staff to notify the provider if there were concerns with R83's toenails. Furthermore, any refusal of appointments should have been communicated to R83's guardian. A facility policy titled Notification of Change Policy dated 3/2024, directed staff to communicate changes in a resident's condition to the resident and/or representative and report to the attending physician or delegate. R53 R53's significant change Minimum Data Set (MDS) dated [DATE] identified R53 had intact cognition and required assistance with some activities of daily living (ADLs). R53's diagnoses included hemiplegia following cerebral infarction affecting the left non-dominant side (left-sided weakness or paralysis after stroke), hypertension (high blood pressure), gastroesophageal reflux disease (GERD) (acid reflux), renal failure (impaired kidney function), diabetes mellitus (impaired glucose regulation), arthritis (joint inflammation), stroke (brain injury from interrupted blood flow), anxiety disorder (continued on next page)

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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(excessive anxiety), and adjustment disorder with mixed anxiety and depressed mood (emotional response to stress). The MDS also indicated R53 was not experiencing constipation. Record review on 12/2/25, revealed documentation indicating R53 experienced multiple episodes of diarrhea during the period from 11/4/25 through 12/2/25. The medical record lacked documentation showing the provider was notified of the change in condition. During an interview on 12/3/25 at 1:34 p.m., nursing assistant (NA)-A stated R53 had experienced frequent diarrhea since returning from the hospital approximately one month prior. During an interview on 12/3/25 at 2:08 p.m., nurse practitioner (NP)-A stated R53 had chronic diarrhea. NP-A stated R53's order for Senna (stool softener) should have been written as needed. NP-A stated Senna may have been initiated during R53's hospitalization and continued on the discharge orders when he returned to the facility. NP-A confirmed scheduled Senna was initiated on 10/30/25 and confirmed R53 also had an order for loperamide (anti-diarrheal). NP-A stated she would have expected notification if the resident was experiencing diarrhea and confirmed she had not been made aware of any episodes since the end of October. During an interview on 12/3/25 at 2:36 p.m., licensed practical nurse (LPN)-D stated R53 had been experiencing diarrhea for a while. LPN-D confirmed R53 had an order for scheduled Senna and stated the resident was aware of the medication and refused it at times. LPN-D stated she would not notify the provider of diarrhea episodes and would instead review the resident's orders for an as-needed medication. During an interview on 12/3/25 at 2:25 p.m., registered nurse (RN)-E stated R53 experienced episodes of diarrhea for approximately the past month and occasionally refused the scheduled Senna. RN-E stated R53 had an as-needed medication for diarrhea, which was administered when symptoms occurred. During an interview on 12/4/25 at 11:21 a.m., the assistant director of nursing (ADON) stated R53 had chronic diarrhea and administering both a scheduled laxative and an as-needed anti-diarrheal medication was contraindicated, as neither intervention would be effective. The ADON stated the provider should be notified of any change in condition interfering with the resident's activities of daily living. The ADON confirmed the provider should have been notified of R53's episodes of diarrhea and stated she was unable to provide documentation showing notification occurred. During an interview on 12/4/25 at 12:19 p.m., the director of nursing (DON) confirmed the episodes of diarrhea represented a change in R53's condition and stated the provider should have been notified. R55 R55's quarterly Minimum Data Set (MDS) dated [DATE], identified R55 had intact cognition and required assistance with activities of daily living (ADLs). R55's diagnoses included heart failure (impaired heart pumping function), hypertension (high blood pressure), hyperlipidemia (elevated blood cholesterol), schizophrenia (chronic thought disorder), pulmonary embolism without acute cor pulmonale (blood clot in the lung without acute heart strain), hypoxemia (low blood oxygen levels), thrombocytopenia (low platelet count), acute embolism and thrombosis of deep veins of the left upper extremity (blood clot in a deep vein of the arm), hypothyroidism (underactive thyroid), and dysthymic disorder (chronic low-grade depression). (continued on next page)

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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review on 12/2/25 revealed R55 had a physician's order dated 8/27/24, to notify the provider of a weight gain greater than two (2) pounds in 24 hours or five (5) pounds in one week. Review of weight records revealed R55 experienced weight gains exceeding two pounds on six separate occasions between 11/1/25 and 12/3/25: On 11/6/25, R55 weighed 287.1 pounds, and on 11/7/25, weighed 290.1 pounds, reflecting a weight gain of 3.0 pounds. On 11/11/25, R55 weighed 284.0 pounds, and on 11/12/25, weighed 287.8 pounds, reflecting a weight gain of 3.8 pounds. On 11/12/25, R55 weighed 287.8 pounds, and on 11/13/25, weighed 291.1 pounds, reflecting a weight gain of 3.3 pounds. On 11/16/25, R55 weighed 279.2 pounds, and on 11/17/25, weighed 283.2 pounds, reflecting a weight gain of 4.0 pounds. On 11/24/25, R55 weighed 280.0 pounds, and on 11/25/25, weighed 282.4 pounds, reflecting a weight gain of 2.4 pounds. On 12/1/25, R55 weighed 281.4 pounds, and on 12/2/25, weighed 288.9 pounds, reflecting a weight gain of 7.5 pounds. R55's medical record lacked documentation showing the provider was notified of the weight gains in accordance with the physician-ordered parameters. During an interview on 12/3/25 at 1:34 p.m., NA-A stated nursing assistants obtained residents' weights and recorded them in a binder located at the nurses' station. During an interview on 12/3/25 at 2:08 p.m., NP-A stated R55 had a history of edema and did not always like to wear TED stockings, but staff needed to encourage their use because they were important for managing edema. NP-A stated she expected staff to notify her when parameters were included in a resident's orders. NP-A stated she could not recall being notified of R55's occurrences of weight gain During an interview on 12/3/25 at 2:25 p.m., RN-E stated R55 had a history of edema and an order for leg wrapping. RN-E stated nursing assistants obtained weights and recorded them in a binder at the nurses' station, after which nurses documented the weights in the electronic medical record (EMR). RN-E confirmed R55 had an order for daily weights and initially stated she was unaware of notification parameters. Upon review of R55's orders, RN-E confirmed parameters were present and stated she did not always notify the provider of weight changes. During an interview on 12/3/25 at 2:25 p.m., LPN-D stated R55 was ordered to have daily weights due to edema. LPN-D stated weights were obtained by nursing assistants, recorded in a binder, and then documented by nursing staff in the EMR. LPN-D confirmed notification parameters were present and stated provider notification would have been documented in the EMR if it had occurred. During an interview on 12/4/25 at 11:21 a.m., the ADON stated R55 had an order for daily weights and initially stated no notification parameters were present. Upon review of R55's orders, the ADON (continued on next page)

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	12/04/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed parameters were present. The ADON stated she expected staff to notify the provider based on the order and stated the order should be revised if the provider did not wish to receive notifications. The ADON reviewed R55's weight records and confirmed the provider should have been notified. The ADON stated she was unable to provide documentation showing notification occurred. During an interview on 12/4/25 at 12:19 p.m., the DON confirmed R55's weight gains met the notification parameters outlined in the physician's order and stated she expected staff to follow the order and notify the provider accordingly. A facility policy related to notification of changes in condition was requested but was not provided.

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	12/04/2025

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain the confidentiality of resident personal and medical information for 1 of 1 resident observed (R98) by allowing resident-identifiable information to be visible on a computer screen located on a medication cart in a public area. This deficient practice resulted in the potential for unauthorized disclosure of protected health information to residents, staff not involved in care, visitors, and others who walked through the area.Findings include:R98's annual Minimum Data Set (MDS) dated [DATE], identified R98 had intact cognition and was independent with activities of daily living (ADLs). R98's diagnoses included heart failure (impaired heart pumping function), hypertension (high blood pressure), diabetes mellitus (impaired blood glucose regulation), renal failure (impaired kidney function), and anxiety disorder (persistent excessive anxiety).During observation on 12/2/25 from 9:26 a.m. to 9:34 a.m., the surveyor observed a medication cart unattended in the hallway outside resident rooms. The medication cart contained a laptop computer with the screen open and facing outward toward the hallway. The computer screen displayed resident-specific information, including the resident's full name, date of birth , medication list, and diagnoses. The information was clearly visible to anyone walking past the medication cart. At the time of observation, multiple staff members, visitors, and residents passed through the hallway, and no staff member was present to monitor or secure the computer screen.During an interview on 12/2/25 at 9:34 a.m., registered nurse (RN)-A confirmed the laptop on the medication cart was logged into the facility's electronic medical record system and acknowledged the resident information displayed was confidential. RN-A stated staff were expected to log off or close the screen when stepping away from the medication cart but confirmed this was not done at the time of observation.During an interview on 12/4/25 at 12:54 p.m., the Director of Nursing (DON) stated staff were educated on protecting resident privacy and acknowledged the computer screen should not have been left unattended with resident information visible in a public area. The DON confirmed leaving resident information visible on an unattended computer screen was not consistent with facility expectations or resident privacy requirements.A facility policy addressing the protection of resident confidential information, including the secure use of electronic medical records on mobile devices and medication carts, was requested but was not received.

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	12/04/2025

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to maintain a clean and sanitary environment for 2 of 2 residents reviewed (R55 and R108) by failing to ensure resident room floors were kept clean and free of visible dirt and debris. This deficient practice resulted in the potential for infection transmission, unpleasant living conditions, and compromised resident comfort and dignity.Findings include:R55R55's quarterly Minimum Data Set (MDS) dated [DATE], identified R55 had intact cognition and required assistance with activities of daily living (ADLs). R55's diagnoses included heart failure (impaired heart pumping function), hypertension (high blood pressure), hyperlipidemia (elevated blood cholesterol), schizophrenia (chronic thought disorder), pulmonary embolism without acute cor pulmonale (blood clot in the lung without acute heart strain), hypoxemia (low blood oxygen levels), thrombocytopenia (low platelet count), acute embolism and thrombosis of deep veins of the left upper extremity (blood clot in a deep vein of the arm), hypothyroidism (underactive thyroid), and dysthymic disorder (chronic low-grade depression).During observation on 12/1/25 at 1:08 p.m., R55's room floor was visibly soiled. The floor contained accumulated dust, darkened residue adhered to the floor surface, and debris beneath the bed and bedside table. The floor appeared sticky in areas near the bed and wheelchair path. No evidence of recent cleaning was observed.During observation on 12/2/25 at 9:40 a.m., R55's room floor was noted to have the same visible dirt and debris as was noted on 12/1/25, indicating the floor had not been cleaned since the prior observation.During observation on 12/3/25 at 12:21 p.m., the surveyor again observed R55's room floor and noted the same visible dirt and debris remained present, indicating the floor had not been cleaned since the prior observation.R108R108's quarterly Minimum Data Set (MDS) dated [DATE] identified R108 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R108's diagnoses included stroke (interrupted blood flow to the brain), hemiplegia following cerebral infarction affecting the right dominant side (right-sided weakness or paralysis after stroke), anemia (low red blood cell count), hypertension (high blood pressure), renal failure (impaired kidney function), wound infection (infection at a wound site), diabetes mellitus (impaired glucose control), hyperlipidemia (elevated blood lipids), arthritis (joint inflammation), aphasia (impaired speech or language), seizure disorder (recurrent seizures), anxiety disorder (persistent excessive anxiety), depression (persistent low mood), chronic obstructive pulmonary disease (COPD) (chronic lung disease affecting airflow), furuncle of the buttock (localized skin abscess), immunodeficiency (reduced immune function), and mood disorder due to a known physiological condition (mood changes caused by a medical condition).During observation on 12/1/25 at 12:57 p.m., the surveyor observed R108's room floor was visibly soiled. The floor contained accumulated dust, darkened residue adhered to the floor surface, and debris beneath the bed and bedside table. No evidence of recent cleaning was observed.During observation on 12/2/25 at 1:36 p.m., R108's room floor was noted with the same visible dirt and debris, indicating the floor had not been cleaned since the prior observation.During observation on 12/3/25 at 7:15 a.m., R108's room floor was noted with the same visible dirt and debris, indicating the floor had not been cleaned since the prior observation.During an interview on 12/4/25 at 10:24 a.m., the environmental Services manager (HSK)-A stated resident room floors were expected to be cleaned daily and acknowledged the observed floors were not in a clean condition.During an interview on 12/4/25 at 12:50 p.m., the Director of Nursing (DON) stated resident rooms were expected to be maintained in a clean and sanitary condition at all times.A facility policy regarding routine cleaning and maintenance of resident room floors was requested but was not received.

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	12/04/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) was accurately coded to reflect anticoagulation status for 1 of 2 residents (R2) reviewed for coding accuracy. Findings include: The Resident Assessment Instrument 3.0 User's Manual version 1.20.1 dated 10/2025, indicated under a heading, Coding Instructions not to code antiplatelet medications such as clopidogrel as N0415E, an anticoagulant. R2's admission MDS dated [DATE], indicated R2 had a stroke, coronary artery disease, and hypertension. Further, a section, N0415 High-Risk Drug Classes: Use and Indication directed staff to check whether a resident took any medications by pharmacological classification, not how it is used, during the last 7 days or since admission/entry or reentry if less than 7 days. The MDS indicated R2 took an anticoagulant, and the indication was noted. Additionally, the MDS indicated R2 took an antiplatelet. - 10/22/25, clopidogrel bisulfate (an antiplatelet medication used to prevent blood clots) give 75 milligrams (MG) by mouth once daily to prevent a stroke. - 10/22/25, monitor for discolored urine, black tarry stools, sudden severe headache, nausea and vomiting, diarrhea, muscle and joint pain, lethargy, bruising, sudden changes in mental status and or vital signs every shift every Monday. The Physician's order form lacked information R2 took an anticoagulant. R2's medication administration record (MAR) and treatment administration record (TAR) dated October 2025, was reviewed and indicated R2 took clopidogrel bisulfate daily starting 10/23/25, through 10/31/25.R2's October 2025 MAR and TAR lacked evidence R2 received an anticoagulant medication.During interview on 12/4/25 at 11:55 a.m., registered nurse (RN)-C stated she was the MDS nurse for the facility and completed all the sections of the MDS with the exceptions of sections C, D, E, and Q. RN-C stated R2's lookback period for the MDS under section N was from 10/22/25 to 10/28/25, and used the MAR to determine whether a medication was administered during the timeframe. RN-C verified R2 was on clopidogrel after viewing the MAR and that the medication was an antiplatelet and stated she did not see where R2 was administered an anticoagulant. RN-C stated she would have to modify the MDS and stated it was important to code the MDS correctly for consistency because R2 did not receive anticoagulants.During interview on 12/4/25 at 2:47 p.m., the director of nursing (DON) stated she expected the MDS to be coded accurately and further stated they reviewed coding and stated she forgot that clopidogrel was an antiplatelet and the MDS RN completed the coding based on the orders. A policy was requested, but the DON was not sure if the facility had one.

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	12/04/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure resident-centered care plans were developed, implemented, and revised to accurately reflect resident's current needs for 3 of 3 residents reviewed (R55, R102, and R109). Specifically, the facility failed to include required interventions for edema management, failed to update the care plan to remove discontinued enhanced barrier precautions, and contained conflicting information regarding the level of assistance required for eating. These deficient practices resulted in the potential for inconsistent care, unmet resident needs, and compromised resident safety and well-being.Findings include:R55R55's quarterly Minimum Data Set (MDS) dated [DATE] identified R55 had intact cognition and required assistance with activities of daily living (ADLs). R55's diagnoses included heart failure (impaired heart pumping function), hypertension (high blood pressure), hyperlipidemia (elevated blood cholesterol), schizophrenia (chronic thought disorder), pulmonary embolism without acute cor pulmonale (blood clot in the lung without acute heart strain), hypoxemia (low blood oxygen levels), thrombocytopenia (low platelet count), acute embolism and thrombosis of deep veins of the left upper extremity (blood clot in a deep vein of the arm), hypothyroidism (underactive thyroid), and dysthymic disorder (chronic low-grade depression).Record review on 12/3/25, revealed R55 had documented bilateral lower extremity edema noted in nursing progress notes and physician documentation. The medical record indicated R55 had an order for ACE wraps to the lower extremities as part of edema management. Review of R55's care plan revealed no interventions addressing the use of ACE wraps or management of edema.During an interview on 12/3/25 at 1:23 p.m., nursing assistant (NA)-A stated R55 had edema in the lower legs and was supposed to wear ACE wraps during the day.During an interview on 12/3/25 at 2:08 p.m., nurse practitioner (NP)-A stated R55 had edema in the lower extremities and needed staff to encourage R55 to wear ACE wraps, as they were important for edema management.During an interview on 12/4/25 at 11:23 a.m., the assistant director of nursing (ADON) confirmed R55 had orders for ACE wraps related to edema and acknowledged the intervention should have been reflected in the care plan. The ADON stated the care plan had not been updated to include this intervention.During an interview on 12/4/25 at 12:19 p.m., the director of nursing (DON) stated ACE wraps were an intervention for edema management and should have been included in R55's care plan.R102R102's annual Minimum Data Set (MDS) dated [DATE], identified R102 had severe cognitive impairment and required assistance with activities of daily living (ADLs). R102's diagnoses included anemia (low red blood cell count), hypertension (high blood pressure), gastroesophageal reflux disease [GERD] (acid reflux), benign prostatic hyperplasia [BPH] (enlarged prostate causing urinary obstruction), renal failure (impaired kidney function), depression (persistent low mood), malnutrition (insufficient nutritional intake), dehydration (inadequate body fluids), hypovolemia (decreased blood volume), and dysphagia, oropharyngeal phase (difficulty swallowing during the mouth and throat phase). The MDS also indicated R102 required substantial to maximal assistance with eating.Record review on 12/4/25, revealed R102 previously required enhanced barrier precautions (EBP); however, documentation indicated the precautions had been discontinued. Review of R102's current care plan continued to list enhanced barrier precautions as an active intervention.During an interview on 12/4/25 at 11:35 a.m., the ADON confirmed R102 was no longer on enhanced barrier precautions and acknowledged the care plan had not been revised to reflect the current precaution status.During an interview on 12/4/25 at 11:35 a.m., the director of nursing/infection prevention nurse (DON) confirmed R102 was no longer on enhanced barrier precautions and acknowledged the care plan had not been revised to reflect the current precaution status. DON stated enhanced barrier precautions should have been removed from the care plan immediately after the precautions were discontinued.R109R109's quarterly Minimum Data Set (MDS) dated [DATE], identified R109 had intact (continued on next page)

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	12/04/2025

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition and required assistance with activities of daily living (ADLs). R109's diagnoses included hemiplegia following cerebral infarction affecting the right dominant side (paralysis or weakness on the right side due to stroke), hypertension (high blood pressure), diabetes mellitus (impaired blood glucose regulation), hyperlipidemia (elevated cholesterol or fats in the blood), malnutrition (insufficient nutrient intake), bipolar disorder (mood disorder with manic and depressive episodes), dysphagia following cerebral infarction (difficulty swallowing after stroke), unspecified protein-calorie malnutrition (general deficiency of protein and calories), and constipation (infrequent or difficult bowel movements).Record review on 12/2/25, revealed conflicting information within R109's care plan regarding the level of assistance required for eating. One section of the care plan indicated the resident required assistance of one person with eating, while another section indicated the resident required set-up assistance only. The inconsistency did not clearly define the appropriate level of assistance staff were expected to provide.During an interview on 12/3/25 at 1:23 p.m., NA-A stated R109 required staff assistance with eating but was able to drink independently.During an interview on 12/3/25 at 2:38 p.m., licensed practical nurse (LPN)-D stated R109 fed himself and did not require assistance.During an interview on 12/3/25 at 2:48 p.m., NA-F stated R109 could feed himself but needed staff present in the room while eating.During an interview on 12/4/25 at 11:45 a.m., the ADON acknowledged the care plan contained conflicting information regarding eating assistance and stated the care plan should have clearly reflected one consistent level of assistance to ensure appropriate care delivery. The ADON acknowledged the identified care plan issues were not consistent with facility expectations.During an interview on 12/4/25 at 12:18 p.m., the DON stated care plans were expected to be accurate, individualized, and updated to reflect current resident needs.A facility policy regarding the development, updating, and revision of resident care plans was requested but was not received.

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	12/04/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure activities of daily living (ADLs) related to hygiene and grooming were provided in accordance with resident needs for 1 of 1 residents reviewed (R88) by failing to ensure the resident wore clean clothing throughout the survey period. This deficient practice resulted in the potential for compromised dignity, discomfort, and negative psychosocial impact to the resident.Findings include:R88's quarterly Minimum Data Set (MDS) dated [DATE], identified R88 had moderate cognitive impairment and required assistance with activities of daily living (ADLs). R88's diagnoses included cancer (abnormal cell growth), anemia (low red blood cells), hypertension (high blood pressure), renal failure (impaired kidney function), obstructive uropathy (blocked urine flow), diabetes mellitus (impaired blood sugar regulation), arthritis (joint inflammation), non-Alzheimer's dementia (cognitive decline not due to Alzheimer's disease), urinary retention (inability to fully empty the bladder), generalized edema (fluid-related swelling), hydronephrosis (kidney swelling from urine backup), benign prostatic hyperplasia (BPH) (enlarged prostate causing urinary obstruction), and presence of urogenital implants (surgically placed urinary devices). The MDS also indicated R88 had an indwelling urinary catheter (continuous bladder drainage) and did not exhibit any behaviors.During observation on 12/1/25 at 1:52 p.m., surveyor observed R88 wearing visibly soiled clothing, including a shirt with food stains and pants with darkened areas and debris. During observation on 12/2/25 at 9:13 a.m., surveyor again observed R88 wearing the same clothing with the same visible stains noted on the prior day, indicating the clothing had not been changed.During observation on 12/3/25 at 7:09 a.m., surveyor again observed R88 wearing the same clothing with the same visible stains noted on the prior day, indicating the clothing had not been changed.During observation on 12/3/25 at 1:42 p.m., the surveyor again observed R88 wearing the same visibly soiled clothing. The stains remained present, indicating the resident had worn the same dirty clothing throughout the survey period.During an interview on 12/3/25 at 1:42 p.m., nursing assistant (NA)-A stated R88 required staff assistance with dressing and acknowledged the resident should have been provided clean clothing daily. NA-A confirmed the resident's clothing had not been changed during the observed days.During an interview on 12/3/25 at 2:44 p.m., licensed practical nurse (LPN)-D stated R88 dresses himself and if staff notice his clothing is dirty, staff should remind him to go and change clothing with staff assistance.During an interview on 12/3/25 at 2:48 p.m., NA-F stated R88 dressed himself but if clothing were dirty staff needed to assist him with changing his clothing.During an interview on 12/4/25 at 11:23 a.m., assistant director of nursing (ADON) stated if a resident was wearing visibly dirty clothing, staff should assist resident with changing them immediately even if the resident is independent with grooming and dressing.During an interview on 12/4/25 at 1:05 p.m., the Director of Nursing (DON) stated residents were expected to be dressed in clean clothing daily to maintain hygiene and dignity. The DON stated staff should have offered and attempted to assist the resident with changing clothing at least twice daily. The DON stated if the resident continually refused to change clothing, management should have been updated. The DON acknowledged the condition observed was not consistent with facility expectations.A facility policy regarding the provision of clean clothing and assistance with dressing as part of activities of daily living was requested but was not received.

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	12/04/2025

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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure activities were provided or offered in accordance with resident needs and preferences for 1 of 1 resident reviewed (R109). Specifically, the resident remained in bed for the duration of the survey without activities being offered or provided. This deficient practice resulted in the potential for social isolation, decline in psychosocial well-being, and decreased quality of life.Findings include:R109's quarterly Minimum Data Set (MDS) dated [DATE], identified R109 had intact cognition and required assistance with activities of daily living (ADLs). R109's diagnoses included hemiplegia following cerebral infarction affecting the right dominant side (paralysis or weakness on the right side due to stroke), hypertension (high blood pressure), diabetes mellitus (impaired blood glucose regulation), hyperlipidemia (elevated cholesterol or fats in the blood), malnutrition (insufficient nutrient intake), bipolar disorder (mood disorder with manic and depressive episodes), dysphagia following cerebral infarction (difficulty swallowing after stroke), unspecified protein-calorie malnutrition (general deficiency of protein and calories), and constipation (infrequent or difficult bowel movements).During observation on 12/1/25 at 4:40 p.m., R109 was lying in bed. The room was dark with the curtains drawn, with no activities present. During observation on 12/2/25 at 1:40 p.m., R109 was lying in bed. The room was dark. No activity materials were present, and no staff were observed offering or providing activities to the resident.During observation on 12/3/25 at 10:02 a.m., R109 was lying in bed. The room was dark. No activity materials were present, and no staff were observed offering or providing activities to the resident.During observation on 12/3/25 at 11:27 a.m., R109 was lying in bed in the same position as previous observations. The resident had not been transported to group activities, and no individualized activities were observed to be offered or provided.During observation on 12/3/25 at 1:23 p.m., R109 was lying in bed in the same position as previous observations. The resident had not been transported to group activities, and no individualized activities were observed to be offered or provided.Record review revealed no documentation indicating activities were offered to R109 during the survey period. The activity record did not reflect resident participation or refusal of activities.During an interview on 12/3/25 at 1:23 p.m., nursing assistant (NA)-A stated R109 typically stayed in bed and staff did not routinely offer activities unless the resident requested them.During an interview on 12/4/25 at 12:02 p.m., activity aide (AA)-A stated residents were expected to be offered activities daily, including individualized activities for residents who remained in their rooms. AA-A acknowledged R109 should have been offered activities during the survey period and confirmed one-to-one activities were not occurring due to low staffing in the activities department.During an interview on 12/4/25 at 12:57 p.m., the Director of Nursing (DON) confirmed residents were expected to be encouraged and assisted to participate in activities and acknowledged R109 remaining in bed without activities being offered was not consistent with facility expectations.A facility policy regarding the provision, documentation, and offering of activities for residents, including residents who remained in their rooms or in bed, was requested but was not received.

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	12/04/2025

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure audiology appointments were available for 1 of 1 resident (R67) who requested audiology services. Findings include:R67's annual Minimum Data Set (MDS) dated [DATE], indicated R67 had adequate hearing and had no difficulty in normal conversation, social interaction, listening to the TV and did not wear a hearing aid. Further, R67 had moderate cognitive impairment, was very important to have family or a close friend involved in discussion about care and was very important to listen to music.R67's quarterly MDS dated [DATE], indicated R67 had adequate hearing and did not use a hearing aid, had moderate cognitive impairment, and had initially been admitted to the facility on [DATE].R67's Medical Diagnosis form, undated, indicated the following diagnoses: Parkinson's disease, dementia, and depression. R67's HealthDrive consent form dated 1/31/24, indicated R67 wanted to be seen for audiology.R67's HealthDrive consent form dated 4/18/25, indicated R67 wanted to be seen for audiology services. R67's Care Conference Forms dated 12/13/24, 3/21/25, 6/13/25, 9/9/25, 10/13/25, indicated a Heading, Exams that included dental and eye exams. The forms lacked information when R67 was seen by audiology.R67's social services note dated 8/2/23 at 10:34 a.m., indicated a consent form for dental, podiatry, vision, and audiology was mailed to R67's family member. R67's social services note dated 8/15/23 at 4:50 p.m., indicated R67 spoke with staff regarding her need for dental, vision, and audiology services and R67's daughter gave verbal consent and R67 was agreeable to sign the form. R67's therapeutic recreation progress notes dated 4/19/23 at 8:48 a.m., indicated R67 reported having difficulty hearing on the phone.R67's therapeutic recreation progress notes dated 10/12/23 at 5:06 p.m., indicated R67 had minimal difficulty in hearing with no hearing appliance used and a hearing plan of care was completed. R67's record was reviewed and lacked information R67 was seen by audiology.During interview and observation on 12/1/25 at 6:51 p.m., R67's hair was covering her ears, no hearing assist devices were visible. R67 required surveyor to speak into her left ear in order for R67 to hear. During interview on 12/2/25 at 8:29 a.m., R67 stated she did not wear hearing aids.During interview on 12/3/25 at 1:50 p.m., family member (FM)-A stated the facility won't bring R67 to an ear doctor. FM-A did not provide information why the facility would not bring R67 to the ear doctor.During interview on 12/4/25 at 8:53 a.m., nursing assistant (NA)-D stated R67 didn't hear well, did not wear hearing aids and staff had to talk closely to R67 for her to hear them.During interview on 12/4/25 at 9:18 a.m., social worker (SW)-B stated HealthDrive covered vision, dental, podiatry, and audiology. If a resident was seen by these specialties, a note was scanned in the Miscellaneous section of the resident's electronic medical record (EMR) along with the consent form. If a resident refused to be seen, the specialties would document the refusals on a note in the Miscellaneous section. SW-B did not know how often audiology came but stated podiatry came monthly, dental came monthly, or every other month and vision came every three months. SW-B stated the health unit coordinator (HUC)-I would know. SW-B stated she did not see a record R67 had been seen by audiology and was not sure how appointments worked. During interview on 12/4/25 at 9:31 a.m., HUC-I stated HealthDrive specialties send the facility dates when they are coming and stated audiology hadn't been out for a while. HUC-I further stated they had not had an audiologist for at least 6 months and would send residents out for appointments. HUC-I stated she could check under the Miscellaneous section for any appointments R67 had and added R67 did not have an appointment set up outside of the facility for audiology. Residents were automatically signed up for audiology appointments when a resident signed a consent form. HUC-I stated the HealthDrive form need to be updated because they did not have audiology any longer. HUC-I verified R67 had not seen audiology in the facility and has not gone out for any hearing appointments.During interview on 12/4/25 at 11:49 a.m., licensed practical nurse (LPN)-C stated if a resident signed a consent form they were placed on a list right away for specialty services and stated they were working on getting (continued on next page)

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	12/04/2025

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	someone from audiology.During interview on 12/4/25 at 12:34 p.m., social worker (SW)-A stated the facility was in the process of acquiring a new audiologist and was not sure when an audiologist came to the facility. SW-A was aware staff had to get close for R67 to hear. When R67 was in the day room, she needed to be moved to a quieter location in order for SW-A to talk with R67.During interview on 12/4/25 at 2:39 p.m., the director of nursing (DON) stated they obtained consents and residents were added to a list and further stated HUC-I added R67 to the list in October and contacted HealthDrive who had no audiologist. Residents could see outside providers if they wanted, this was something that could be offered. DON stated R67 did not have an acute concern so it was not brought up again. DON further stated, the goal was to get in contact with another company and did not know what transpired with previous consent for audiology.A policy was requested but was not received.

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	12/04/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure prescribed treatment for urinary tract infection (UTI) prevention was administered or reported as refused for 1 of 2 residents (R47) reviewed for recurring UTIs. Findings include:R47's admission Minimum Data Set (MDS) dated [DATE], indicated R47 was cognitively intact, was dependent on staff for toileting and required substantial/maximum assistance for transfers and mobility. The MDS indicated R47 was frequently incontinent of bowel and bladder, did not have any urinary device. R47 did not exhibit rejection of care behavior. R47's diagnoses included chronic kidney disease, diabetes mellitus, and urinary tract infection.R47's care plan dated 1/13/26, indicated alteration in elimination with a goal to be free from signs and symptoms of UTI.R47's October 2025, medication administration record (MAR) indicated, Estradiol Vaginal Cream 0.1 MG/GM (milligrams/gram)[Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly, with a start date of 10/18/25. The MAR indicated three days marked with a 2 (drug refused) and one day with a 9 (other-see nurses note).R47's November 2025, MAR indicated, Estradiol Vaginal Cream 0.1 MG/GM [Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly. The MAR indicated eight days marked with a 2 (drug refused) and one day with a checkmark (administered).Review of R47's December 2025, MAR on 12/3/25, indicated, Estradiol Vaginal Cream 0.1 MG/GM [Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly. The MAR indicated one day (12/3) marked with a 2 (drug refused). R47's MAR further indicated, Macrobid Oral Capsule [an antibiotic commonly used to treat UTIs] Give 100 mg by mouth two times a day related to [UTI] with a start date of 11/20/25.R47's lab result report dated 11/19/25, indicated an abnormal urinalysis/urine culture lab result from a urine sample collected on 11/16/25, indicating a UTI.During interview on 12/2/25 at 8:47 a.m., R47 reported concerns regarding timeliness of medication administration. R47 further stated she had frequent UTIs and had recently finished a round of antibiotics for a UTI. During observation and interview on 12/3/25 at 7:36 a.m., registered nurse (RN)-B entered R47's room with a medicine cup full of pills. R47 was sitting up with bedside table in front of her awaiting breakfast. R47 took all the pills provided and RN-B left the room. RN-B did not offer to administer the Estradiol. R47 stated she had been offered the Estradiol one time that she could remember and refused it at that time. R47 could not remember being offered the Estradiol other than that one time. R47 could not recall when that offer/refusal took place. R47 stated RN-B did not offer the Estradiol yet today.During interview on 12/3/25 at 7:51 a.m., RN-B stated R47 had recently finished antibiotics for a UTI which was her second UTI since admission. RN-B stated R47 had Estradiol ordered, but always refuses it. RN-B further stated she had not offered the Estradiol to R47 yet and was going to offer it later when she was back in bed. RN-B confirmed she had signed off R47's MAR with a 2, indicating refused, even though she had not offered the medication yet. RN-B stated she should not have documented the refusal prior to offering, even if she thinks R47 will end up refusing it. RN-B further stated continued refusals of any treatment by a resident should be reported to the provider so they could re-evaluate and possibly order an alternative medication for UTI prevention. During interview 12/3/25 at 9:36 a.m., nurse practitioner (NP)-A stated would expect to be notified when residents consistently refuse a medication and was not aware that R47 had not been receiving Estradiol as ordered due to consistent refusals. During interview on 12/3/25 at 1:01 p.m., license practical nurse (LPN)-A stated when a resident continuously refused prescribed treatment or medication, the provider should be notified. LPN-A further stated staff should not document a refusal on a MAR without actually offering the treatment or medication.During interview on 12/4/25 at 11:38 (continued on next page)

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	12/04/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a.m., director of nursing (DON) stated staff should not be documenting refusals prior to offering a treatment or medication even if they had a history of refusals. DON further stated would expect staff to notify the provider of consistent refusals.A facility policy on UTIs and nursing documentation was requested but not received.

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	12/04/2025

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure specific patient centered orders were in place and implemented for colostomy care for 1 of 1 resident (R81) reviewed for colostomy care. Findings include:R81's annual Minimum Data Set (MDS) dated [DATE], indicated intact cognition, did not have hallucinations or delusions, did not reject care, used a wheelchair, was dependent on staff for toileting hygiene, showering or bathing, and lower body dressing. Additionally, R81 had an colostomy and diagnoses included unspecified dementia, anxiety, depression, and malnutrition and did not have any skin conditions. R81's Physician's Orders form saved on 12/1/25 at 2:05 p.m., indicated the following orders:7/28/23, and discontinued on 8/1/23, left lower quadrant colostomy remove pouch and discard. Cleanse the peristomal skin with only tap water, pat dry. Apply [NAME] number 8664, 1 1/4 inch precut convex drainable pouch. Have the resident hold her hand over the pouch for a few minutes. 7/28/23, and discontinued on 8/1/23, colostomy and fistula pouches need to be changed at the same time every 2 to 3 days depending on the seal. The abscess drain will be secured under the pouch barrier tape, so the drain tube attachment device is removed. Colostomy supplies: [NAME] number 8413 pouches 20/month change three times weekly, [NAME] number 89520 barrier rings 20 per month change 3 times weekly and [NAME] colostomy belt number 7300.10/7/23, Change pouch every other day until follow up appointment or if leakage. Wash stoma and skin with tap water, pat dry, cut opening for stoma in wafer. Apply pouch in the morning every other day.8/9/24, Empty colostomy bag each shift.10/29/24, May use facility standing orders as signed by provider.10/4/25, staff and nursing to ensure the use of non-sting skin preps post cleansing to peristome with tap water with all colostomy bag changes. Do not use regular sting skin preps due to pain and discomfort to the resident. Use enhanced barrier precautions/EBP. The current orders lacked information on what type of colostomy bag to use, or whether to use any barrier rings. R81's Standing Orders for Skilled Nursing Facilities indicated the following:All orders initiated from standing orders should be communicated to the provider. Apply ice and cold pack for 20 minutes four times daily as needed to injuries with inflammation. Under a heading, Skin and Wound Management, assess wound and or dressing daily, and complete wound measurements with dressing changes, indicated directives for stage two or three pressure injuries, however lacked directions what to do with excoriated skin due to leakage from an colostomy.R81's care plan dated 11/14/22, indicated R81 had an alteration in skin integrity related to colostomy bag placement and was at risk for breakdown due to incontinence and R81's goal was to remain free of any breakdown. Interventions included a skin integrity check weekly, notify physician as needed with any changes and deterioration in incision and or need for change in treatment.R81's care plan dated 11/14/22, indicated R81 had a colostomy with a goal of not having complications with the colostomy and interventions included applying appropriate skin barrier before applying adhesive around the stoma with each bag change, clean the area with warm water and pat dry, use soap only, if paste has collected on the skin, let it dry and then peel it off gently, inspect stoma peristomal skin area with each pouch changes. Note irritation, bruises, or rash and report findings to the physician as needed, colostomy emptying and pouch changing per MD orders.The care plan lacked information on the specific colostomy supplies R81 required.R81's medication administration record (MAR) and treatment administration record (TAR) dated November 2025, indicated R81 had her colostomy pouch changed 15 times on 11/1/25, 11/3/25, 11/5/25, 11/7/25, 11/9/25, 11/11/25, 11/13/25, 11/15/25, 11/17/25, 11/19/25, 11/21/25, 11/23/25, 11/25/25, 11/27/25, and 11/29/25. R81's MAR and TAR dated December 2025, indicated R81's pouch was changed on 12/1/25. R81's Weekly Skin Evaluation forms dated 11/10/25, 11/17/25, 11/24/25, and 12/1/25, indicated a bruise to the left outer wrist otherwise skin was intact on 11/10/25, a faint bruise to the left wrist and the rest of the skin was intact on 11/17/25, the bruise on the left wrist (continued on next page)

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	12/04/2025

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was healed and there were no other skin concerns on 11/24/25, and on 12/1/25 at 7:31 a.m., R81's skin remained intact.R81's nursing progress note dated 11/26/25 at 11:07 a.m., indicated R81 reported pain around her colostomy and the bag was removed and her skin was raw. The area was cleansed and dried, an Adapt ring was applied to the surrounding stoma, covering raw area to prevent stool from touching it and a new colostomy bag was applied and R81 was given an ice pack.R81's nursing progress notes dated 11/26/25 at 11:11 a.m., indicated acetaminophen was administered for pain to raw skin surrounding the stoma.R81's nursing progress notes dated 11/26/25 at 12:04 p.m., indicated R81 reported pain at an eight out of ten indicating severe pain, to the area around R81's stoma and the bag was changed, and Tylenol and ice were administered.R81's nursing progress note dated 11/27/25 at 6:19 a.m., indicated R81's colostomy bag was emptied and changed. The note lacked information regarding R81's skin condition around the colostomy area.R81's nursing progress note dated 11/28/25 at 8:02 a.m., indicated R81 reported pain at an eight out of ten indicating severe pain around her stoma site. The note lacked information whether R81's stoma site was assessed.R81's nursing progress notes dated 12/1/25 at 2:02 p.m., indicated R81's colostomy bag was leaking, and stool was resting on the skin. R81's bag was removed and the peristoma (area around the stoma) was cleansed and patted dry and an Adapt ring was applied to create a better seal around the stoma and to keep the stool off of the skin. Further the skin was excoriated and R81 reported burning to the skin rating discomfort a 5 out of 10 and requested an ice pack.R81's nursing progress notes dated 12/3/25 at 7:03 a.m., indicated the surrounding skin to the colostomy was intact. During interview on 12/1/25 between 12:54 p.m., and 12:56 p.m., R81 reported having loose stools from her colostomy and her skin was sore and raw adding she had the wrong bag used, and staff changed the bag whenever it needed to be changed.During interview and observation on 12/1/25 at 1:35 p.m., licensed practical nurse (LPN)-B had a box of Ceraplus Holister CeraRing box number 8805, along with an empty Holister colostomy pouch box numbered 8931 in R81's room. R81 stated she rated her pain an eight because her skin around the stoma was irritated. LPN-B stated she had a new Holister box number 8931 and would have to reorder supplies. During observation, R81's colostomy pouch had brownish liquid stool and LPN-B verified R81 did not have a CeraRing when she removed the colostomy pouch. LPN-B stated that was why R81's skin was excoriated when she removed R81's previous colostomy pouch. R81's skin surrounding her stoma site was excoriated and had opened reddened areas around the stoma approximately 1/2 inch wide with a blotchy, reddened rash. LPN-B stated she sometimes placed two CeraRings to cover the stoma because R81's stool pushed the bag off. LPN-B placed the CeraRing and applied the new pouch. LPN-B stated the purpose of the CeraRing was to create a better seal and to keep the stool off the skin. LPN-B stated the CeraRing was a nursing standard and verified R81's orders did not identify the CeraRing and stated she used the CeraRing since R81 had the stoma. LPN-B stated R81's skin excoriation would come and go and stated the CeraRing prevented the skin from being exposed to the stool. During interview on 12/3/25 at 12:26 p.m., LPN-B stated providers were at the facility today and LPN-B usually called to notify a provider and if there were non-urgent needs LPN-B stated she would write a note for the provider for when they came to the facility and stated she called on most things and documented a note if a provider is contacted. LPN-B stated she updated LPN-C on R81's skin 12/1/25, and LPN-C spoke with nurse practitioner (NP)-A and got an order for specific colostomy supplies. LPN-B stated she took R81's bag off and stated her skin was healed. LPN-B stated knowing which specific bag supplies to use was a contentious topic and the health unit coordinator (HUC) used to order supplies and staff let the HUC know what was needed. LPN-B was not sure how they came to a specific bag number and further stated the care plan and orders lacked information for specific colostomy supplies. LPN-B stated the NP should be updated when skin changes occur and verified she did not document the provider was updated when R81's skin was excoriated on 11/26/25, and stated the provider should have been updated. LPN-B stated she would have updated NP-A and further stated she updated LPN-C regarding R81's skin change from 12/1/25, and LPN-B was going to take care of (continued on next page)

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	12/04/2025

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	it. LPN-B stated she looked at the excoriation as tiny areas and did not measure them. LPN-B added she should have, and skin assessments would be documented in the progress notes. LPN-B further stated R81's stoma was depressed, and the stool worked its way under the supplies. During interview on 12/3/25 at 12:58 p.m., LPN-C stated the provider is notified right away of any skin concerns. When the physician is notified, LPN-C expected it to be documented in the resident's record. If a resident had skin changes skin would be assessed on treatment days and further added R81's provider should have been notified when they found the excoriation. LPN-C stated she did not know if she called the provider the same day on 12/2/25. LPN-C thought R81 first had excoriation on 12/1/25, but verified R81 had excoriation on 11/26/25, after viewing R81's record. LPN-C stated she would have expected staff to document if the skin was resolved and verified the progress notes lacked information the provider was notified. LPN-C further stated R81 now had orders for the CeraRing because they thought they should obtain an order if they were using them. LPN-C stated they had wound rounds on Tuesdays; however, ostomies were not looked at. LPN-C stated the ostomies were looked at when they are changed and had weekly skin assessment notes, but staff do not remove an colostomy for the bath. LPN-C stated she expected wounds to be documented when they have resolved because they utilize pool staff and would have to put something in place for pool staff to know. During interview on 12/3/25 at 2:04 p.m., NP-A stated she was at the facility Mondays, Wednesdays, and Thursdays. NP-A stated she had not been notified R81 had excoriation on 11/26/25, and further stated she was notified 12/3/25, for the skin excoriation from 12/1/25.During interview on 12/3/25 at 2:27 p.m., the director of nursing (DON) stated they usually had colostomy orders with specific detailing and what supplies to use. DON expected staff would update the provider and per their standing orders this would be done by the next business day for non-urgent items. DON viewed R81's orders and verified R81's orders lacked specific information for which colostomy supplies R81 required. The DON stated they received their supplies from Gentell and further stated the supply numbers had to be in her orders at some point because that was how Gentell knew what supplies to send. She would go by the most recent order and viewed R81's discontinued orders that indicated to use a [NAME] 8531. Further, the DON stated she expected staff to document the status of skin when issues were present and continue to follow up and assess when they changed the pouch. The DON stated all colostomy supplies were sent specific to each resident and the supply number was important to know because the specific supplies were in place for a reason. Each nurse should know which supplies a resident required in case they ran out and needed to be reordered. DON expected staff document when skin issues were resolved, still present, or if they got worse.On 12/3/25 at 3:46 p.m., the DON sent an email that indicated she included a screen shot from their Gentell order which included R81's order section. The screen shot indicated R81 received [NAME] 8931 colostomy pouches and Adapt 8805 colostomy wafers along with a box of skin preps. An order was later created on 12/3/25 at 5:57 p.m., from the DON that indicated to change the pouch every other day or as needed for leakage. Wash stoma and skin with tap water. Pat dry. Use [NAME] 8931 pouch, cut the opening in the wafer for the stoma, apply adapt 8805 barrier ring, apply the pouch over and document any signs or symptoms of skin breakdown and update the provider as needed. On 12/4/25 at 10:37 a.m., an invoice that included all the supplies ordered for R81 and the date ordered was requested in an email to the DON. At 11:32 a.m., the DON replied in an email and attached R81's delivery tickets for 7/1/25, 8/5/25, 11/3/25. The tickets indicated R81 received [NAME] 8930 pouches, [NAME] 8805 CeraRing, and no sting skin Barrier film for each date listed. During interview on 12/4/25 at 10:41 a.m., the Gentell DME (durable medical equipment) provider program supervisor (GDPPS) stated the last three colostomy supply orders for R81 on 7/1/25, 8/5/25, and 11/3/25, contained the following supplies: [NAME] 8930 which was 20 drainable pouches and a [NAME] 8805, which contained 20 CeraRing and a box of No Sting barrier prep. GDPPS stated the CeraRing prevented drainage around the stoma, so skin did not become excoriated and further stated R81 had these supplied since her first order February 2025. During follow up interview on 12/4/25 at 2:37 p.m., the DON stated she (continued on next page)

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	12/04/2025

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 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected staff follow physician orders and if they received barrier rings, expected staff clarify and further stated they could not memorize every resident's order supply numbers. A policy, Skin Assessment and Wound Management, dated 2/2025, indicated the purpose of the policy was to provide guidelines for assessing and managing wounds and to implement appropriate preventative skin measures.

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	12/04/2025

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care and services were provided in accordance with physician orders and professional standards of practice for 1 of 1 residents reviewed (R109). Specifically, the facility administered oxygen therapy without a physician's order. This deficient practice resulted in the potential for improper oxygen administration, respiratory compromise, and harm to the resident.Findings include:R109's quarterly Minimum Data Set (MDS) dated [DATE] identified R109 had intact cognition and required assistance with activities of daily living (ADLs). R109's diagnoses included hemiplegia following cerebral infarction affecting the right dominant side (paralysis or weakness on the right side due to stroke), hypertension (high blood pressure), diabetes mellitus (impaired blood glucose regulation), hyperlipidemia (elevated cholesterol or fats in the blood), malnutrition (insufficient nutrient intake), bipolar disorder (mood disorder with manic and depressive episodes), dysphagia following cerebral infarction (difficulty swallowing after stroke), unspecified protein-calorie malnutrition (general deficiency of protein and calories), and constipation (infrequent or difficult bowel movements).During observation on 12/2/25 at 9:18 a.m., the surveyor observed R109 receiving oxygen via nasal cannula.During observation on 12/2/25 at 2:09 p.m., the surveyor again observed R109 receiving oxygen via nasal cannula.During observation on 12/3/25 at 7:11 a.m., the surveyor again observed R109 receiving oxygen via nasal cannula.Record review on 12/2/25 revealed no physician's order for oxygen therapy for R109. The medical record lacked documentation authorizing oxygen use, including the liter flow rate, route of administration, or parameters for use. There was no documentation indicating oxygen therapy had been initiated per provider order or that the provider had been notified the resident was receiving oxygen.During an interview on 12/3/25 at 1:23 p.m., nursing assistant (NA)-A stated R109 received oxygen via nasal cannula continuously.During an interview on 12/3/25 at 2:38 p.m., licensed practical nurse (LPN)-D stated R109 received oxygen continuously and the oxygen was set at 2 liters per minute. LPN-D reviewed R109's medical record, confirmed R109 was receiving oxygen, and acknowledged there was no active physician's order for oxygen therapy in the medical record.During an interview on 12/4/25 at 11:45 a.m., the assistant director of nursing (ADON) stated R109 had been receiving oxygen since admission on [DATE]. The ADON reviewed R109's electronic medical record and confirmed there were no orders for oxygen. The ADON stated it was important to have an order for oxygen to ensure the correct flow rate was used, for staff to monitor oxygen saturations, and to ensure oxygen equipment was changed on a regular basis.During an interview on 12/4/25 at 12:57 p.m., the Director of Nursing (DON) stated oxygen therapy should only have been initiated with a physician's order specifying the flow rate and parameters for use. The DON acknowledged R109 was receiving oxygen without an order and confirmed this was not consistent with facility expectations or professional standards of practice.A facility policy regarding the initiation, monitoring, and discontinuation of oxygen therapy, including requirements for physician orders and documentation, was requested but was not received.

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	12/04/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to maintain accurately documented medical records for 3 of 3 residents (R47, R68, R83) reviewed who had inaccurate documentation. Findings Include: Findings include: R47 R47's admission Minimum Data Set (MDS) dated [DATE], indicated R47 was cognitively intact, was dependent on staff for toileting and required substantial/maximum assistance for transfers and mobility. The MDS indicated R47 was frequently incontinent of bowel and bladder, did not have any urinary device. R47 did not exhibit rejection of care behavior. R47's diagnoses included dislocation of left patella (kneecap), chronic kidney disease, diabetes mellitus, and urinary tract infection. R47's care plan dated 1/13/26, indicated alteration in elimination with a goal to be free from signs and symptoms of UTI. R47's October 2025, medication administration record (MAR) indicated, Estradiol Vaginal Cream 0.1 mg (milligram)/GM (Gram) [Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly, with a start date of 10/18/25. The MAR indicated three days marked with a 2 (drug refused) and one day with a 9 (other-see nurses note). R47's November 2025, MAR indicated, Estradiol Vaginal Cream 0.1 MG/GM [Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly. The MAR indicated eight days marked with a 2 (drug refused) and one day with a checkmark (administered). R47's December 2025, MAR indicated, Estradiol Vaginal Cream 0.1 MG/GM [Estradiol Vaginal] Apply to inner vulvar & urethral topically one time a day every Wed, Sat for UTI prevention. Apply 5g to inner vaginal area two times weekly. The MAR indicated one day (12/3) marked with a 2 (drug refused). R47's MAR further indicated, Macrobid Oral Capsule [an antibiotic commonly used to treat UTIs].Give 100 mg by mouth two times a day related to [UTI]. with a start date of 11/20/25. During observation and interview on 12/3/25 at 7:36 a.m., registered nurse (RN)-B entered R47's room with a medicine cup full of pills. R47 was sitting up with bedside table in front of her awaiting breakfast. R47 took all the pills provided and RN-B left the room. RN-B did not offer to administer the Estradiol. R47 stated she had been offered the Estradiol one time that she could remember and refused it at that time. R47 could not remember being offered the Estradiol other than that one time. R47 could not recall when that offer/refusal took place. R47 stated RN-B did not offer the Estradiol yet today (12/3). During interview on 12/3/25 at 7:51 a.m., RN-B stated she had not offered the Estradiol to R47 yet and was going to offer it later when she was back in bed. RN-B confirmed she had signed off R47's MAR with a 2, indicating refused, even though she had not offered the medication yet. RN-B stated she should not have documented the refusal prior to offering, even if she thought R47 would end up refusing it. (continued on next page)

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	12/04/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R68 R68's admission MDS dated [DATE], indicated R68 was cognitively intact and required dialysis. R68's diagnosis included end stage renal disease (ESRD). R68's care plan (CP) printed 12/2/25, indicated R68 was at risk for complications related to R external chest port. R68's November 2025 treatment administration record (TAR) indicated, Dialysis-Monitor fisutla [sic] for Bruit and Thrill every shift Bruit [Whooshing sound] and Thrill [a powerful pulse felt at the top of the fistula]. If this is not heard or felt, you must contact MD. The TAR indicated task completed 55 times from 11/12/25 through 11/30/25. R68's progress note (PN) dated 11/14/25 at 18:35 p.m., indicated, Has port for dialysis. Bruit/Thrill present. No complications noted following return from dialysis. R68's PN dated 11/19/25 at 9:37 p.m., indicated, Has port for dialysis. Bruit/Thrill present. No complications noted following return from dialysis. R68's PN dated 11/26/25 at 9:39 p.m., indicated Has port for dialysis. Bruit/Thrill present. No complications noted following return from dialysis. During interview on 12/3/25 at 8:25 a.m., R68 stated went to dialysis three times a week and staff would usually check a set of vital signs (VS) and look at the external port on her chest on days when she returned from dialysis. R68 stated staff did not palpate anything or listen to anything except for her lungs on occasion. R68 further stated she did not have a fistula. During interview on 12/3/25 at 9:37 a.m., nurse practitioner stated would not expect staff to be feeling for thrill or listening for bruit around an external central catheter and would only expect it with a fistula. During interview on 12/3/25 at 1:23 p.m., RN-B stated when R68 returned from dialysis, she would check VS and observe the site for bleeding. RN-B further stated was not really sure about bruit and thrill but thought she could just feel above the port site for thrill. RN-B then stated that bruit and thrill assessment were appropriate in the presence of a fistula and would not be necessary for an external central catheter port site. RN-B stated the order for that assessment was entered automatically with the dialysis orders and that staff were just signing it off. RN-B stated signing items off on the TAR when not really doing the task should not be done. During interview on 12/3/25 at 3:00 p.m., medical doctor (MD)-A stated assessing bruit and thrill was not appropriate with a central line and was only appropriate with a fistula. During interview on 12/3/25 at 1:01 p.m., license practical nurse (LPN)-A stated staff should not document a refusal on a MAR without actually offering the treatment or medication. LPN-A stated documenting task not actually completed would be falsifying a medical record. During interview on 12/4/25 at 11:38 a.m., director of nursing (DON) stated staff should not be documenting refusals prior to offering a treatment or medication even if they had a history of refusals. DON further stated staff should be documenting accurately and documenting things when they were (continued on next page)

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	12/04/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not actually done would be considered an inaccurate entry. R83's quarterly Minimum Data Set (MDS) dated [DATE], indicated R83 had severe cognitive impairment and diagnoses of intellectual disabilities, seizure disorder, and personality disorder. R83 had no rejection of cares and was dependent on staff for lower body dressing, including socks and shoes. R83's Therapy ADL communication form dated 10/31/25, indicated R83 was dependent of staff for clothing management. R83's provider order dated 8/16/26. Indicated R83 required a nurse skin check weekly. R83's weekly skin inspection dated 10/27/25, indicated R83 had a shower and R83's toenails did not require trimming. R83's weekly skin inspection dated 11/1/25, indicated R83 had a bed bath and R83's toenails were trimmed. R83's weekly skin inspection dated 11/8/25, indicated R83 had a shower and R83's toenails did not require trimming. R83's weekly skin inspection dated 11/17/25, indicated R83 had a bed bath and R83's toenails were trimmed. R83's care plan revised 8/22/25, indicated R83 required interventions with ADL care. R83 required extensive assist of one person for lower body dressing and two persons assist with bathing. R83's emergency room provider progress note dated 11/25/25, indicated R83 had bad toenail infection and was started on Lamisil 250 milligram (MG) tablet (medication for fungal infection) daily for 28 days. The note further described R83's bilateral feet with significant thickening and discoloration of all the toenails with red non-blanching papules on bilateral feet. R83's diagnosed with fungal infection of the toenails. When interviewed on 12/2/25 at 9:06 a.m., registered nurse (RN)-A stated nail care was completed on shower days. The NA were responsible to complete them if the resident was diabetic. Documentation was completed by the nurses in the weekly skin assessment. When interviewed on 12/2/25 at 10:3 a.m., the assistant director of nursing (ADON) stated nail care was documented on the weekly skin assessments. ADON verified R83's weekly skin assessments indicated toenail care was not needed or had been completed. Pictures of R83's nails were shown and ADON. ADON verified R83's toenails looked overgrown, yellow and thick and R83's toenails could not have been done as indicated in the documentation. When interviewed on 12/2/25 at 2:04 p.m., guardian-A stated R83 had discharged recently from the facility to a group home. When arriving at the group home it was noted R83's toenails were in terrible shape. They were all yellow and appeared some were almost falling off. R83 was sent into the emergency room for treatment, and it was determined R83 had a bad toenail infection and was started on some medication. (continued on next page)

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	12/04/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When interviewed on 12/3/25 at 9:10 a.m., physician assistant (PA)-A stated she was the provider for R83 at the group home. PA-A stated the group home called and requested an urgent visit to assess the toenails when R83 had arrived, however was not able to. The facility sent R83 in to the emergency room for treatment. PA-A stated the description of the nails by the emergency room provider would lead her to believe the condition has been going on for a few months. When interviewed on 12/3/25 at 10:47 a.m., the Director of Nursing (DON) expected staff to document assessments and care accurately. R83's medical record should have indicated the description of his toenails in the weekly assessments or in a progress note. A facility policy on accuracy of medical records was requested however was not received.

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	12/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure appropriate infection control measures were in place for maintaining a central line with dressing changes and use of enhanced barrier precautions (EBP) with personal protective equipment (PPE) for 1 of 2 residents (R36) reviewed who had a central line indwelling device.Findings include:R36's admission Minimum Data Set (MDS) dated [DATE], indicated R36 had moderate cognitive impairment and required substantial/maximal assistance for most activities of daily living (ADL) and transfers. R36's diagnoses include spastic hemiplegia (paralysis on one side of the body) affecting the right, dominant side, osteomyelitis (infection of the bone), and history of traumatic brain injury. R36's care plan (CP) dated 10/8/25, indicated resident was on EPB related to IV (central line). The CP instructed staff to use appropriate PPE when providing high contact cares. R36's CP indicated EBP was resolved 11/3/25. R36's treatment administration record (TAR) for October 2025, indicated, Change dressing Location RIGHT CHEST using sterile technique weekly and as needed. The TAR indicated the dressing was changed four times in October, 2025, with the last time 10/27/25. The TAR further indicated, Staff to follow: Enhanced barrier Precautions every shift for IV. The TAR indicated staff completing three times a day. R36's TAR for November 2025, indicated, Staff to follow: Enhanced Barrier Precautions every shift for IV. The TAR indicated task completion three times a day on 11/1/25 and 11/2/25 and then discontinued on 11/3/25. The TAR further indicated Change dressing Location RIGHT CHEST using sterile technique weekly and as needed. The TAR lacked evidence of completion at all in November, 2025. The TAR further indicated, Remove PICC [peripherally inserted central catheter] line one time only until 11/5/25. The TAR lacked evidence this was completed. During observation and interview on 12/1/25 at 2:13 p.m., R36 stated not sure if still on antibiotics but did not think they were using the central line any longer. The dressing on R36's central line was not dated, and the sides of the dressing were curling up as if pretty old. During interview on 12/2/25 at 3:15 p.m., R36 stated cannot remember the last time they used the central line, flushed it or changed the dressing. R36 further stated they stopped donning gowns a while ago. During observation on 12/3/25 at 8:40 a.m., nursing assistant (NA)-B entered R36's room. NA-B completed hand hygiene with alcohol based hand sanitizer and donned gloves. NA-B did not don a gown. R36 was still in bed when NA-B assisted R36 with a brief change, peri care, and donning new pants. NA-B then assisted R36 into a sitting position on the edge of the bed and changed his shirt. While R36's shirt was off, NA-B confirmed the presence of the central line, stated they were not using it anymore, and agreed the dressing appeared to be curling up on the edges and peeling off. NA-B then transferred R36 into a wheelchair and assisted with washing face and oral and denture care. During interview on 12/3/25 at 1:20 p.m., NA-B stated R36 used to be on EBP due to the presence of a central line and that meant appropriate PPE was required when performing any cares. NA-B stated since the central line was still present, EBP should still be in place for R36 and confirmed she only donned gloves earlier when assisting R36 with morning cares. NA-B stated the PPE was to protect the resident from staff germs. During interview on 12/3/25 at 1:58 p.m., licensed practical nurse (LPN)-A stated EBP should have been continued for R36 since the central line remained in place. During interview on 12/3/25 at 3:00 p.m., medical doctor (MD)-A stated was just made aware that R36's central line had not been pulled last month as ordered. MD-A stated there was some confusion as to who could pull the central line and thought it was now scheduled to be removed next week. MD-A further stated would have expected proper care to continue on the central line like dressing changes and flushes and therefore, would also expect EBP to have been continued. During interview on 12/4/25 at 11:30 a.m., director of nursing (DON) stated the maintenance and care orders for R36's central line catheter should not have been discontinued until the catheter was actually removed and would have expected staff to identify this oversight and continue to follow EBP. Facility policy Enhanced Barrier Precautions dated 4/1/24, (continued on next page)

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	12/04/2025

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated EBP referred to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO [multi drug resistant organisms] as well as those at increased risk of MDRO acquisition [e.g., residents with wounds or indwelling medical devices]. The policy further indicated EBP were initiated when a resident had an indwelling medical device such as a central line and continued for the duration of the resident's stay or until the indwelling medical device was removed.