STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	06/17/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD CARE CENTER	1900 SHERREN AVENUE 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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure a resident-to-resident allegation of abuse was reported to the state agency (SA) for 3 of 3 residents (R1, R2, R4) reviewed for abuse. Findings include: R1's Admission Record printed 6/17/20, indicated R1's [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 was cognitively intact, and had no symptoms of verbal or physical behaviors. R1's care plan initiated 5/15/19, indicated R1 had the potential for verbal aggression, directed staff to remove R1 from potentially abusive situations, provide a safe environment, and ensure safety for R1 and others. R2's Admission Record printed 6/17/20, indicated R2's [DIAGNOSES REDACTED]. R2's annual Minimum Data Set ((MDS) dated [DATE], indicated R2 was cognitively intact, and had no symptoms of verbal or physical behaviors. R2's care plan initiated 4/28/20, indicated R2 had behaviors and potential for verbal altercations which included to abuse others related to yelling and screaming at others, and throwing objects when frustrated. R2's care plan directed staff to allow R2 space to cool off and calm down, as well as keeping conversations short to prevent further escalation. R4's Admission Record printed 6/17/20, indicated R4's [DIAGNOSES REDACTED]. R4's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R4 was cognitively intact, and had no symptoms of verbal or physical behaviors. R4's care plan initiated 2/8/19, indicated R4 had the potential for physical altercations towards residents, and had a vulnerability to abuse related to inability to remove self from situations. The care plan further directed staff to remove R4 from potentially abusive situations, and prevent opportunities for aggression. R4's progress notes dated 5/31/20, at 10:20 p.m. indicated an individual to individual altercation occurred involving R4. This altercation was reported to nursing at 8:20 p.m., and to the social services designee (SS)-A at 10:00 p.m. The incident report indicated on 5/31/20, at 8:48 p.m. outside in the designated resident smoking area, R1 and R4 were involved in a verbal altercation which included the use of profanity and swearing. The report indicated R1 and R4 de-escalated themselves, and R4 went to his room without incident. The facility report filled with the state agency indicated the incident occurred on 5/31/20 at 10:20 p.m., however was not reported to the state agency until 6/1/20, at 10:30 a.m. The facility incident report undated indicated on 5/31/20, at 11:15 p.m. R1 and R2 were involved in a verbal altercation on the units hallway which included the use of threats of physical harm with an unknown object, profanity and swearing. The report indicated R1 and R4 were separated, and later went to the designated smoking area together. The report indicated the police were called, and R1 and R4 de-escalated. The police recovered a nail file from R2. R2 indicated he was frustrated with how R1 treated female staff and residents, as well as his frustration regarding R1 leaving the facility on a regular basis during the COVID-19 outbreak. The facility report filled with the state agency indicated the incident occurred on 5/31/20 at 11:15 p.m., however was not reported to the state agency until 6/1/20, at 11:30 a.m. On 6/16/20, at 10:32 a.m. R1 stated he and R4 were friends, and had no issues with each other. R1 denied any verbal or physical abuse towards R2, R4, or any other residents living at the facility. On 6/16/20, at 9:41 a.m., R2 refused to be interviewed. On 6/16/20, at 10:32 a.m. R1 stated he and R2 were friends, and had no issues with each other. R1 denied any verbal or physical abuse towards R2, or any other residents living at the facility. On 6/16/20, at 11:10 a.m. social worker (SW)-A stated all reports or allegations of resident to resident abuse were to be reported immediately. SW-A stated reporting was important for the safety of residents living in the facility. SW-A further stated she was responsible to report as well as the social service director, and someone is always on call to report abuse timely to the SA. On 6/17/20, at 10:03 a.m. the administrator and SW-B were interviewed. SW-B stated timely reporting was important to protect residents from abuse, and to implement interventions to prevent further abuse from occurring. SW-B state she was responsible primarily to file reports to the SA, however, SW-A was also able to report. SW-B stated all reports were to be reported immediately, but no later than 2 hours. SW-B verified the incident involving R1 and R4 which occurred on 5/31/20, at 10:20 p.m. was not reported until 6/1/20, at 10:30 a.m. SW-B verified the incidents involving R1 and R2 which occurred on 5/31/20, at 11:15 p.m. was not reported until 6/1/20, at 11:30 a.m. SW-B stated again those two incidents had not been reported timely and should have been. The facility policy Resident/Client/Participant Protection/Freedom From Abuse, Neglect and Misappropriation Policy and Procedure revised 5/20, directed staff to report all suspicion of abuse is to be reported to the State reporting Agency in accordance with the state law immediately.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** Based on observation, interview, and document review, the facility failed to ensure personal protective equipment (PPE) was worn to reduce the spread of infection by 2 of 4 facility staff (LPN-A, RN-B) observed on the facilities designated COVID-19 unit. This had the potential to affect all 11 residents on the COVID-19 unit. Findings include: On 6/16/20, at 2:10 p.m. licensed practical nurse (LPN)-A was observed working on the COVID-19 unit. LPN-A was not wearing appropriate PPE (facial mask, gloves, face shield, or eye protection). LPN-A was observed wearing a hair covering, gown, and foot coverings. At 2:13 p.m. registered nurse (RN)-C verified LPN-A was not wearing appropriate PPE to be on the COVID-19 unit, and immediately instructed LPN-A to put on an N-95 mask (a type of face piece respirator which removes particles from the air that are breathed in), face shield, and gloves. On 6/16/20, at 2:17 p.m. RN-B just started her shift, and was observed entering the COVID 19 unit wearing only a surgical mask. RN-B stated she was going to put on the rest of her PPE (gown, gloves, and face shield) that was located on the COVID-19 unit. On 6/16/20, at 2:20 p.m. LPN-A stated she only worked on the COVID-19 unit, and was trained on the appropriate PPE that was need. LPN-A stated she was informed at the beginning of her shift before entering the COVID-19 unit, staff must donn a gown, gloves, and face shield. LPN-A stated prior to today, staff donned all of their PPE after they entered the COVID-19 unit. LPN-A verified she had removed her gloves, mask, and face shield while working on the COVID-19 during her shift. LPN-A stated she was taking a quick break, and only had the PPE off for a few minutes while she was in the hallway working at the medication cart. LPN-A stated not wearing the proper PPE could put her and others at risk of spreading COVID-19. On 6/17/20, at 11:57 a.m. RN-C stated LPN-A should have been wearing the appropriate PPE to protect herself and others from the potential spread of COVID-19. RN-C stated yesterday morning , staff were being educated on donning their PPE prior to entering the COVID-19 unit rather than donning on the COVID-19 unit. The facility policy for required PPE for caring for a resident with positive or presumptive COVID-19 was requested but not provided. The facility Infection Prevention and Control Manual Transmission-Based Precautions directs the importance to use the standard approaches, as defined by the Centers for Disease Control (CDC) for transmission-based precautions: airborne, contact, and droplet precautions. The category of transmission-based precaution determines the type of PPE to be used. The facility Questions and Answers Related to the COVID19, directed to use disposable dishes and if using regular dishes, cups and silverware, anyone touching the dishes must wear gloves.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245276	A. BUILDING _____ B. WING _____	**06/17/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MAPLEWOOD CARE CENTER	**1900 SHERREN AVENUE 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 -** Some	(continued... from page 1)