DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 14QG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00846

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245352**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1699760785**

3. NAME AND ADDRESS OF FACILITY
(L3) **RAMSEY COUNTY CARE CENTER**
(L4) **2000 WHITE BEAR AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55109**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/30/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 08/30/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 09/02/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 09/20/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/23/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245352
September 2, 2016

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

Dear Mr. Robinson:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective August 15, 2016 the above facility is certified for or recommended for:

164 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 164 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
September 2, 2016

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

RE: Project Number S5352025

Dear Mr. Robinson:

On July 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 14, 2016. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On August 30, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on August 24, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 14, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 15, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 14, 2016, effective August 15, 2016 and therefore remedies outlined in our letter to you dated July 26, 2016, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245352 Y1	A. Building B. Wing Y2	8/30/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RAMSEY COUNTY CARE CENTER	2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282	Correction	ID Prefix F0312	Correction	ID Prefix F0318	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(e)(2)	Completed
LSC	08/15/2016	LSC	08/15/2016	LSC	08/15/2016
ID Prefix F0328	Correction	ID Prefix F0332	Correction	ID Prefix	Correction
Reg. # 483.25(k)	Completed	Reg. # 483.25(m)(1)	Completed	Reg. #	Completed
LSC	08/15/2016	LSC	08/15/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/KJ	09/02/2016	16022	08/30/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
7/14/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245352	A. Building 01 - MAIN BUILDING 01 B. Wing	8/24/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
RAMSEY COUNTY CARE CENTER	2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 08/08/2016	ID Prefix Reg. # NFPA 101 LSC K0054	Correction Completed 08/08/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/KJ	DATE 09/02/2016	SIGNATURE OF SURVEYOR 37009	DATE 08/24/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
7/19/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 14QG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00846

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245352**

2.STATE VENDOR OR MEDICAID NO.
(L2) **1699760785**

3. NAME AND ADDRESS OF FACILITY
(L3) **RAMSEY COUNTY CARE CENTER**
(L4) **2000 WHITE BEAR AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55109**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/14/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **164** (L18)

13.Total Certified Beds **164** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	164			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Susan Miller, HFE NE II — 08/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/16/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
03/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

Posted 08/23/2016 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 26, 2016

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

RE: Project Number S5352025

Dear Mr. Robinson:

On July 14, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the July 14, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5352045 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 28, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of

compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by October 14, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by January 14, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245352	A. BUILDING _____ B. WING _____	07/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RAMSEY COUNTY CARE CENTER	2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. An investigation of complaint H5352045 was completed and found not to be substantiated.	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for 1 of 3 residents (R52) in the area of grooming; and for 1 of 1 resident (R52) identified with limited range of motion.	F 282	The plan and response to CMS 2567 is written solely to maintain certification in Medicare and Medical assistance programs. These written responses do not constitute an admission of	8/15/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2016

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.

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	245352	A. BUILDING _____ B. WING _____	07/14/2016

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F 282	Continued From page 1 Findings include: R52's care plan dated 6/9/14, directed staff R52 was capable of washing own hands and face. The care plan directed staff R52 required extensive assistance with activities of daily living and there was a goal identified for R52 to continue to wash own face and hands. The care plan also had a plan, developed on 9/10/14, which directed staff to implement the following plan: "FMP-PROM to AAROM in supine, straight leg raise, hib abduction x20. In seated position to do knee extension PROM slow and gently x20 every day." On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A began morning cares for R52. Instead of encouraging and handing R52 a washcloth to wash hands and face, NA-A completed the task/s. R52 was transferred via a mechanical lift into a wheelchair at 9:48 a.m. and brushed own teeth after set up. Passive range of motion (PROM) and/or active range of motion (AAROM) was not performed. On 7/13/16, at 2:30 p.m. NA-A stated she did not encourage R52 to wash own face and hands because R52 liked NA-A to do it for her. At 2:32 p.m. registered nurse (RN)-A stated nursing assistants were responsible for doing the functional maintenance program (FMP); and NA-A stated the ROM had not been completed for the resident during morning cares, but would complete it at this time, as R52 was laying down in bed.	F 282	non-compliance with any requirement or an agreement with any findings. We wish to preserve the right to dispute these findings in their entirety should any remedies be imposed without jeopardizing the right to challenge the validity of the F-Tags and without admitting that any non-compliance with this regulation exists. We have implemented the following measures: The Nurse Manager reviewed and revised the care plan for R 52. All resident records were reviewed that may be affected by the same practice. Re-education was provided for the nursing staff to include utilizing appropriate goals that are attainable within the residents desire to participate/capabilities. NA/R□s were re-educated on following the plan of care and importance of notifying the licensed nurse if the resident is unwilling or unable to participate. Audits will be conducted by the Nurse Managers these audits will be conducted on a quarterly basis. The nurse managers will be responsible for continued compliance	

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F 312	Continued From page 2	F 312		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R52) who required extensive assist from staff to perform own cares, was provided the opportunity to maintain the ability to complete personal hygiene tasks. Findings include: R52's most recent annual Minimum Data Set dated 6/9/16, identified R52 scored a "3" under self-performance, requiring extensive assistance of one person with personal hygiene. R52's care plan dated 6/9/14, included a goal for R52 to wash face and hands after set up, as R52 was capable of completing these tasks. On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A began morning cares for R52. Instead of encouraging and handing R52 a washcloth to wash own face and hands, NA-A completed the task/s for R52. On 7/13/16, at 2:30 p.m. NA-A stated she did not encourage R52 to wash own face and hands because R52 liked NA-A to do it for her.	F 312	The Nurse Manager reviewed and revised the care plan for R 52. All resident records were reviewed that may be affected by the same practice. Re-education was provided for the nursing staff to include utilizing appropriate goals that are attainable within the residents desire to participate/capabilities. NA/R□s were re-educated on following the plan of care and importance of notifying the licensed nurse if the resident is unwilling or unable to participate. Audits will be conducted by the Nurse Managers these audits will be conducted on a quarterly basis. The nurse managers will be responsible for continued compliance	8/15/16

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F 318	Continued From page 3	F 318		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure range of motion (ROM) was completed for 1 of 1 resident (R52) identified as having functional ROM limitations. Findings include: On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A was observed to provide morning cares for R52. During the observation, no passive (PROM) or active range of motion (AAROM) was performed. An annual Minimum Data Set dated 6/9/16, revealed R52 had ROM limitations on both sides of the body in the upper and lower extremities. The most recent physical therapy note dated 6/30/14, documented the following: "This is follow up to screen for pt. having increased knee contractures. PT. to have gentle prom fmp to prevent further contractures. T.O. written for fmp." The care plan developed on 9/10/14, directed	F 318	The Interdisciplinary team reviewed and revised the care plan for R52. All resident records were reviewed that may be affected by the same practice. R52 was re-evaluated by the Physical therapy department and the Nursing rehab program was changed to accommodate her current limitations/capabilities. NA/R that provided care for the resident was re-educated on Range of motion. NA/R□s were re-educated on the Nursing rehab program. Licensed nursing staff will review the resident□s ROM program and observe the NA/R□s monthly to ensure the program is being completed and the resident is capable of performing the tasks. Audits will be conducted by the Nurse	8/15/16

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F 318	Continued From page 4 staff to do 20 repetitions of straight leg raises and hip abductions; and when in a seated position to do 20 repetitions of slow and gentle PROM knee extensions "every day." On 7/13/16, at 2:32 p.m. registered nurse (RN)-A stated nursing assistants were responsible for doing functional maintenance programs (FMP); and nursing assistant (NA)-A stated they had not done the ROM for R52 during morning cares or at any other time during the day, but would complete it at this time, as R52 was laying down in bed.	F 318	Managers on a quarterly basis.	
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure proper insulin administration for 2 of 2 residents (R241, R245) observed while utilizing insulin pens. This had the potential to affect 5 residents who received insulin via insulin pens. Findings include:	F 328	The current policy and procedure was reviewed. The Licensed nurses were re-educated on the policy and procedure and the proper technique for insulin injection utilizing the pen.	8/15/16

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F 328	Continued From page 5 R241's insulin administration was observed on 7/11/16, at 4:51 p.m. by licensed practical nurse (LPN)-B. After checking the resident's blood sugar and Humalog insulin dose, the nurse dialed up the 2 unit dose, attached the needle, and administered the insulin to R241 without first priming the KwikPen insulin pen. LPN-B was later unavailable for an interview regarding the observation. R241's diagnostic report (printed 7/14/16) revealed the resident had type 2 (adult onset) diabetes mellitus. The Order Summary dated 7/4/16, indicated physician orders for Humalog KwikPen solution Pen-injector 100 unit/milliliter (ml). Staff was directed to administer insulin three times daily based on blood sugar readings, and using a sliding scale: if 150-199 = 2 units; 200-249 = 4 units; 250-299 = 6 units; 300-350 = 8 units; 351+ = 10 units. Blood sugar readings from 7/4 through 7/13/16, indicated R241's blood sugar was greater than 150 milligrams per deciliter (mg/dl) for 20 out of 28 tests. R245's insulin administration was observed on 7/13/16, at 7:24 a.m. by a registered nurse (RN)-B. After checking R245's blood sugar, the nurse wiped the top of the Lantus Solostar pen with an alcohol wipe, attached a needle and dialed up 60 units of Lantus. RN-B did not prime the Solostar pen. RN-B then prepared R245's Novolog FlexPen by wiping the top of the pen with an alcohol wipe, attached a needle and dialed up 33 units of Novolog. RN-B did not prime the FlexPen. At 7:25 a.m. RN-B gave both injections to R245 in the resident's abdomen.	F 328	The Licensed nurses will be required to Re-certify on use of the Insulin pens quarterly including skill demonstration. Nurse Managers on the TCU will randomly audit the licensed nurses on the unit to ensure the policy and procedure is being followed. Audits will be reviewed at the Quality Assurance meeting for one quarter to determine if further action is required.	

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F 328	Continued From page 6	F 328		

R245's diagnostic report printed on 7/13/16, indicated R245 had type 2 diabetes mellitus with hyperglycemia (too much sugar in the blood). The Order Summary dated 6/26/16, for Lantus Solution 100 unit/ml directed staff to inject 60 units of insulin twice daily. R245 also had an order for Novolog solution 100 unit/ml inject 30 units before meals and four times daily as per sliding scale: if 141-180 =3 units; 181-220 = 6 units; 221-260 = 9 units; 261-300 = 12 units; 301-340 = 15 units; 341-400 = 18 units; 401+ = 21 units before meals and if 141-180 = 0 units; 181-220 = 3 units; 221-260 = 5 units; 261-300 = 6 units; 301-340 = 8 units; 341-400 = 9 units; 401+ = 10 units. R245's blood sugars from 7/1 through 7/13/16, were greater than 141 mg/dl in 49 out of 52 tests.

On 7/13/16, at 2:35 p.m. RN-B was interviewed regarding insulin administration procedures. RN-B explained that she would prime the unit, clean the pen's rubber stopper and then attach the needle. RN-C joined the interview and explained the procedure she followed when preparing insulin pens. RN-C stated she cleaned the pen's rubber stopper, attached the needle, and then primed the pen with 2 units of insulin. She did this by dialing up 2 units and pressing the end of pen. RN-C further indicated that priming was important to ensure the air was expressed from the needle and that the correct insulin dose was administered. RN-B stated she thought she needed to prime the pen before the needle was attached. RN-B reported she had been incorrectly priming the insulin pens, and confirmed she had not correctly primed R241's pens prior to insulin administration.

When interviewed on 7/13/16, at 3:00 p.m. RN-D

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F 328	Continued From page 7	F 328		

stated staff should have been priming insulin pens using 2 units of insulin prior to dialing the prescribed dose of insulin. RN-D said it was an important step in ensuring residents received the accurate prescribed dose. RN-D further stated that if the insulin pen was not primed a resident may not receive an accurate dose, which could adversely affect blood sugar levels.

The director of nursing (DON) stated in an interview on 7/13/16, at 3:10 p.m. that insulin pens should have been primed by turning dose dial to 2 units, then pressing the end of pen several times to express the air from the needle. The DON also stated without proper priming, the resident may not receive the correct dose of insulin, which could affect their blood sugar levels. The DON also stated that staff had been trained in insulin priming, however, they had recently hired several new staff. The DON said only residents on the second floor utilized insulin pens, and she was unaware of the staffs' lack of knowledge on how to prime the pens.

The facility's 6/1/16, Injections: Insulin Pen Use policy was "To ensure accurate administration of insulin using a pen administration device." Staff was directed to use the following priming instructions: "Select a dose of 2 units by turning the dosage selector on the pen body. 1. Hold the pen with the needle pointing upwards
2. Tap the insulin reservoir so any air bubbles rise up towards the needle 3. Press and hold the injection button all the way in for several seconds and to see if insulin comes out of the needle tip."

The 1/10, Instruction Leaflet for Lantus Solostar directed the user to:
"Perform a safety test; Always perform a safety

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F 328	Continued From page 8 test before each injection. This ensures that you get an accurate dose by: -ensuring that pen and needle work properly -removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip." The 3/13/15, Instructions for Use for the Humalog KwikPen directed the user to "Prime before each injection; Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin." The 2/15, Instructions for Use for the Novolog FlexPen directed the user as follows: "Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing...E. Turn the dose selector to select 2 units F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubble collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip."	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE	F 332		8/15/16

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F 332	Continued From page 9 The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered without error for 2 of 6 residents (R241, R245) whose medication administration was observed. This resulted in a 10 percent medication error rate. Findings include: R241's insulin administration was observed on 7/11/16, at 4:51 p.m. by licensed practical nurse (LPN)-B. After checking the resident's blood sugar and Humalog insulin dose, the nurse dialed up the 2 unit dose, attached the needle, and administered the insulin to R241 without first priming the KwikPen insulin pen. LPN-B was later unavailable for an interview regarding the observation. R241's Order Summary dated 7/4/16, indicated physician orders for Humalog KwikPen solution Pen-injector 100 unit/milliliter (ml). Staff was directed to administer insulin three times daily based on blood sugar readings. R245's insulin administration was observed on 7/13/16, at 7:24 a.m. by a registered nurse (RN)-B. After checking R245's blood sugar, the nurse wiped the top of the Lantus Solostar pen with an alcohol wipe, attached a needle and dialed up 60 units of Lantus. RN-B did not prime	F 332	Re-education will be provided to all licensed nurses of the policy and procedure for medication error. Nurse Managers on the unit will review all residents that are admitted on the TCU with orders for Insulin administration utilizing a pen. Medication error reports will be reviewed at the Quality Assurance meeting quarterly to determine if further action is required.	

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F 332	Continued From page 10	F 332		

the Solostar pen. RN-B then prepared R245's Novolog FlexPen by wiping the top of the pen with an alcohol wipe, attached a needle and dialed up 33 units of Novolog. RN-B did not prime the FlexPen. At 7:25 a.m. RN-B gave both injections to R245 in the resident's abdomen.

R245's Order Summary dated 6/26/16, for Lantus Solution 100 unit/ml directed staff to inject 60 units of insulin twice daily. R245 also had an order for Novolog solution 100 unit/ml inject 30 units before meals and four times daily as per sliding scale.

On 7/13/16, at 2:35 p.m. RN-B was interviewed regarding insulin administration procedures. RN-B explained that she would prime the unit, clean the pen's rubber stopper and then attach the needle. RN-C joined the interview and explained the procedure she followed when preparing insulin pens. RN-C stated she cleaned the pen's rubber stopper, attached the needle, and then primed the pen with 2 units of insulin. She did this by dialing up 2 units and pressing the end of pen. RN-C further indicated that priming was important to ensure the air was expressed from the needle and that the correct insulin dose was administered. RN-B stated she thought she needed to prime the pen before the needle was attached. RN-B reported she had been incorrectly priming the insulin pens, and confirmed she had not correctly primed R241's pens prior to insulin administration.

When interviewed on 7/13/16, at 3:00 p.m. RN-D stated staff should have been priming insulin pens using 2 units of insulin prior to dialing the prescribed dose of insulin. RN-D said it was an important step in ensuring residents received the

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F 332	Continued From page 11	F 332		

accurate prescribed dose. RN-D further stated that if the insulin pen was not primed a resident may not receive an accurate dose, which could adversely affect blood sugar levels.

The director of nursing (DON) stated in an interview on 7/13/16, at 3:10 p.m. that insulin pens should have been primed by turning dose dial to 2 units, then pressing the end of pen several times to express the air from the needle. The DON also stated without proper priming, the resident may not receive the correct dose of insulin, which could affect their blood sugar levels. The DON also stated that staff had been trained in insulin priming, however, they had recently hired several new staff. The DON said only residents on the second floor utilized insulin pens, and she was unaware of the staffs' lack of knowledge on how to prime the pens.

The facility's 6/1/16, Injections: Insulin Pen Use policy was "To ensure accurate administration of insulin using a pen administration device." Staff was directed to use the following priming instructions: "Select a dose of 2 units by turning the dosage selector on the pen body. 1. Hold the pen with the needle pointing upwards
2. Tap the insulin reservoir so any air bubbles rise up towards the needle 3. Press and hold the injection button all the way in for several seconds and to see if insulin comes out of the needle tip."

The 1/10, Instruction Leaflet for Lantus Solostar directed the user to:
"Perform a safety test; Always perform a safety test before each injection. This ensures that you get an accurate dose by: -ensuring that pen and needle work properly -removing air bubbles. A. Select a dose of 2 units by turning the dosage

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 12	F 332		

selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip."

The 3/13/15, Instructions for Use for the Humalog KwikPen directed the user to "Prime before each injection; Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin."

The 2/15, Instructions for Use for the Novolog FlexPen directed the user as follows: "Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing...E. Turn the dose selector to select 2 units F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubble collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245352	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2016**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on July 19, 2016. At the time of this survey, Ramsey County Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/04/2016

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.

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	245352	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**07/19/2016**

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K 000	Continued From page 1 Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ramsey County Care Center is a 2-story building with no basement. The building was constructed in 1979 and was determined to be of Type II(222) construction. The building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 164 beds and had a census of 141 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by:	K 052		8/8/16

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K 052	Continued From page 2 Based on document review and staff interview, the facility's fire alarm system maintenance is not documented in accordance with NFPA 72, (99). This deficient practice could affect all 141 residents. Findings include: On a facility tour between the hours of 10:30 AM and 02:30 PM on July 19, 2016, observation revealed that the fire alarm system annual inspection was conducted on September 21, 2015, however the facility did not have the report on file. This deficient practice was verified by the Administrator at the time of the inspection.	K 052	A report of the Fire Alarm Inspection will be kept on file for the Fire Marshall's annual review. The Director of Environmental Services is responsible and will assure we are in compliance.	
K 054 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on document review and staff interview, the facility has not been documenting sensitivity testing of the smoke detectors on the fire alarm system in accordance with NFPA 72 (99), Sec. 7-3.2.1. This deficient practice could affect all 141 residents. Findings include: On a facility tour between the hours of 10:30 AM and 02:30 PM on July 19, 2016, observation revealed that there is no documentation of a current smoke detector sensitivity test. The facility has a fully addressable fire alarm system that conducts it's own sensitivity tests.	K 054	A report of the Fire Alarm Sensitivity Inspection will be kept on file for the Fire Marshall's annual review. The Director of Environmental Services is responsible and will assure we are in compliance.	8/8/16

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K 054	Continued From page 3 This deficient practice was verified by the Administrator at the time of inspection.	K 054		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
July 26, 2016

Mr. Frank Robinson, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5352025 & H5352045

Dear Mr. Robinson:

The above facility was surveyed on July 11, 2016 through July 14, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5352045 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Susanne Reuss, Unit Supervisor at (651) 201-3793.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00846	A. BUILDING: _____ B. WING _____	07/14/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the Minnesota Department of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: The facility has agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the Minnesota Department of	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

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2 000	Continued From page 1 Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. Then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On July 11, 12, 13 and 14, surveyors of this Department's staff visited the above provider and the following correction orders are issued. An investigation of complaint H5352045 was also completed during the standard survey and found not to be substantiated.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care	2 565		

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2 565	Continued From page 2	2 565		

plan for 1 of 3 residents (R52) in the area of grooming; and for 1 of 1 resident (R52) identified with limited range of motion.

Findings include:

R52's care plan dated 6/9/14, directed staff R52 was capable of washing own hands and face. The care plan directed staff R52 required extensive assistance with activities of daily living and there was a goal identified for R52 to continue to wash own face and hands.

The care plan also had a plan, developed on 9/10/14, which directed staff to implement the following plan: "FMP-PROM to AAROM in supine, straight leg raise, hib abduction x20. In seated position to do knee extension PROM slow and gently x20 every day."

On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A began morning cares for R52. Instead of encouraging and handing R52 a washcloth to wash hands and face, NA-A completed the task/s. R52 was transferred via a mechanical lift into a wheelchair at 9:48 a.m. and brushed own teeth after set up. Passive range of motion (PROM) and/or active range of motion (AAROM) was not performed.

On 7/13/16, at 2:30 p.m. NA-A stated she did not encourage R52 to wash own face and hands because R52 liked NA-A to do it for her.

At 2:32 p.m. registered nurse (RN)-A stated nursing assistants were responsible for doing the functional maintenance program (FMP); and NA-A stated the ROM had not been completed for the resident during morning cares, but would complete it at this time, as R52 was laying down

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2 565	Continued From page 3 in bed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, document review and interview, the facility failed to ensure range of	2 895		

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2 895	Continued From page 4 motion (ROM) was completed for 1 of 1 resident (R52) identified as having functional ROM limitations. Findings include: On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A was observed to provide morning cares for R52. During the observation, no passive (PROM) or active range of motion (AAROM) was performed. An annual Minimum Data Set dated 6/9/16, revealed R52 had ROM limitations on both sides of the body in the upper and lower extremities. The most recent physical therapy note dated 6/30/14, documented the following: "This is follow up to screen for pt. having increased knee contractures. PT. to have gentle prom fmp to prevent further contractures. T.O. written for fmp." The care plan developed on 9/10/14, directed staff to do 20 repetitions of straight leg raises and hip abductions; and when in a seated position to do 20 repetitions of slow and gentle PROM knee extensions "every day." On 7/13/16, at 2:32 p.m. registered nurse (RN)-A stated nursing assistants were responsible for doing functional maintenance programs (FMP); and nursing assistant (NA)-A stated they had not done the ROM for R52 during morning cares or at any other time during the day, but would complete it at this time, as R52 was laying down in bed. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for a decline in range of motion to assure they are receiving the necessary	2 895		

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2 895	Continued From page 5 treatment/services to maintani or prevent a decline in range of motion. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R52) who required extensive assist from staff to perform own cares, was provided the opportunity to maintain the ability to complete personal hygiene tasks. Findings include: R52's most recent annual Minimum Data Set dated 6/9/16, identified R52 scored a "3" under self-performance, requiring extensive assistance of one person with personal hygiene. R52's care plan dated 6/9/14, included a goal for R52 to wash face and hands after set up, as R52 was capable of completing these tasks.	2 920		

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2 920	Continued From page 6 On 7/13/16, at 9:23 a.m. nursing assistant (NA)-A began morning cares for R52. Instead of encouraging and handing R52 a washcloth to wash own face and hands, NA-A completed the task/s for R52. On 7/13/16, at 2:30 p.m. NA-A stated she did not encourage R52 to wash own face and hands because R52 liked NA-A to do it for her. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and	21426		

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21426	Continued From page 7 unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure adequate testing for tuberculosis (TB) was conducted for 2 of 3 staff (LPN-A, NA-B, NA-D) with undocumented evidence to a positive tuberculin skin test or undocumented evidence of having been treated for tuberculosis. Findings include: A review of personnel records revealed LPN-A, NA-B, NA-D, were all hired on 6/15/16. LPN-A's Baseline TB Screening Tool For Health Care Workers form dated 6/13/16, indicated LPN-A had a history of a positive TB skin test. A negative chest X-ray dated 4/29/16, was found in the personnel record. However, there was no written documentation of the TB skin test, which would have indicated the millimeters (mm) of induration, an interpretation of the skin test results and the date of the positive TB test. NA-B's Baseline TB Screening Tool For Health Care Workers form dated 6/13/16, indicated	21426		

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21426	Continued From page 8 LPN-A had a history of a positive TB skin test. A negative chest X-ray dated 5/12/09, was found in the personnel record. However, there was no written documentation of the TB skin test, which would have indicated the mm of induration, an interpretation of the skin test results and the date of the positive TB test. NA-D's Baseline TB Screening Tool For Health Care Workers form dated 6/27/16, indicated NA-D had a history of a positive tuberculin test of 15 mm on 9/17/07. A handwritten note on the screening indicated NA-D had been treated for the tuberculosis however, there was no documentation as to when the Isonaizid (INH) treatment had been completed. On 7/14/16 at 10:10 a.m. registered nurse (RN)-E, who in charge of the infection control program was interviewed. RN-E stated that before being hired the new employee was to show proof they were free of communicable diseases. If the employee has had a BCG vaccination or no history of a positive TB skin test, then the two-step TB skin test would be administered. RN-E stated they had seen the document titled Regulations for Tuberculosis Control in Minnesota Health Care Settings, but did not know written documentation of the positive TB skin test was required. RN-E stated if a new hire stated they had a history of a positive TB skin test, then the facility required documentation of a negative chest X-ray. RN-E stated they would try to get the information from the employees about their positive history test and get for NA-D documentation of the INH treatment. A review of the facility's Tuberculin Skin Test	21426		

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21426	Continued From page 9 (TST) Mantoux Testing Program, approved by the medical director on 7/12/16, did not include the requirement of written proof of a positive TB skin test; and did not include the requirement of a physician's examination and statement there was no TB elsewhere in the body. SUGGESTED METHOD OF CORRECTION: The medical director, director of nursing (DON) and infection control nurse could review and revise policies and procedures for TB testing of new hires. The infection control nurse should also attempt to obtain written documentation regarding the positive TB skin test results for any newly hired employee. A member of the human resources department could audit newly hired personnel records on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications.	21545		

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21545	Continued From page 10 B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered without error for 2 of 6 residents (R241, R245) whose medication administration was observed. This resulted in a 10 percent medication error rate.	21545		

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21545	Continued From page 11 Findings include: R241's insulin administration was observed on 7/11/16, at 4:51 p.m. by licensed practical nurse (LPN)-B. After checking the resident's blood sugar and Humalog insulin dose, the nurse dialed up the 2 unit dose, attached the needle, and administered the insulin to R241 without first priming the KwikPen insulin pen. LPN-B was later unavailable for an interview regarding the observation. R241's Order Summary dated 7/4/16, indicated physician orders for Humalog KwikPen solution Pen-injector 100 unit/milliliter (ml). Staff was directed to administer insulin three times daily based on blood sugar readings. R245's insulin administration was observed on 7/13/16, at 7:24 a.m. by a registered nurse (RN)-B. After checking R245's blood sugar, the nurse wiped the top of the Lantus Solostar pen with an alcohol wipe, attached a needle and dialed up 60 units of Lantus. RN-B did not prime the Solostar pen. RN-B then prepared R245's Novolog FlexPen by wiping the top of the pen with an alcohol wipe, attached a needle and dialed up 33 units of Novolog. RN-B did not prime the FlexPen. At 7:25 a.m. RN-B gave both injections to R245 in the resident's abdomen. R245's Order Summary dated 6/26/16, for Lantus Solution 100 unit/ml directed staff to inject 60 units of insulin twice daily. R245 also had an order for Novolog solution 100 unit/ml inject 30 units before meals and four times daily as per sliding scale. On 7/13/16, at 2:35 p.m. RN-B was interviewed	21545		

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regarding insulin administration procedures. RN-B explained that she would prime the unit, clean the pen's rubber stopper and then attach the needle. RN-C joined the interview and explained the procedure she followed when preparing insulin pens. RN-C stated she cleaned the pen's rubber stopper, attached the needle, and then primed the pen with 2 units of insulin. She did this by dialing up 2 units and pressing the end of pen. RN-C further indicated that priming was important to ensure the air was expressed from the needle and that the correct insulin dose was administered. RN-B stated she thought she needed to prime the pen before the needle was attached. RN-B reported she had been incorrectly priming the insulin pens, and confirmed she had not correctly primed R241's pens prior to insulin administration.

When interviewed on 7/13/16, at 3:00 p.m. RN-D stated staff should have been priming insulin pens using 2 units of insulin prior to dialing the prescribed dose of insulin. RN-D said it was an important step in ensuring residents received the accurate prescribed dose. RN-D further stated that if the insulin pen was not primed a resident may not receive an accurate dose, which could adversely affect blood sugar levels.

The director of nursing (DON) stated in an interview on 7/13/16, at 3:10 p.m. that insulin pens should have been primed by turning dose dial to 2 units, then pressing the end of pen several times to express the air from the needle. The DON also stated without proper priming, the resident may not receive the correct dose of insulin, which could affect their blood sugar levels. The DON also stated that staff had been trained in insulin priming, however, they had recently hired several new staff. The DON said

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21545	Continued From page 13 only residents on the second floor utilized insulin pens, and she was unaware of the staffs' lack of knowledge on how to prime the pens. The facility's 6/1/16, Injections: Insulin Pen Use policy was "To ensure accurate administration of insulin using a pen administration device." Staff was directed to use the following priming instructions: "Select a dose of 2 units by turning the dosage selector on the pen body. 1. Hold the pen with the needle pointing upwards 2. Tap the insulin reservoir so any air bubbles rise up towards the needle 3. Press and hold the injection button all the way in for several seconds and to see if insulin comes out of the needle tip." The 1/10, Instruction Leaflet for Lantus Solostar directed the user to: "Perform a safety test; Always perform a safety test before each injection. This ensures that you get an accurate dose by: -ensuring that pen and needle work properly -removing air bubbles. A. Select a dose of 2 units by turning the dosage selector. B. Take off the outer needle cap and keep it to remove the used needle after injection. Take off the inner needle cap and discard it. C. Hold the pen with the needle pointing upwards. D. Tap the insulin reservoir so that any air bubbles rise up towards the needle. E. Press the injection button all the way in. Check if insulin comes out of the needle tip." The 3/13/15, Instructions for Use for the Humalog KwikPen directed the user to "Prime before each injection; Priming ensures the pen is ready to dose and removes air that may collect in the cartridge during normal use. If you do not prime before each injection, you may get too much or too little insulin."	21545		

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21545	Continued From page 14 The 2/15, Instructions for Use for the Novolog FlexPen directed the user as follows: "Giving the airshot before each injection. Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing...E. Turn the dose selector to select 2 units F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubble collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push-button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip." SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper priming and administration of insuling, when an insulin pen was ordered. Nursing staff could be educated as necessary to the importance of properly administering insulin via an insulin pen. The DON or designee, along with the pharmacist, could conduct audits on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		