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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 979K

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 **12/06/2013** (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 **178** (L18)

13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor — 12/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 03/072014 (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)
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
12/09/2013
(L33)

DETERMINATION APPROVAL

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective November 5, 2013, the facility is certified for 178 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245352

February 12, 2014

Mr. Steve Fritzke, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, MN 55109

Dear Mr. Fritzke:

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 November 5, 2013, the above facility is certified for:

178 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 178 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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

November 18, 2013

Mr. Steve Fritzke, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, Minnesota 55109

Re: Enclosed Reinspection Results - Project Number S5352022

Dear Mr. Fritzke:

On November 13, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 13, 2013, with orders received by you on November 4, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245352	A. Building B. Wing	11/13/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **11/05/2013**	ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **11/05/2013**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/05/2013**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/05/2013**	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** SR/KJ	**Date:** 11/18/2013	**Signature of Surveyor:** 16022	**Date:** 11/13/2013
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 9/26/2013

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245352	A. Building B. Wing **01 - MAIN BUILDING 01**	12/6/2013

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **10/09/2013**	ID Prefix	Correction Completed **10/01/2013**	ID Prefix	Correction Completed **10/04/2013**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0017		LSC K0018		LSC K0029	
ID Prefix	Correction Completed **11/05/2013**	ID Prefix	Correction Completed **10/07/2013**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0050		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	2/12/2014	12424	12/6/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
9/24/2013	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 979K

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 **09/26/2013** (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 **178** (L18)

13.Total Certified Beds **178** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	178			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Heim - HFE NEII 11/05/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon - Enforcement Specialist 12/04/2013 (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)

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
12/09/2013
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN# 245352

At the time of the September 26, 2013 standard survey the facility was not in substantial compliance with Federal participation requirements. 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. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 6541

October 29, 2013

Mr. Steve Fritzke, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, Minnesota 55109

RE: Project Number S5352022

Dear Mr. Fritzke:

On September 26, 2013, 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.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Plan of Correction</u> - 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
P.O. Box 64900
St. Paul, Minnesota 55108-2970

Telephone: (651) 201-3793
Fax: (651) 201-3790

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 November 5, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

If an acceptable PoC 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 PoC 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 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. In order for your allegation of compliance to be acceptable to the Department, the PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 December 26, 2013 (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 March 26, 2014 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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.

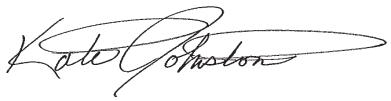
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

PRINTED: 10/29/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	09/26/2013

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. 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 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.	F 000	**This Plan of Correction constitutes our allegation of compliance for the deficiencies cited.** **Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.**	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to maintain sanitary mechanical lifts for 4 of 6 mechanical lifts on the first floor which had the potential to impact 12 of 82 residents in the facility who were dependent with transfers and/or required a mechanical lift. Findings include: Four mechanical lifts (serial numbers 52165, 20015, 43138, 51170) used room to room for 12 residents who resided on the "Vadnais" and "Phalen" units had dried food, paper particles, dust, sand, and dried brown stains visible. Random observation of mechanical lifts on	F 253	11/6/13 SER	

RECEIVED
NOV - 6 2013
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 11/5/13

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.

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 _____	09/26/2013

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

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F 253	Continued From page 1 9/23/13, from 4:00 p.m. until 7:30 p.m. and on 9/24/13 from 8:00 a.m. until 3:30 p.m. had visible accumulations of dried food, paper particles, dust, sand, dried brown stains. On 9/25/13, at 7:00 a.m. all four mechanical lifts were still not clean. When interviewed on 9/25/13, at 7:20 a.m. housekeeping (H)-A stated, "It looks like food, probably is food or salad. The aides told me not to clean the lifts because they are supposed to wash their own machines." (Referring to mechanical lifts 52165, and 20012). H-A verified was not aware of any policy/procedure for cleaning the mechanical lifts. At 7:35 a.m. H-B was interviewed and stated, "It used to be the aides that were to clean the machines but I guess it's us now." H-B validated the accumulation of debris on mechanical lifts (43138, and 51170). H-B stated, "It looks like probably food." When interviewed at 7:40 a.m. nursing assistant (NA)-A stated, "That is dust or food" regarding the debris on the mechanical lifts (43138, and 51170). However, NA-A was not sure whose responsibility it was when asked who was to clean the base of the mechanical lifts. When interviewed at 7:40 a.m. NA-B stated, "Laundry on the night shift does them." NA-B verified there was an accumulation of dried food, paper particles, dust, sand and various brown stains visible on the stands. (Referring to mechanical lifts 43138, and 51170). The policy titled Mechanical Lift Cleaning and Safety Inspection Schedule dated 8/1/12, read housekeeping was responsible to thoroughly clean each mechanical lift daily and to check daily for safety/repairs needed.	F 253	On October 14, 2013 four mechanical lifts (serial numbers 52165, 20015, 43138,51170) were cleaned. All other mechanical lifts in the facility have been cleaned since that time. The Mechanical Lift Cleaning and Safety Inspection policy has been reviewed and updated. A Mandatory housekeeping and laundry meeting has been scheduled to review the Mechanical Lift Cleaning and Safety Inspection. This meeting will be conducted by the Housekeeping Supervisor. Housekeeping Supervisor will spot check for 3 months and report findings to the Quality Assurance meeting (January 21, 2014) to determine any further action.	

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F 253	Continued From page 2 On 9/26/13, at 1:00 p.m. the acting director of environmental services (DES) validated the policy was accurate and correct. The DES stated housekeeping was responsible for daily cleaning and inspection of the mechanical lifts.	F 253	Housekeeping Supervisor will conduct weekly audits cleaning compliance and report findings to the administrator weekly. Administrator is responsible for oversight.	The Plan of Correction will be completed by November 5th, 2013.
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE 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 administer medications to 2 of 9 residents (R265, R144) without errors. This resulted in a 7% error rate, based on 26 observed medication opportunities. Findings include: The facility failed to flush the intravenous (within the vein) line (IV line) with normal saline prior to administration of an antibiotic, as ordered by the physician for R265. The physicians orders dated 9/17/13, indicated the resident was ordered Piperacillin Sodium-Tazobactam Sodium 3-0.375 grams (an antibiotic) twice daily through the IV piggyback (administering the medication by attaching it to an established IV line) into the PICC line (a peripherally inserted central catheter) every 8 hours. The order directed the staff to flush the IV line with 10 ml (milliliters) of Normal Saline (NS) before and after the medication.	F 332	It is the policy of this facility to follow safe medication practices to ensure that residents are free of medication errors. **Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;** On 9/24/13, the facility Nurse Manager reviewed and re-educated LPN-A on procedures for IV medication. LPN-A was able to verbally explain and physically demonstrate the correct procedure, including all required flushes of an IV.	

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	245352	A. BUILDING _____ B. WING _____	09/26/2013

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F 332	Continued From page 3 On 9/24/13, at 8:15 a.m. licensed practical nurse (LPN)-A was observed administering an antibiotic to R265. The IV antibiotic was piggybacked into the (PICC) line. LPN-A cleansed the site and connected the tubing and bottle which contained the antibiotic. LPN-A failed to administer the NS prior to the antibiotic. When asked, immediately after connecting the antibiotic, LPN-A agreed had missed that step. LPN-A stopped the antibiotic, unhooked the IV, cleansed the port site, and flushed the port with the 10 ml of NS. LPN-A then reattached the antibiotic line to the PICC line. At 9:42 a.m. on 9/24/13, after the antibiotic had infused, LPN-A flushed the PICC line with 10 ml's of NS. The facility failed to ensure correct measurement of an as needed dose of narcotic pain relief medication for R144. Physician orders dated 9/11/13, indicated R144 had a diagnose of end stage chronic obstructive pulmonary disease (COPD) and received hospice services. The physician orders also indicated R144 had orders for Morphine Sulfate (concentrate) 20 mg/ml solution sublingually, 5 mg (0.25 ml) every 3 hours as needed (PRN), in addition to the MS Contin (Morphine Sulfate) 60 mg tablets every 8 hours. On 9/25/13, at 1:45 p.m. LPN-B was preparing to administer MS concentrate 0.25 ml to R144. LPN-B took the liquid medication to the room along with a syringe to administer the liquid medication sublingually (administered under the tongue). The syringe had markings from 0.10 ml up to 1.0 ml. LPN-B withdrew the medication up to the 0.5 ml mark on the syringe. Before the	F 332	On 9/25/13, LPN-B was removed from passing medications until retraining could occur. On 9/27/13, LPN-B received retraining from the Pharmacy Nurse Consultant, including a Medication Pass Observation. LPN-B performed return skills demonstration on converting dosages, measuring medication, and accurately drawing up medication for injection. LPN-B followed all medication pass guidelines. The calculated error rate was 0%. **Address how the facility will identify other residents having the potential to be affected by the same deficient practice;** All residents receiving medication have the potential to be affected. **Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;**	

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F 332	Continued From page 4 medication was administered LPN-B was asked to check the amount in the syringe against the order on the bottle. After checking the amount in the syringe against the instructions on the bottle LPN-B indicated was giving the correct amount. Without giving the medication, LPN-B left the room, and went to check the original physician order for the MS concentrate and confirmed the dosage with the nurse manager. After reviewing the medication order and looking at the syringe LPN-B acknowledged was about to give too much Morphine. LPN-B agreed R144 would have received a double dose of the PRN Morphine. Registered nurse (RN)-A was also present and agreed 0.5 ml would have been an incorrect dose of Morphine for R144. After verifying the correct dosage LPN-B went back to R144's room to draw up the medication and administer it. Before giving the medication the syringe was checked and the dosage was closer to 0.30 ml than to 0.25 ml. After LPN-B was made aware she put some of the narcotic back into the bottle and then gave the correct dose. On 9/25/13, at 2:30 p.m. the director of nursing (DON) was informed of LPN-B's errors in measuring narcotic pain relief medication for R144 and indicated LPN-B would not be administering medications until after being retrained on 9/27/13. The pharmacist was interviewed on 9/26/13, at 11:00 a.m. and indicated anytime a double dose of a medication was given it could be a problem. The pharmacist indicated R144 had been on MS for more than 6 months and was "probably used to it" and thus able to tolerate it. The pharmacist indicated the potential error needed to be assessed and followed up on. The pharmacist	F 332	Mandatory re-education by the facility Staff Development RN and the Pharmacy Consultant will be provided to facility licensed nurses and trained medication aides. This training and skill set review includes demonstration of accurate reading of labels and dispensing of correct medication dosage and strength; accurate recording in the narcotic book of medications; successful completion of a scenario based test requiring the nurse to determine/calculate dosing; ability to state the role of the TMA in the administration of controlled substances and their practice limitations; IV flushes and cap changes; and availability and location of resource material. **Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.**	

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F 332	Continued From page 5 further indicated giving a double dose of MS to anyone was always a risk.	F 332	Medication Pass Observations will continue to be done by the Pharmacy Consultant during routine visits. The Nurse Manager/Nursing Supervisor will perform random audits of IV medication administration and flushes for residents with IV's for 3 months. Results of Medication Pass Observations and IV audits will be reviewed at QA meetings to identify any issues or trends, and develop action plans as indicated. The Director of Nursing/Designee is responsible for ongoing compliance to F332.	The Plan of Correction will be completed by November 5th, 2013.
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		

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F 441	Continued From page 6 infection. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to store, process and transport resident personal laundry and facility linen to prevent the spread of infection which had the potential to affect 130 out of 163 residents in the facility who had personal clothing laundered at the facility. Findings include: Resident personal laundry and facility linen bins were not covered when stored or transported in the hallways to prevent the potential spread of infection. During random observations on 9/23/13, at 5:00 p.m.; 9/24/13, at 10:00 a.m.; and on 9/25/13, at 11:00 a.m. there were two six foot clothing racks full of resident personal clothing hanging in the hallway by numerous employee lockers. Contaminated dirty linen barrels/bins were being wheeled down the same hallway to the dirty linen room throughout the day and evening shift observations on 9/23/13, and 9/25/13. The clean personal laundry (resident clothing) was not covered as maintenance came by with tools, carts, and various equipment back/forth to the elevators and at times came into contact with the clean personal laundry by brushing up against it. The dirty linen bins were transported through the same area and were observed to come in contact with the clean personal laundry at various times. Furthermore, employees were going to their lockers a variety of different times and were	F 441	A policy has been developed for transportation and storage of clean personal linen. Return demonstration of proper handling, transferring and storage of personal and commercial linen will be mandated by each laundry staff personnel. A Mandatory housekeeping and laundry educational meeting has been scheduled to review the Clean Personal Clothing Policy. This meeting will be conducted by the Housekeeping Supervisor. Housekeeping Supervisor will conduct an audit for 4 consecutive weeks and then spot check for the following two months. Audits/Findings will be presented to the Administrator weekly. Information will be presented to the Quality Assurance meeting on January 21, 20114.	

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F 441	Continued From page 7 observed brushing up against the clean clothes hanging in the hallway on the clothing racks. There were two bins that were supposed to be used for clean facility linen, however, the entire bottom of these bins was observed to be filled with what looked like napkins, papers, wrappers, fabric softener sheets and tissues. When interviewed on 9/26/13, at 11:00 a.m. the acting director of environmental services (DES) stated the personal clothing rack for residents should not be stored in the hallway and, if it was, it must be covered and stored until delivered to the residents. The DES further indicated the two clean linen bins should not be stored in the hallway and it looked like they were being used for "trash disposal." According to the DES, there were no policies available for the storage and transportation of personal laundry for residents or for cleaning of the facility linen bins.	F 441	The Infection Control Nurse will be consulted as needed. Administrator is responsible for oversight.	The Plan of Correction will be completed by November 5th, 2013.
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide a clean, sanitary environment for 163 of 182 residents who currently resided at the facility, staff, and the public. All doorway/hallway entrances of the carpeted second floor had large	F 465	On September 28, 2013 the two identified kick plates on rooms 157 and 158 have been checked and fastened. Carpet cleaning on the second floor was cleaned by October 9, 2013. Carpet cleaning has been placed on the Preventative Maintenance Program to be completed	

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F 465	Continued From page 8 soiled areas. In addition, door kick plates were loose in 2 rooms (157, and 158), and the first floor "Vadnais" porch dining room furniture, 3 of 3 chairs were stained and 2 of 3 tables, legs were in disrepair. Findings include: Random observations of the second floor on 9/23/13, at 11:30 a.m. and 9/24/13, at 3:00 p.m. revealed a three to five foot area of visible black grime ingrained in the carpet at the entrance of all doorways in the hallway. Rooms 157 and 158's door kick plates were coming loose. Random observations in the first floor "Vadnais" porch dining room had three of three dining room chairs stained/soiled with white/brown spots. Two of the three dining room tables, legs were scratched/gouged with the paint worn away, creating an uncleanable surface. An environmental tour of the facility was completed on 9/25/13, at 10:00 a.m. with the administrator and the acting director of environmental services (DES) who validated the above mentioned findings. An interview with the administrator and the acting DES on 9/25/13, at 11:00 a.m., confirmed the carpet areas were dirty and verified there was no carpet cleaning program for the past year at the facility. The administrator and the acting DES verified the door kick plates for room 157, and 158 were loose and could be a potential safety issue. The administrator and the acting DES also verified the "Vadnais" dining room chairs would need cleaning and the table legs painted. The administrator and the acting DES stated there was not a repair request submitted for any repairs	F 465	monthly. Spot cleaning of the carpet will be completed by housekeeping as needed. Vadnais porch dining chairs were cleaned by October 15, 2013. Identified Vadnais/first floor dining tables will be sanded and painted. A facility audit facilitated by Infection Control Nurse and Administrator will be completed to identify areas of potential infection control safety and cleanliness concerns such as, but not limited to: kick plates, doors, furniture, carpeting, dining room tables. All areas of concern will be completed on a timely basis. All findings will be reported to the Quality Assurance meeting on 1/14/14.	

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F 465	Continued From page 9 related to the dining room furniture or the door kick plates. When asked for policy/procedures/documents pertaining to the previously mentioned environmental concerns the administrator and the acting DES confirmed there were none.	F 465	An Environmental Services Preventative Plan will be finalized, including instructions for conducting periodic audits. The Environmental Services Preventative Plan audit tool will identify needs in Maintenance, Housekeeping and Laundry. This ongoing work will target safe functional and sanitary and comfortable environment. Administrator is responsible for oversight.	The Plan of Correction will be completed by November 5th, 2013.

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

F5352021

PRINTED: 10/29/2013
FORM APPROVED
OMB NO. 0938-0391

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 _____	**09/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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. 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	POC ok FS 11-21-13 This Plan of Correction constitutes our allegation of compliance for the deficiencies cited. Preparation and/or execution of this plan of correction does not constitute admission to nor agreement with either the existence of, or scope and severity of any of the cited deficiencies, or conclusions set forth in the statement of deficiencies. This plan of correction is prepared and executed to ensure continuing compliance with Federal and State regulatory law.	

DC: 11-5-13
EXIT: 9-26-13

RECEIVED
NOV 20 2013
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	11/20/13

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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RAMSEY COUNTY CARE CENTER	**2000 WHITE BEAR AVENUE** **MAPLEWOOD, MN 55109**

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K 000	Continued From page 1 Barbara.Lundberg@state.mn.us and Marian.Whitney@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 Nursing Home 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 178 beds and had a census of 161 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 017 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In sprinklered buildings, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls properly extend above the ceiling. (Corridor walls may terminate	K 017	This deficiency was corrected on October 9, 2013	

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	245352	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/24/2013**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 017	Continued From page 2 at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to the corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2.1, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observations, the facility has failed to provide the proper corridor separation from use areas. This deficient practice could affect the exiting of all residents, staff and visitors within the smoke compartment. NFPA 101 section 19.3.6.1, 19.3.6.2.1, 19.3.6.5 Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/24/2013, it was observed that the Canteen Corner is an area open to the corridor and is not covered by automatic smoke detection. This does not meet the exceptions to NFPA 101, 2000 Ed., Section 19.3.6.1. This deficient practice was verified facility Engineer (KL).	K 017		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as	K 018	This deficiency was corrected on October 1, 2013	

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K 018	Continued From page 3 those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation the facility did not have corridor doors that meet the requirements of NFPA 101 LSC (00) Section 19.3.6.3.2. This deficient practice could affect the safety of the residents within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/24/2013, it was observed that it was observed that the corridor door to Nursing Supplies Room 148-U, did not latch when tested. This deficient practice was verified facility Engineer (KL).	K 018		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour	K 029	This deficiency was corrected on October 4, 2013	

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K 029	Continued From page 4 fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 This deficient practice could affect staff within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/24/2013, it was observed that the door to the corridor of Soiled Utility Room 138-U and 222-U, did not automatically close and latch when tested. This deficient practice was verified facility Engineer (KL).	K 029		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is	K 050	This deficiency was corrected on November 5, 2013	

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K 050	Continued From page 5 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports and records, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/24/2013, based on review of available documentation it was reveled that fire drills were not varied throughout the shift during the evening shift. 3 of 4 drills were conducted between 3:50 PM and 5:00 PM and the fourth drill was conducted at 6:44 PM. This deficient practice was verified facility Engineer (KL).	K 050		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Electrical installations are not in accordance with NFPA 70 "The National Electrical Code 1999 edition. section 9.1.2. This deficiency could	K 147	This deficiency was corrected on October 7, 2013	

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K 147	Continued From page 6 negatively effect the patients, staff and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 09/24/2013, it was observed that Room 155 had electrical extension cords piggy backed together. This deficient practice was verified facility Engineer (KL).	K 147	All deficiencies will be monitored for compliance by the Administrator and the Director of Environmental Services.	