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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IDRO

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 **11/21/2017** (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:

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
	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 :
Michelle Torrance, HFE NE II 06/21/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist 06/21/2018 (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 11/09/2017 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/09/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245352 December 4, 2017

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 November 21, 2017 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
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
November 21, 2017

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

RE: Project Number S5352026 and F5352025

Dear Mr. Robinson:

On October 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 14, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

However, compliance with the health and Life Safety Code (LSC) deficiencies issued pursuant to the September 14, 2017 standard survey has not yet been verified. The most serious deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective December 14, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective December 14, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 14, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Ramsey County Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation

Programs for two years effective December 14, 2017. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program

Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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

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 14, 2018 (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 electronic 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
Minnesota Department of Health
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered December 4, 2017

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

RE: Project Number S5352026

Dear Mr. Robinson:

On October 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 14, 2017. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On November 21, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on November 22, 2017 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 September 14, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 17, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 14, 2017, effective November 21, 2017 and therefore remedies outlined in our letter to you dated October 20, 2017, 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
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: IDRO

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 **09/14/2017** (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:

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
	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 :
Momodou Fatty, HFE NE II — 11/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 11/09/2017 (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
11/09/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 20, 2017

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

RE: Project Number S5352026

Dear Mr. Robinson:

On September 14, 2017, 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 widespread pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (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 October 24, 2017, 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 December 14, 2017 (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 14, 2018 (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
Minnesota Department of Health
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 _____	09/14/2017

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 On September 11, 12, 13, and 14, 2017, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. 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.	F 000		
F 172 SS=D	483.10(f)(4)(i)-(vi) RIGHT TO/FACILITY PROVISION OF VISITOR ACCESS (f)(4) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident. (i) The facility must provide immediate access to any resident by: (A) Any representative of the Secretary, (B) Any representative of the State, (C) Any representative of the Office of the State	F 172		11/17/17

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

Electronically Signed | 10/30/2017

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 _____	09/14/2017

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F 172	Continued From page 1 long term care ombudsman, (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq.), (D) The resident's individual physician, (E) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq), (F) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. 10801 et seq.), and (G) The resident representative. (ii) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time; (iii) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time; (iv) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time; and	F 172		

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F 172	Continued From page 2 (v) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation. (vi) A facility must meet the following requirements: (A) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section. (B) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time. (C) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability. (D) Ensure that all visitors enjoy full and equal	F 172		

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F 172	Continued From page 3 visitation privileges consistent with resident preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to advocate, communicate and discuss potential visitation rights, for 1 of 1 resident in the sample (R238) who was restricted from having visitors. Findings include: On 9/11/17 at 4:15 p.m. and at 7:03 p.m., and during subsequent days of the survey on 9/12/17, 9/13/17 and 9/14/17, R238's door was observed to have a sign posted, "STAFF ONLY NO VISITORS PERMITTED". R238's medical record was reviewed on 9/11/17, which indicated R238 had moderate cognitive impairment. R238's admission Minimum Data Set (MDS) dated 8/29/17, identified R238 as able to make self understood, ability to understand others. R238's admission/clinical record was reviewed and indicated R238 had been admitted to the facility 8/23/17, with diagnoses which included: insomnia, anemia, displaced pilon fracture of right tibia, displaced bimalleolar fracture of left lower leg. R238's care assessment area dated 9/5/17 indicated: "Triggered mood, psychosocial, and activity care areas as evidence by patient scoring 19/27 on PHQ-9 (Patient Health Questionnaire-9) indicating moderate-severe depression. No HX (history) of depression was noted in medical record. A referral was subsequently made to the	F 172	This 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 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: Ramsey County Care Center informed R238 of his right to have visitors on 8/28/17 (and on 8/10/17 for his first admission) which he signed for, and was given a copy of the Combined Federal and State Resident Bill of Rights. Ramsey County Care Center informs all new residents of their right to visitors and periodically updates residents on this right and others under the Resident Bill of Rights. On September 14, 2017, the sign on his door was changed from "No visitors allowed" to "visitors please stop at desk before entering." On 10/30/17 all signs have been removed from his room door	

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F 172	Continued From page 4 house psychologist to review mood further... When meeting with psychologist, patient acknowledged feeling more confined due to limitations and restrictions vs. feelings of depression..." The care plan dated 7/26/17 identified: "BEHAVIOR: Altered Behavior r/t (related to) recent environment chane [change]. Allow resident to make decisions about treatment regime to provide a sense of control. Give as many choices as possible about care and activities..." In addition the care plan dated 7/30/17, identified R238 had alteration in ADLs (activities of daily living) and directed staff, "COMMUNICATION: Strength in communication r/t (related to) speech clear, cognitively intact, hears adequately, able to communicate needs". On 9/14/17 at 11:33 a.m., nursing assistant (NA)-A was interviewed and acknowledged the sign on R238's door, "STAFF ONLY NO VISITORS PERMITTED", and explained that if asked about it, staff were directed to refer persons to the charge nurse. On 9/14/17 at 11:42 a.m., social worker (SW)-A confirmed the sign posted on the door and explained that due to a current situation, R238 was restricted from having visitors while in the facility. On 9/14/17 at 11:55 a.m., registered nurse (RN)-A verified the sign posted on the door and explained not wanting volunteers, residents or visitors to go into R238's room mistakenly. RN-A stated, the director of resident services/social services (DRS) had reviewed Patient Rights with R238 on admission.	F 172	and the risks and benefits of having visitors was discussed with R238. Staff have been educated that no signage will be posted on the door. The Resident Services Director will monitor this individuals situation to ensure his advocacy and his rights are being upheld. This will be reviewed at the November 21st, 2017 Quality Assurance Committee meeting.	

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F 172	Continued From page 5 On 9/14/17 at 3:38 p.m., the DRS was interviewed and stated the sign on R238's door was posted by a non-employee of the facility. During an interview with R238 on 9/14/17 at 12:52 p.m., R238 was asked if aware of the sign on the door that read, "STAFF ONLY NO VISITORS PERMITTED", R238 replied, "Yes". When asked if it was R238's choice to not have visitors R238 replied, "No, it is not my choice", and explained that no visitors had been allowed while being in the hospital and that this was carried over to the nursing facility. During interview on 9/14/17 at 3:08 p.m., the director of nursing (DON) and administrator acknowledged the sign on R238's door and stated that a non-employee from another entity had advised the facility to post the sign restricting visitors. The DON and administrator made reference to a, Centers for Medicare and Medicaid Services (CMS) Survey and Certification (S&C) Group memo, S&C 16-21, revised 12/23/16, which gives direction related to providing services to justice involved individuals. The administrator acknowledged an awareness of the facility's responsibility related to visitation rights when another entity is involved however, stated that in this situation agreed with the outside entity, versus having included R238 in the conversation to discuss risks/benefits of visitation rights, or to identify visitors that would potentially be appropriate, approved and authorized to visit.	F 172		
F 241 SS=D	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each	F 241		11/17/17

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F 241	Continued From page 6 resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide a dignified care experience for 1 of 1 (R20) residents reviewed for dignity during cares. Findings include: R20's minimum data set (MDS), dated 6/22/17, revealed R20 had moderate cognitive impairment and no behaviors such as disrobing in public and was extensively or totally dependent on staff for activities of daily living such as personal hygiene, transfers, toilet use and bed mobility. R20 was observed on 9/14/17 at 9:22 a.m., to be in bed, in room, with breasts and genital area uncovered. There was no curtain around R20 and nursing assistant (NA)-B was in R20's bathroom. Upon exiting the bathroom, NA-B straightened out R20's leg bag and tugged on the wrap around R20's abdomen to straighten it out. NA-B did not explain cares to R20. NA-B then went back to the bathroom to fill a basin with soap and water. NA-B did not attempt to provide cover for R20's breasts or genital area. NA-B then proceeded cares without or with little explanation. NA-B turned R20 slightly to the side and used a wipe to clean and dry between R20's legs. R20 cringed and NA-B said "relax your legs." NA-B pulled on R20's incontinence pad underneath R20 and turned R20 to the side and wiped R20's bottom. The smell of feces was noticeable in room. NA-B	F 241	R20 is in a private room that was previously a double room equipped with two separate ceiling tracks for privacy curtains. The privacy curtain was on the track for bed-1 and resident R20s bed is in the bed-2 position. The Privacy Curtain was moved to be suspended from the ceiling track that encircles the R20□s bed. All private resident rooms throughout the facility were reviewed to ensure appropriate placement of privacy curtains. This document was read to and reviewed in detail with NA-B. NA-B was reeducated on privacy, dignity, communication, customer service and handwashing at time of occurrence and upon review of this document. A bedside audit has been completed with NA-B and will be repeated as necessary until satisfactory performance is observed. All NAR(s) annual bedside audits will be repeated until satisfactory performance is observed. Vadnais Station NAR(s) will be re-educated on dignified care experience, privacy, communication, customer service, and indications for handwashing by November 17th 2017. NAR(s) will complete a competency quiz focused on	

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F 241	Continued From page 7 then removed and changed gloves and gathered supplies in room and bathroom. R20's genitals and breasts remained uncovered. NA-B returned to R20. R20 looked at NA-B with squinted eyes. NA-B then rolled R20 to the side and wiped R20's bottom. NA-B said "are you going? I think you're going?" No other explanations or conversation made with R20. NA-B then removed and changed gloves and gathered and tied garbage. R20 remained with her genitals and breasts uncovered. NA-B then rolled R20 to the side and put a soaker pad under R20 and rolled R20 to the other side to gather a cloth and a night shirt, without explanation or conversation with R20. NA-B said "ok scoot one more time" and rolled R20 to side to put soaker pad under R20. R20 remained looking at NA-B with squinted eyes and grunted. R20 remained with uncovered breast and genital area. NA-B then dressed R20 in a pair of socks over the pair of socks R20 was wearing. NA-B dressed R20 in a long shirt and pair of pants. R20 lifted up and looked under her shirt, although breasts were not exposed, except to R20. NA-B looked at surveyor and said "she takes the clothes off." NA-B then rolled R20 to one side and the other and placed and straightened a soaker pad under R20's clothes, without any explanation to R20. R20 grunted. NA-B then removed gloves and picked up the call light from the floor to put on R20's bed and raised the head of the bed and lowered it, without explanation or conversation with R20. NA-B looked at the sling in the room and reported it was the small one. NA-B looked at surveyor and said "I am going to come back. That's a small sling." NA-B did not say anything to R20. NA-B then looked in R20's drawers and closet and left room. On 9/14/17 at 9:42 a.m., NA-B re-entered room and closed door. NA-B did not say anything	F 241	indications for hand washing. Vadnais Licensed Nurses will observe Vadnais NAR(s) during cares with non-verbal, selectively verbal or have highly impaired communication 3x weekly for 4 weeks. Observation results will be reviewed by Quality Assurance Committee to determine frequency moving forward. During observation, licensed nurses will be auditing for dignified care experience; privacy; staff communicating and explanation of tasks; attempted conversation during cares; customer service and appropriate situational handwashing. Observing license nurses will be using a standardized form specific to areas listed. Staff exhibiting substandard performance will be referred to the nurse educator for re-education and subsequent re-evaluation until performance expectations are met. Nurse managers reviewed the communication section of the care plans for all residents who are non-verbal, selectively verbal or have highly impaired communication, and revised if necessary. IDT reviewed the Hygiene, AM and HS cares policy that was provided to the surveyors and no changes were indicated. Responsible Person: Nurse Managers and Nurse Educator.	

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F 241	Continued From page 8	F 241		

to R20 and raised R20's bed and lowered the head of the bed. NA-B called for assistance and transferred R20 to the chair, with assistance from the floor nurse (LPN)-B. LPN-B provided explanations and conversation to R20 during transfer. LPN-B left room. NA-B then combed and fastened R20's hair. NA-B looked at surveyor and reported she was looking for something to hold R20's neck. NA-B straightened R20's feet on foot pedals and said "ok, let's go out" R20 was frowning with lips pursed out. NA-B left room to wipe lift out and tidied the room. NA-B did not say anything to R20. NA-B rolled R20 to the dining room and quickly said "goodbye" without first checking if anything else was needed or offering an explanation of what was happening next.

On 9/14/17 at 10:08 a.m., NA-B reported sometimes forgeting to talk with R20 as R20 did not respond to NA-B. NA-B reported R20 would look at people when they talked to her and she should talk with R20. NA-B reported she left R20 uncovered because she was working with R20.

On 9/14/17 at 10:42 a.m., the nurse manager (RN)-B reported NA-B regularly worked with R20 during the day shift. RN-B reported R20 generally did not talk but would talk to select people and in select situation. RN-B reported she expected staff to explain cares and talk with R20 during cares, whether or not R20 responded. RN-B explained staff should cover R20, or at least attempt to cover, R20's breasts and genitals when they were not working with them for cares.

The Hygiene, AM and HS cares policy and procedure, dated 5/31/16, directed staff. "Begin by introducing yourself to the resident and explaining what you will be doing for them. Close

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F 241	Continued From page 9 doors and curtains. Wash your hands and apply gloves. Expose only the body areas necessary for the cares being provided." R20's care plan, last revised 7/6/17, directed staff "Resident chooses who to speak with, resident has not lost ability to hear or verbally communicate." The care plan further directed staff "Speak to resident clearly and directly. Observe for non-verbal indicators-body language, facial expressions." and "Give clear explanation of all care activities prior to and as they occur."	F 241		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		11/17/17

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F 279	Continued From page 10 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop the care plan to include monitoring for bleeding and bruising for	F 279	All resident records were reviewed that may be affected by the same practice.	

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F 279	Continued From page 11 1 of 5 (R43) residents reviewed for unnecessary drugs, who was on a blood thinning medication. Findings include: During observation on 9/11/17, at 7:10 p.m. bruises speckled the outside of both of R43's forearms. During an interview on 9/13/17, at 1:08 p.m. R43 confirmed taking a blood thinning medication, and said the forearm bruising was from bumping into things. Review of R43's medication orders revealed an order for Coumadin (an anticoagulant, or blood thinning medication) for the diagnosis of chronic atrial fibrillation (when the heart beats at irregular and often accelerated rates). R43's Care Area Assessment Worksheet, dated 9/12/17, noted R43 to be on daily Coumadin. The assessment listed other skin concerns that were unrelated to Coumadin use, but required staff to perform skin inspections and observe for changes. Review of the care plan on the morning of 9/14/17, revealed there was no direction for staff to monitor R43 for bruising or bleeding related to Coumadin use. During an interview on 9/14/17, at 2:47 p.m. registered nurse (RN)-A said R43 was on Coumadin, and that part of monitoring Coumadin use, was to watch for resident bruising. RN-A explained that staff were supposed to document all bruising when it happens, document if they know how it happened, and monitor until it gets	F 279	An Anticoagulant use section has been developed in the electronic medical record care plan library. The interventions include routine daily monitoring for discolorations and bleeding. This intervention will appear on the residents Kardex. The electronic medical record has also been updated to include a nursing order, alerting the nurse every shift to observe for discolorations/bleeding related to anticoagulant therapy. This order appears on the treatment administration record. Nurse managers initiated these care plan and order items for all residents receiving anticoagulant therapy. Anticoagulation Therapy Monitoring, CoagChek XS Monitor Policy and Procedure was updated to reflect these practices. The care plan will be reviewed and revised per the facility RAI Care Plan Policy. The care plan library Anticoagulation Use items will be reviewed at the Quality Assurance Committee meeting and revised as determined necessary. The nurse managers will be responsible for continued compliance per RAI Care Plan Policy.	

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F 279	Continued From page 12 better. When asked whether skin monitoring due to Coumadin use should be in the care plan, RN-A said yes, and that she usually writes something in the skin portion of the care plan about monitoring related to anticoagulants. Upon review of R43's care plan, RN-A confirmed it did not include language about monitoring the skin related to R43's Coumadin use, and immediately began updating the care plan.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) 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 follow the care plan for 1 of 1 (R20) resident reviewed for communication. Findings include: R20's minimum data set (MDS), dated 6/22/17, revealed R20 had moderate cognitive impairment and was extensively or totally dependent on staff for activities of daily living such as personal hygiene, transfers, toilet use and bed mobility. R20's care plan, last revised 7/6/17, directed staff "Resident chooses who to speak with, resident has not lost ability to hear or verbally	F 282	It is the policy of Ramsey County Care Center to follow the plan of care. Staff are expected to communicate with the residents according to the plan of care and based on their level of cognition. NA-B was reeducated on communication and customer service at the time of occurrence and upon review of this document. A bedside audit has been completed with NA-B and will be repeated as necessary until satisfactory performance is observed. All NAR(s) annual bedside audits will be repeated until satisfactory performance is	11/17/17

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F 282	Continued From page 13 communicate." The care plan further directed staff "Speak to resident clearly and directly. Observe for non-verbal indicators-body language, facial expressions." and "Give clear explanation of all care activities prior to and as they occur." During observations, on 9/14/17 at 9:22 a.m., R20 was lying on the bed in R20's room and the nursing assistant (NA)-B was in R20's bathroom. Upon exiting the bathroom, NA-B straightened out R20's leg bag and tugged on the wrap around R20's abdomen to straighten it out. NA-B did not explain cares to R20. NA-B then went back to the bathroom to fill a basin with soap and water. NA-B then proceeded with cares and partially turned R20 to the side. NA-B used a wipe to clean and dry between R20's legs as R20 was partially on her back. R20 cringed. NA-B said "relax your legs." NA-B pulled the incontinence pad underneath R20, and turned R20 to the side and wiped R20's bottom. The smell of feces was noticeable in room. NA-B then removed and changed gloves and gathered supplies in room and bathroom. NA-B returned to R20. R20 looked at NA-B with squinted eyes. NA-B then rolled R20 to the side and wiped R20's bottom. NA-B said "are you going? I think you're going?" No other explanation or conversation was made with R20. NA-B then removed and changed gloves and gathered and tied garbage. NA-B rolled R20 to the side, put a soaker pad under R20 and rolled R20 to the other side to retrieve a cloth and a night shirt, without explanation or conversation with R20. NA-B said "ok scoot one more time" and rolled R20 to side to put soaker pad under R20. R20 remained looking at NA-B with squinted eyes and grunted. NA-B then dressed R20 in a pair of socks over the pair of socks R20 was wearing. NA-B dressed R20 in a long shirt and	F 282	observed. Vadnais Station NAR(s) will be re-educated on communication and customer service, by November 17th 2017. Vadnais Licensed Nurses will observe Vadnais NAR(s) during cares with non-verbal, selectively verbal or have highly impaired communication 3x weekly for 4 weeks. Observation results will be reviewed by Quality Assurance Committee to determine frequency moving forward. During observation, licensed nurses will be auditing for dignified care experience; privacy; staff communicating and explanation of tasks; attempted conversation during cares; customer service. Observing license nurses will be using a standardized form specific to areas listed. Staff exhibiting substandard performance will be referred to the nurse educator for re-education and subsequent re-evaluation until performance expectations are met. Nurse managers reviewed the communication section of the care plans for all residents who are non-verbal, selectively verbal and have highly impaired communication, and revised if necessary. IDT reviewed the Hygiene, AM and HS cares policy that was provided to the	

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F 282	Continued From page 14 pair of pants. NA-B then rolled R20 to one side and the other and placed and straightened a soaker pad under R20's clothes, without any explanation to R20. R20 grunted. NA-B then removed gloves and picked up the call light from the floor to put on R20's bed and raised the head of the bed and lowered it, without explanation or conversation with R20. NA-B looked at surveyor and said "I am going to come back". At 9:42 a.m., NA-B re-entered room and closed door. NA-B did not say anything to R20 and raised R20's bed and lowered the head of the bed. NA-B called for assistance and transferred R20 to the chair with assistance from the floor nurse (LPN)-B. Although LPN-B provided explanations and conversations during transfer, LPN-B left room and NA-B continuted with cares. NA-B combed and fastened R20's hair. NA-B straightened R20's feet on foot pedals and said, "ok, let's go out". R20 was frowning with lips pursed out. NA-B left room to wipe lift out and tidied the room. NA-B did not say anything to R20. NA-B rolled R20 to the dining room and quickly said "goodbye" without first checking if anything else was needed and/or offer an explanation of what was happening next. On 9/14/17 at 10:08 a.m., NA-B reported sometimes forgetting to talk with R20 as R20 did not respond to NA-B. NA-B reported R20 would look at people when they talked to her and NA-B should have talked with R20. On 9/14/17 at 10:42 a.m., the nurse manager (RN)-B reported NA-B regularly worked with R20 during the day shift. RN-B reported R20 generally did not talk but would talk to select people and in select situations. RN-B reported she expected staff to explain cares and talk with R20 during cares, whether or not R20 responded.	F 282	surveyors and no changes were indicated. Responsible Person: Nurse Managers and Nurse Educator.	

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F 282	Continued From page 15 The Hygiene: AM and HS cares policy and procedure, dated 5/31/16, directed staff. "Begin by introducing yourself to the resident and explaining what you will be doing for them."	F 282		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the	F 329		11/17/17

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F 329	Continued From page 16 clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to adequately monitor 1 of 5 (R43) residents reviewed for unnecessary drugs, when the resident was on a blood thinning medication and was not monitored for bruising. Findings include: During observation on 9/11/17, at 7:10 p.m. bruises speckled the outside of both of R43's forearms. During an interview on 9/13/17, at 1:08 p.m. R43 confirmed taking a blood thinning medication, and said the forearm bruising was from bumping into things. Review of R43's medication orders revealed an order for Coumadin (an anticoagulant, or blood thinning medication) for the diagnosis of chronic atrial fibrillation (when the heart beats at irregular and often accelerated rates). R43's Care Area Assessment Worksheet, dated 9/12/17, noted R43 to be on daily Coumadin. The assessment listed other skin concerns that were unrelated to Coumadin use, but required staff to perform skin inspections and observe for changes.	F 329	R43s Anticoagulation Monitoring record was reviewed for INR results as follows: 9/5/17 his INR was 1.5; 9/12/17 his INR was 1.7. The recommended INR for a patient with atrial fibrillation is 2.0 - 3.0. R43's MD was updated with current INR level on 9/12/17 and dose remained appropriate and unchanged. All resident records were reviewed that may be affected by the same practice. An Anticoagulant use section has been developed in the electronic medical record care plan library. The interventions include routine daily monitoring for discolorations and bleeding. This intervention will appear on the residents Kardex. The electronic medical record has also been updated to include a nursing order, alerting the nurse every shift to observe for discolorations/bleeding related to anticoagulant therapy. This order appears on the treatment administration record. Nurse managers initiated these care plan and order items for all residents receiving anticoagulant therapy. Anticoagulation Therapy Monitoring,	

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F 329	Continued From page 17 Review of the care plan on the morning of 9/14/17, revealed there was no direction for staff to monitor R43 for bruising or bleeding related to Coumadin use. At this same time, review of skin assessment documents, skin observation tasks, and progress notes in the electronic medical record failed to provide evidence that staff had noted the current bruising along R43's forearms, and were monitoring it. The skin observation task in R43's electronic medical record had different skin condition options for staff to document observing, including discoloration of skin. At the time of review on the morning of 9/14/17, staff had not documented in the skin observation task any observations of skin discoloration over the previous 14 days. During an interview on 9/14/17, at 9:23 a.m. nursing assistant (NA)-C said that staff try to pay attention to bruising on all residents. NA-C said that if staff noted bruising on a resident, they would tell the nurse right away. NA-C continued to explain that if the nurse had not already noted the bruising, then NA-C would document it on a form used to communicate skin concerns. During an interview on 9/14/17, at 9:32 a.m. licensed practical nurse (LPN)-B confirmed that it was important to look for bruising in residents taking blood thinners. During an interview on 9/14/17, at 2:47 p.m. registered nurse (RN)-A said R43 was on Coumadin, and that part of monitoring Coumadin use, was to watch for resident bruising. RN-A explained that staff were supposed to document all bruising when it happens, document if they know how it happened, and monitor until it gets better. RN-A thought staff could document	F 329	CoagChek XS Monitor Policy and Procedure was updated to reflect these practices. The care plan will be reviewed and revised per the facility RAI Care Plan Policy. The care plan library Anticoagulation Use items will be reviewed at the Quality Assurance Committee meeting and revised as determined necessary. The nurse managers will be responsible for continued compliance per RAI Care Plan Policy.	

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F 329	Continued From page 18 bruising in a progress note or on an incident report, and clarified that staff should document bruise color and size. When asked whether skin monitoring due to Coumadin use should be in the care plan, RN-A said yes, and that she usually writes something in the skin portion of the care plan about monitoring related to anticoagulants. Upon review of R43's care plan, RN-A confirmed it did not include language about monitoring the skin related to R43's Coumadin use, and immediately began updating the care plan.	F 329		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.	F 371		11/17/17

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F 371	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure ice and water dispensers were clean on 2 out of 3 unit kitchenettes. This had the potential to impact 102 of 143 residents residing at the facility. Findings include: On 9/14/17 at 11:05 a.m., an inspection of the unit kitchenettes was completed with the dietary manager (DM). The ice and water dispensers on Keller and Phalen were observed to have a heavy yellow and white buildup on the inside and outside of the spouts used to dispense the water and ice. DM confirmed findings and reported she was not sure when the ice and water dispensers were cleaned last. The Ice Chest and Machines policy and procedure, undated, directed staff "2. b. Thoroughly clean the machine and the parts. If buildup of a sediment is noted, follow routine maintenance procedures for removing lime, rust or other elements."	F 371	All ice and water dispensers were assessed. The facility coordinated a vendor to preform to descaling for all ice and water dispensers. This will be completed by November 3, 2017. The facility initiated a preventative maintenance program and contracted the vendor to descale all facility ice and water dispensers on a routine basis. The Ice Chest and Machines Policy and Procedure was updated to reflect this practice. Responsible Person: Housekeeping and Laundry services manager.	
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff,	F 441		11/17/17

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F 441	Continued From page 20 volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which 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; and	F 441		

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F 441	Continued From page 21 (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate hand hygiene during cares for 1 of 2 (R20) residents reviewed for infection control, during morning cares. Findings include: On 9/14/17 at 9:22 a.m., NA-B was observed wiping feces off R20's bottom. NA-B then removed the gloves. One glove fell on the floor and NA-B picked it off floor and tossed in the garbage. NA-A tied the garbage bag full of wipes, put it on the floor and grabbed new gloves from the bathroom. NA-B then dressed R20 in a clean shirt, socks and pants. NA-B removed gloves from hands. NA-B picked up the call light from the floor and used the remote to raise the head of the bed and lower the bed. NA-B opened closet and dresser drawers and then left the room with garbage. NA-B was not observed to wash or sanitize hands after removing gloves used to	F 441	The facility infection prevention and control program includes a hand hygiene policy. The current policy was reviewed and no changes are required. NA-B has been reeducated at the time of occurrence and upon review of this document on hand hygiene best practice and facility policy regarding hand hygiene. NA-B will complete a hand washing competency and quiz. A bedside audit has been completed with NA-B and will be repeated as necessary until satisfactory performance is observed. All NAR(s) annual bedside audits will be repeated until satisfactory performance is observed. Vadnais Station NAR(s) will be re-educated on indications for handwashing by November 17th 2017.	

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F 441	Continued From page 22 clean feces off R20's bottom. During interview, 09/14/17 at 10:08 a.m., NA-B reported she did not recall washing or sanitizing hands, but did change gloves after cleaning feces off R20's bottom. On 9/14/17 at 10:42 a.m., the nurse manager (RN)-B explained staff should wash or sanitize hands after removing gloves used to clean feces. The Hand Hygiene, Hand Washing, Hand Rubs policy and procedure, dated 11/15/16, directed staff "Gloves and Hand Hygiene Gloves reduce the hand contamination by 70-80 percent, prevent cross contamination and protect patients and health care personnel from infection. However, the use of gloves does not eliminate the need for hand hygiene. 1. Wear gloves when contact with blood or other potentially infectious materials (other body fluids, secretions and excretions), mucous membranes, non-intact skin and contaminated items will or could occur. 2. Change gloves during patient care if moving from a contaminated body site to a clean body site. 3. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces, and before caring for another patient. 4. After removing gloves, decontaminate hands by washing or using hand rub as indicated. 5. Dispose of gloves before exiting the room. 6. Perform hand hygiene before exiting the room."	F 441	NAR(s) will complete a competency quiz focused on indications for hand washing. Vadnais Licensed Nurses will observe Vadnais NAR(s) during cares with non-verbal, selectively verbal or have highly impaired communication 3x weekly for 4 weeks. Observation results will be reviewed by Quality Assurance Committee to determine frequency moving forward. During observation, licensed nurses will be auditing for appropriate situational hand washing among other identified concerns. Observing license nurses will be using a standardized form specific to areas listed. Staff exhibiting substandard performance will be referred to the nurse educator for re-education and subsequent re-evaluation until performance expectations are met. Nurse managers reviewed the communication section of the care plans for all resident who are non-verbal, selectively verbal and highly impaired communication, and revised if necessary. IDT reviewed the Hygiene, AM and HS cares policy that was provided to the surveyors and no changes were indicated. Responsible Person: Nurse Managers and Nurse Educator.	

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	245352	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**09/20/2017**

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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. An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on September 20, 2017. At the time of this survey, Ramsey County Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/01/2017

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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K 000	Continued From page 1 St. Paul, MN 55101-5145, OR By email to: 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 that was constructed in 1979 and was determined to be of Type II(222) construction. The building is fully protected throughout by an automatic fire sprinkler system and 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 140 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 712 SS=C	NFPA 101 Fire Drills Fire Drills	K 712		11/17/17

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K 712	Continued From page 2 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. 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 assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that a transmission of the fire alarm signal was sent as required by 2012 NFPA 101, Section 19.7.1.4. through 19.7.1.7. This deficient practice could affect all 140 residents. Findings include: On a facility tour between the hours of 1000 and 1500 on September 20, 2017, documentation review revealed that the third shift fire drill reports were missing the exact date and time that the drills were conducted. This deficient practice was verified by a Chief Engineer at the time of discovery.	K 712	This 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 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 fire drill policy and procedure has been reviewed and updated to reflect the new fire drill report form. A new fire drill report form will be utilized by all shifts when conducting a fire drill. Licensed nurse supervisors will be reeducated on the process for conducting fire drills and	

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K 712	Continued From page 3	K 712	utilization of the new form. Following fire drills the form will be reviewed at the Quality Assurance committee for compliance. Responsible Person: Housekeeping and Laundry Services Manager, General Repair Worker and Licensed Night Shift Supervisor	
K 923 SS=F	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES)	K 923		11/17/17

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K 923	Continued From page 4 STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, that facility did not properly store oxygen cylinders in accordance with NFPA 99. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5. These deficient practices could affect all 140 residents. Findings include: 1. On a facility tour between the hours of 1000 and 1500 on September 20, 2017, observation revealed that there was combustible material stored within five feet of oxygen cylinders in the oxygen storage rooms. 2. On a facility tour between the hours of 1000 and 1500 on September 20, 2017, observation revealed that was no separation between full and empty cylinders in oxygen storage rooms. These deficient practices was verified by the Chief Engineer at the time of discovery.	K 923	The policy for storage of oxygen has been updated to include the separation of combustible materials from oxygen cylinders in the oxygen storage rooms. The policy will also reflect separation of full cylinders and empty cylinders. Signage will include required verbiage and letter size. Storage is organized so that placement for new cylinders are clearly defined and separate from empty cylinders. All flammable materials are removed from O2 storage rooms. Nursing staff will be educated on policy changes. O2 storage rooms audits will be performed 3x for 4 weeks. Findings will be reported to Quality Assurance Committee who will determine the frequency of audits and compliance. Responsible Person: Housekeeping and Laundry Services Manager and General Repair Worker	