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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: LNXQ
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 **11/04/2014** (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

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

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

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 11/04/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/04/2014 (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
10/22/2014
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5352

Electronically Delivered: November 4, 2014

Mr. Steve Fritzke, Administrator
Ramsey County Care Center
2000 White Bear Avenue
Maplewood, Minnesota 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 October 31, 2014 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 questionsabout this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 4, 2014

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

RE: Project Number S5352023

Dear Mr. Fritzke:

On September 30, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on September 18, 2014. 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 4, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on September 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 31, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on September 18, 2014, effective October 31, 2014 and therefore remedies outlined in our letter to you dated September 30, 2014, 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 about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245352	A. Building B. Wing	11/4/2014

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: ID Prefix	Reg. #	LSC	(Y5) Date Correction Completed
F0241	483.15(a)		10/28/2014
F0279	483.20(d), 483.20(k)(1)		10/28/2014
F0280	483.20(d)(3), 483.10(k)(2)		10/28/2014
F0282	483.20(k)(3)(ii)		10/28/2014
F0309	483.25		10/28/2014
F0314	483.25(c)		10/28/2014
F0315	483.25(d)		10/28/2014
F0318	483.25(e)(2)		10/28/2014
F0323	483.25(h)		10/28/2014
F0325	483.25(i)		10/28/2014
F0356	483.30(e)		10/01/2014
F0371	483.35(i)		10/31/2014
F0441	483.65		10/28/2014
F0466	483.70(h)(1)		10/28/2014

	Reviewed By	Date:	Signature of Surveyor:	Date:
Reviewed By State Agency	SR/AK	11/04/2014	16022	11/04/2014
Reviewed By CMS RO				

Followup to Survey Completed on: 9/18/2014

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

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Facility ID: 00846

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

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(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 **09/18/2014** (L34)

8. ACCREDITATION STATUS: ___ (L10)
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2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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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**

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From (a) :
To (b) :

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10.THE FACILITY IS CERTIFIED AS:

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

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

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
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14. LTC CERTIFIED BED BREAKDOWN

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

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 10/13/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 10/15/2014 (L20)

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

19. DETERMINATION OF ELIGIBILITY
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3. Both of the Above :

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 30, 2014

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

RE: Project Number S5352023

Dear Mr. Fritzke:

On September 18, 2014, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

> **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

<u>Informal Dispute Resolution</u> - 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 55164-0900

Email: susanne.reuss@state.mn.us
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 October 28, 2014, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by October 28, 2014 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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.

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 18, 2014 (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 18, 2015 (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 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.

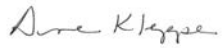
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions about this electronic notice.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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 ______	09/18/2014

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to communicate while providing care and services for 1 of 3 residents (R60) observed dependent on others for activities of daily living, in a manner that promoted dignity and respect. Findings include: R60 did not receive an ongoing explanation of cares throughout the care process while cares were being performed by staff on 9/15/14, at 6:30 p.m.	F 241	1. Individual NA/R re-educated utilizing CMS hand and hand video. Bedside audit completed by 10/8/14. 2. Nursing assistant bedside evaluation tool revised to include narrative section on communication and dignity. 3. Nursing staff re-educated utilizing CMS hand in hand video. 4. Bedside audits completed a minimum of annually by Staff Educator/Nurse	10/28/14

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

Electronically Signed — 10/10/2014

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 ______	09/18/2014

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 241	Continued From page 1 During observation on 9/15/14, at 6:30 p.m. R60 was sitting in a large semi reclining chair on wheels, the staff referred to as a cloud chair. Without informing R60 that he was going to get her ready for bed, nursing assistant (NA)-A began to remove the blouse top R60 was wearing when R60 clenched down very tightly with fists gripped tight and arms folded across her chest. R60 had facial grimacing and mouth clenched tightly but was unable to verbally communicate. NA-A was pulling on R60' hands and arms, tugging to take off the shirt and again tugging to put on a resident gown. There was no communication from NA-A as to what he was doing or encouraging the resident to relax. NA-A washed R60's face without talking. He pulled out the straps for the mechanical lift that R60 was sitting on and the straps from around R60's shoulders. NA-A then stood and waited for help without talking with the resident . NA-A called on his walky-talkie for assistance twice. After six minutes NA-B came to assist with the mechanical lift transfer to bed. The NA-A attached the mechanical sling and proceeded to lift R60 out of the chair without informing R60 when the mechanics of the mechanical lift were taking place in raising her out of the chair and again in lowering the lift onto the bed. The nursing assistant failed to inform the resident of each step in the process to alleviate anxiety with cares. Once R60 was in bed and the mechanical lift sling removed, NA-B left the room and NA-A continued with cares. NA-A pulled up R60's gown and proceeded to remove the tabs on her brief, then pushed the saturated brief between R60's legs, took the cold wet wipes and began perineal cleansing the front of R60. NA-A rolled R60 to her right side to finish pulling the	F 241	managers. Monitored for compliance by Assistant Director of Nursing, Nurse Educator, Nurse Manager.	

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F 241	Continued From page 2 brief between her legs, and again completed perineal cleansing with the cold wipes and not informing R60 of each step in the process of care delivery. With no conversation NA-A adjusted R60's leg protector coverings, put on the blue ankle boots, positioned a cushion under ankles and left her position on her back with no conversation offered. R60's active diagnosis from the Minimum Data Set (MDS) form dated 8/6/14, listed but is not limited to Alzheimer's disease and osteoarthrosis. R60's Brief Interview for Mental Status (BIMS) dated 8/6/14, indicated a summary score of zero out of a possible 15 for cognitive patterns which indicated severe impairment. The plan of care dated 6/21/13, for R60 under communication directed staff to anticipate needs, to provide cues, reminders, directions and explanations. Observe body language and facial expressions and to speak to resident clearly and directly. The undated, nursing assistant assignment sheet, directed staff to speak clearly and directly with R60. During an interview with the director of nursing (DON) on 9/17/14, at 1:45 p.m. she verified NA-A has had Alzheimer's training and would expect all staff to communicate each step in the care process with the residents.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		10/28/14

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F 279	Continued From page 3 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive plan of care regarding weight loss for 1 of 3 residents (R191) reviewed for nutrition. Findings include: Record review on 9/16/14, revealed Progress Notes showing that R191 was admitted on 5/9/14, from a local hospital following a hip fracture, and discharged to an assisted living facility on 6/26/14. The Weights and Vitals Summary listed the resident's weight as 114.1 lbs. on 5/9/14, 97.2 lbs. on 6/18/14, and 98.2 lbs. on 6/25/14--a weight loss of 14% from admission to discharge. The Order Summary Report indicated the physician's diet order for this resident was regular.	F 279	Res R191 discharged from facility on 6/26/14, so a care plan will not be developed at this time. All care plans for any newly admitted resident during the period of June 2014 to September 30, 2014 will be reviewed to assure nutritional and dietary needs are addressed on the comprehensive care plan. On 10/6/14 a supplemental department-specific procedure for developing and updating care plans within appropriate timeframes to comply with RAI requirements was created. This was reviewed in addition to the facility Policy and Procedure for RAI Process	

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F 279	Continued From page 4 A Nutritional Assessment, completed by the dietary manager on 5/21/14, described the resident as having a diagnosis of weight loss and having been placed on a nutritional supplement for nutritional support and weight management. This assessment specified that R191 was near the bottom of her ideal body weight range and was at moderate/high nutritional risk. The permanent plan of care for this resident contained no focus or problem related to nutrition. The only directions for staff related to nutrition in the temporary plan of care dated 5/9/14, were to provide a regular diet and set-up and assist as needed. When interviewed on 9/18/14, at 12:30 p.m. the dietary manager stated that a permanent care plan should have been completed for this resident regarding nutrition.	F 279	Interdisciplinary Care Plan with Nutrition Services clinical staff Registered Dietitians (RD s) and Diet Technicians, Registered (DTR s) with responsibilities for clinical charting on 10/8/14. An audit of current resident nutritional care plans will be done by the Dietary Director every 2 weeks beginning the week of 10/13/14 for the next quarter in collaboration with the MDS coordinators to assure practice is following the newly created department specific procedure. Results of the nutritional department care plan audits will be reported by the Dietary Director at the QA meetings. Further actions may be taken pending results of the audits.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of	F 280		10/28/14

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F 280	Continued From page 5 the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 1 of 3 residents (R248) monitored for accidents, to include decline in weight bearing and ambulation. Findings include: R248 experienced 3 falls since admission 7/6/14, was no longer ambulating and the plan of care directed to ambulate with the rolling walker. During an observation on 9/16/14, at 2:00 p.m. nursing assistant (NA)-C had difficulty transferring R248 to the toilet from the wheel chair, as resident did not stand with the transfer bearing full body weight. NA-C verified R248 was no longer standing very well or ambulating with the rolling walker. R248's active diagnosis from the Minimum Data Set (MDS) form dated 7/13/14, listed but is not limited to, Non-Alzheimer's dementia and unspecified hearing loss. R248's Brief interview for Mental Status (BIMS) dated, 7/13/14, indicated resident was unable to complete the interview due to severe cognitive impairment.	F 280	1. R248 record reviewed by Medical Director, Consulting Pharmacist, Primary Physician, Physical therapy. 2. All resident records that may be affected by the same practice reviewed. 3. Re-education of nursing staff on the use of Stop and Watch for communicating changes in condition. 4. Policies and procedures reviewed. Responsible persons: Nurse Managers, MDS nurses.	

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During surveyor interview with R248,using Microsoft word large type to communicate, when asked about walking with the rolling walker, stated, "Standing is important to me for going to the bathroom but I don't care to walk as much anymore."

The plan of care dated 9/3/14, addressed using a pocket talker or writing on a white board for communication. Speak to resident clearly and directly. The plan of care dated 7/16/14, read; "Mobility; impaired physical mobility related to (r/t) impaired balance, general decondition, low endurance/fatigues easily, confusion/impaired". The approaches read; "Observe for worsening/decline in ROM (range of motion)/mobility, refer to rehab services, as needed. Staff bear weight with assist of 1. Uses rolling walker when ambulating with staff".

The physical therapy discharge note dated 7/17/14, after 9 therapy visits read; "Function at d/c (discharge): ambulate with r/w (rolling walker) up to 40' CGA (contact guard assist), but resident had been refusing to ambulate with therapy (The last 5 times), transfer Mod A (moderate assist), bed mobility Min A (minimum assist) and tolerated sitting LE (lower extremity) strengthening. Resident's progress limited by refusal to participate. Resident to remain in LTC (long term care) facility. Resident was not placed on ambulation program due to refusal to ambulate with therapy."

The current undated, nursing assistant assignment sheet, under mobility and ROM read; "Transfer assist of 1." There was no ambulation addressed on the assignment sheet.

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide services in accordance with the resident's written plan of care for 2 of 5 resident's (R60 and R108) in the sample who required assistance with activities of daily living. Findings include: R60 did not receive assistance of staff for wearing a right hand soft splint. The plan of care for R60 dated 6/21/13, read, "U/E's [upper extremities] holds U/E's in flexed position. Soft splint right hand. Observe for worsening decline in ROM [range of motion] mobility. U/E PROM [passive range of motion] x 10 reps qd [every day]." The physician order dated 1/2/13, read, "Soft splint to right hand, on a.m. and off at bedtime." the order further clarified "OK to keep splint off x24 hours for splint care q [every] sat [Saturday]." During the initial observation on 9-15-14, from 4:00 p.m. until bedtime at 7:00 p.m. R60 did not have the soft splint to the right hand. On 9/16/14 from 9:30 a.m. until 1:40 p.m. R60 did not have the soft right hand splint on until the surveyor	F 282	1) R 60 Hand splint was obtained during the survey process. R108 Oxygen Saturation level was checked at the time the oxygen cannula was displaced 96% no adverse effects noted. 2) Nursing staff were re-educated on the importance of following the established plan of care. 3) Policies and Procedures reviewed. 4) Nursing staff educated using the CMS Hand and Hand videos. 5) All residents records that may be affected by the same practice reviewed. Responsible persons: Director of Nursing/Assistant Director of Nursing/Nurse educator/Nurse managers.	10/28/14

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brought it to the attention of the staff.

Interview on 9/16/14, at 3:40 p.m. with RN-B verified the facility expectations for resident's requiring hand splints is to be followed according to the physician orders.

R108 was without oxygen in nares for 2 hours, could not reach call light for 2 hours and was lying supine with clothing causing pressure to posterior thighs and buttocks for 2 hours without being re-approached in 10 to 15 minutes and without involving other staff to re-approach for care.

R108's active diagnosis from the Minimum Data Set (MDS) form dated 7/23/14, listed, but is not limited to, non-Alzheimer's dementia, diabetes mellitus, and heart failure.

R108's Brief interview for Mental Status (BIMS) dated 7/23/14, indicated a summary score of zero out of a possible 15 for cognitive patterns which indicated severe impairment and never rarely made decisions.

The form titled Braden Scale for predicting Pressure Sore Risk and dated 9/12/14, indicated a score of 14 out of 23 at moderate risk currently for developing pressure ulcers

The plan of care for Cognition/communication, dated 12/19/12, directed staff to "Speak to resident clearly and directly. Provide cues, reminders, explanations and directions. Use guarded simple approach. Do not rush speech or approach." The plan of care directed staff to resident being a fall risk and to keep the call light within reach. The behavior section of the plan of care dated 2/12/14, read, "Approach in a calm

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F 282	Continued From page 9 manner. Give clear explanation of all care activities prior to and as they occur. If resident is resistive to cares, ensure safety, leave and re-approach 10-15 minutes later." For elimination and skin integrity the plan of care dated 6/28/14, read. "Check and change q [every] 2 hrs and PRN [whenever necessary]. Turn and reposition every 2 hrs." The plan of care for Oxygen use directed, "Oxygen at 2 liters per nasal canula continuously." The nursing assistant assignment sheet directed staff to "Re-approach every 15 minutes." During an interview with the director of nursing (DON) on 9/17/14, at 1:45 p.m., verified NA-A has had Alzheimer's training and she would expect all staff to communicate each step in the care process with the residents and to re-approach to ensure care delivery and according to the plan of care.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide the necessary care and services to re-approach for 1 of 2	F 309	1) R 60 Hand splint was obtained during the survey process. R108 Oxygen Saturation level was checked at the time	10/28/14

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F 309	Continued From page 10 residents (R108) who required re-approach for oxygen, call light, and proper positioning. Findings include: R108 was without oxygen in nares for 2 hours, could not reach call light for 2 hours and was lying supine with clothing causing pressure to posterior thighs and buttocks for 2 hours without being re-approached in 10 to 15 minutes and without involving other staff to re-approach for care. During an observation on 9/15/14, at 4:10 p.m., R108 was lying on his back in bed. The oxygen tubing was not in nostrils but on the side of face, The waist of the sweat pants was crumpled below the brief at the bilateral thigh area. The privacy curtain was pulled so R108 was not visible from the doorway. R108 acknowledged surveyor presence with a smile and a wink. Surveyor introduced self and asked R108 if he could adjust the oxygen tubing to be in his nostrils. R108 stated "It's fine." The call light was on the floor under the bed. R108 was observed by surveyor every 5-15 minutes and his position remained lying supine, brief exposed, pants down to thighs and call light on the floor. At 5:30 p.m. Surveyor asked nursing assistant NA-A when cares were provided for R108. NA-A stated, " I started with him when I came in at 3:15 but he refused cares." When asked if NA-A had re-approached or informed the nurse, NA-A stated, "I told the nurse at 4:30 p.m. that R108 refused cares but I have not been in there since 3:15-3:30 or so." Surveyor informed NA-A the oxygen was not on correctly, the call light was lying on the floor, and R108's pants were not pulled up properly to maintain skin integrity. NA-A and surveyor knocked and went into R108's room. R108 immediately upon seeing	F 309	the oxygen cannula was displaced 96% saturation level no adverse effects noted. 2) Nursing staff were re-educated on the importance of following the established plan of care. 3) All residents records that may be affected by the same practice reviewed. 4) Policies and Procedures reviewed. 5) Nursing staff educated using the CMS Hand and Hand videos. 6) Nursing management re-educated utilizing Critical thinking for LTC Leadership. Audits: Random audits will be conducted by the Nurse Managers a minimum of 3 per week times 4 weeks. Results will be reported to the QA committee who will determine when the audits can be discontinued. Responsible persons: Director of Nursing/Assistant Director of Nursing/Nurse educator/Nurse managers.	

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NA-A stated, "Get him out of here." At this time, licensed practical nurse LPN-C was approached and asked if he was aware R108 did not have the oxygen on and was asked about communication with NA-A. LPN-C stated, "At 5:00 p.m., NA-A said he [R108] refused to get up, that is all." After LPN-A was informed the oxygen was not in place LPN-C obtained vital signs and pulse oximeter of 96, normal for R108. LPN-C and NA-B assisted R108 with oxygen, adjustment of clothing and getting up by mechanical lift into the wheelchair for supper. Observation of R108's posterior thighs and buttocks on 9/15/14, at 5:30 p.m. revealed red, deep creases and wrinkling of the skin around the buttocks and posterior thighs, verified by LPN-C and NA-B.

Interview with NA-A on 9/15/14, at 5:25 p.m. verified he did not re-approach R108 since refusal of care at 3:15-3:30 p.m.

R108's active diagnosis from the Minimum Data Set (MDS) form dated 7/23/14, listed, but is not limited to, non-Alzheimer's dementia, diabetes mellitus, and heart failure.

R108's Brief interview for Mental Status (BIMS) dated 7/23/14, indicated a summary score of zero out of a possible 15 for cognitive patterns which indicated severe impairment and never rarely made decisions.

The form titled Braden Scale for predicting Pressure Sore Risk and dated 9/12/14, indicated a score of 14 out of 23 at moderate risk currently for developing pressure ulcers

The plan of care for Cognition/communication, dated 12/19/12, directed staff to "Speak to

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F 309	Continued From page 12 resident clearly and directly. Provide cues, reminders, explanations and directions. Use guarded simple approach. Do not rush speech or approach." The plan of care directed staff to resident being a fall risk and to keep the call light within reach. The behavior section of the plan of care dated 2/12/14, read, "Approach in a calm manner. Give clear explanation of all care activities prior to and as they occur. If resident is resistive to cares, ensure safety, leave and re-approach 10-15 minutes later." For elimination and skin integrity the plan of care dated 6/28/14, read. "Check and change q [every] 2 hrs and PRN [whenever necessary]. Turn and reposition every 2 hrs." The plan of care for Oxygen use directed, "Oxygen at 2 liters per nasal canula continuously." The undated, nursing assistant assignment sheet, directed staff to "Re-approach every 15 minutes." During an interview with the director of nursing (DON) on 9/17/14, at 1:45 p.m. verified NA-A had Alzheimer's training and it would be expected that all staff communicate each step in the care process with the residents and to re-approach to ensure care delivery.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and	F 314		10/28/14

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services to promote healing, prevent infection and prevent new sores from developing.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure a resident identified at risk for pressure ulcers (PU) received timely repositioning for 1 of 3 residents (R60) in the sample identified at risk for pressure ulcers.

Findings include:

R60 was not repositioned every two hours according to the plan of care during continuous observations on 9/15/14, from 4:00 p.m. until 6:45 p.m. (two hours and forty-five minutes) and on 9/16/14, from 10:30 a.m. until 1:30 p.m.(three hours).

Continuous observations of R60 on 9/15/14, from 4:00 p.m. until 6:45 p.m. R60 was sitting up in a semi-reclining chair in the Phalen A porch at a dining table. At 6:30 p.m. R60 was wheeled to her bedroom where nursing assistant NA-A and NA-B utilized a mechanical lift to transfer R60 to bed at 6:45 p.m.. R60's incontinence brief was saturated with urine. R60's buttocks and posterior thighs were red with wrinkling grooves deep in the skin from the incontinence brief and wrinkling from sitting on the mechanical lift sling.

When interviewed on 9/15/14, at 7:00 p.m. NA-A verified R60 did not have a position change for two hours and forty-five minutes while semi-sitting in a facility cloud chair.

Continuous observations of R60 on 9/16/14, from

Provider's Plan of Correction (F 314):

1) R60 had no pressure areas at the time of the survey. Reassessment of tissue tolerance and Braden scale completed.

2) All residents records that may be affected by the same practice reviewed.

3) Policies and procedures reviewed.

4) Nursing staff re-educated on the importance of following the plan of care with focus on repositioning.

Audits: Audits: Random audits will be conducted by the Nurse Managers a minimum of 3 per week times 4 weeks.

Results will be reported to the QA committee who will determine when the audits can be discontinued

Responsible persons: Director of Nursing/Nurse Managers.

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F 314	Continued From page 14 10:30 a.m. until 1:30 p.m. R60 was sitting up in a semi-reclining chair in the Phalen A porch at a dining table. R60 was wheeled to her bedroom where NA-C and NA-D utilized a mechanical lift to transfer R60 to bed at 1:30 p.m.. R60's incontinence brief was saturated with urine. R60's buttocks and posterior thighs were red with wrinkling grooves deep in the skin from the incontinence brief. When interviewed on 9/16/14, at 1:30 p.m. NA-D verified R60 did not have a position change for three hours since getting up in the cloud chair at 10:30 a.m. During an interview on 9/16/14, at 3:40 p.m. RN-B verified R60 is to have her position changed every 2 hours. R60's active diagnosis from the Minimum Data Set (MDS) form dated 8/6/14, listed but is not limited to Alzheimer's disease and osteoarthrosis. R60's Brief Interview for Mental Status (BIMS) dated 8/6/14, indicated a summary score of zero out of a possible 15 for cognitive patterns indicated severe cognitive impairment. R60's skin condition from the MDS dated 8/6/14, indicated a stage two pressure area. (Stage two Partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough. May also present as an intact or open/ruptured serum-filled blister. Documentation in the wound assessment dated 8/1/14, read "Right buttock pressure .3 centimeter (cm) length .2 cm wide with no depth. Skin surrounding macerated (softening of tissue by soaking in fluids, dissolving connective tissue components	F 314		

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F 314	Continued From page 15 and thus causing degenerative changes) looking." The Braden Scale for Predicting Pressure Sore Risk dated 8/3/14, indicated a score of 9 out of 23 placing R60 at a very high risk of developing pressure ulcers. The tissue tolerance assessment dated 5/1/14, directed R60 to re-position at least every two hours due to immobility and incontinence. The plan of care for skin integrity dated 8/13/14, read, "Reposition per tissue tolerance test and facility P [policy] & P [procedure]. A review of the facility policy dated 2/10/12, and titled Tissue Tolerance Testing, indicated the purpose was to provide care to maintain the highest practicable function for the resident and to incorporate toileting and re-positioning based on the individual assessment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 3 residents	F 315	1) R60 bladder re-assessment completed.	10/28/14

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F 315	Continued From page 16 (R60) in the sample who had urinary incontinence received the necessary care and treatment to minimize the risk for complications related to incontinence. Findings include: R60 was not toileted, checked/changed, every two hours according to the plan of care during continuous observations on 9/15/14, from 4:00 p.m. until 6:45 p.m. (two hours and forty-five minutes) and on 9/16/14, from 10:30 a.m. until 1:30 p.m.(three hours) Continuous observations of R60, on 9/15/14, from 4:00 p.m. until 6:45 p.m., R60 was sitting up in a semi-reclining chair in the Phalen A porch at a dining table. At 6:30 p.m. R60 was wheeled to her bedroom where nursing assistant NA-A and NA-B utilized a mechanical lift to transfer R60 to bed at 6:45 p.m.. R60's incontinence brief was saturated with urine. R60's buttocks and posterior thighs were red with wrinkling grooves deep in the skin from the incontinence brief and wrinkling from sitting on the mechanical lift sling. When interviewed on 9/15/14, at 7:00 p.m. NA-A verified, R60 did not toilet or check/change for incontinence for two hours and forty-five minutes. Continuous observations of R60 on 9/16/14, from 10:30 a.m. until 1:30 p.m., R60 was sitting up in a semi-reclining chair in the Phalen A porch at a dining table. R60 was wheeled to her bedroom where NA-C and NA-D utilized a mechanical lift to transfer R60 to bed at 1:30 p.m.. R60's incontinence brief was saturated with urine. R60's buttocks and posterior thighs were red with wrinkling grooves deep in the skin from the	F 315	2) All residents records reviewed the may be affected by the same practice. 3) Nursing staff re-educated on the importance of following the plan of care with focus on incontinence management. 4) Policies and procedures reviewed. Audits: Random audits will be conducted by the Nurse Managers a minimum of 3 per week times 4 weeks. Results will be reported to the QA committee who will determine when the audits can be discontinued. Responsible persons: Nurse Managers	

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F 315	Continued From page 17 incontinence brief. When interviewed on 9/16/14, at 1:30 p.m. NA-D verified R60 did not toilet check/change for three hours since getting up in the cloud chair at 10:30 a.m.. During an interview on 9/16/14, at 3:40 p.m. RN-B verified R60 is to toilet check/change every 2 hours. R60's active diagnosis from the Minimum Data Set (MDS) form dated 8/6/14, listed but is not limited to Alzheimer's disease and osteoarthrosis. R60's Brief Interview for Mental Status (BIMS) dated 8/6/14, indicated a summary score of zero out of a possible 15 for cognitive patterns which indicated severe impairment. R60's quarterly MDS dated 8/6/14 indicated R60 was always incontinent of bowel and bladder. The urinary incontinence care area assessment dated 8/17/11, indicated R60 was "unable to participate in a bowel or bladder retraining program, secondary to impaired cognition and impaired mobility. Staff physically assist resident to toilet check/change every two hours and whenever necessary." The plan of care for R60 titled "Elimination" directed staff "Check and change every two hours and prn (whenever necessary). Totally dependent elimination tasks. The nursing assistant assignment sheet directed staff, "Incontinent-B&B (bowel and bladder) check and change every 2 hours." A review of the facility policy dated 7/16/13, and	F 315		

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F 315	Continued From page 18 titled, "Bladder Management," read, "Each resident who is incontinent of urine is identified, assessed and provided appropriate treatment and services to achieve or maintain as much normal urinary function as possible."	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide nursing rehabilitative services as ordered for 1 of 1 resident's (R60) reviewed for rehabilitative services to maintain or increase range of motion (ROM). Findings include: On 9/15/14, at 4:00 p.m. in the Phalen A porch, R60 was sitting in a recliner chair with eyes closed and was not wearing the soft hand splint for a contracture of her right hand. R60 remained in the porch until she was taken to her bedroom at 6:35 p.m. and transferred to bed using a mechanical lift at 6:50 p.m. Bedtime cares were completed but no soft splint available for the right hand.	F 318	1) R60 Replacement splint was obtained during the survey process. 2) Individual nursing staff re-educated on following the plan of care and intervention if assistive devices not available. 3) All residents records reviewed that may be affected by the same practice. Audits: Random audits will be conducted by the Nurse Managers a minimum of 3 per week times 4 weeks. Results will be reported to the QA committee who will determine when the audits can be discontinued. Responsible person: Nurse Managers	10/28/14

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F 318	Continued From page 19 When interviewed at 7:00 p.m. nursing assistant NA-A verified the bedtime cares were completed and that would be all for tonight except to turn and re-position in two hours. On 9/16/14, at 9:30 a.m. in the Phalen A porch, R60 was sitting in a recliner chair and was being fed breakfast. There was not a soft splint on R60's right hand. At 1:30 p.m. NA-D and NA-C transferred R60 to bed using the mechanical lift. There was no soft hand-splint on R60's right hand. When interviewed on 9-16-14, at 1:35 p.m. NA-D did not know where the right hand splint was because she did not find one in the resident's room. R60's active diagnosis from the Minimum Data Set (MDS) form dated 8/6/14, listed but is not limited to Alzheimer's disease and osteoarthrosis. R60's Brief Interview for Mental Status (BIMS) dated 8/6/14, indicated a summary score of zero out of a possible 15 for cognitive patterns which indicated severe impairment. When interviewed on Tuesday 9/16/14, at 3:40 p.m., registered nurse (RN)-B verified R60 did not have the soft right hand splint but the nursing assistants told her at 1:35 p.m. the splint was missing so RN-B went to therapy to retrieve another soft splint for R60. RN-B did not know what happened to the soft hand splint but assumed it went to laundry and has not returned. The plan of care for R60 dated 6/21/13, read, "U/E's [upper extremities] holds U/E's in flexed position. Soft splint right hand. Observe for	F 318		

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F 318	Continued From page 20 worsening decline in ROM [range of motion] mobility. U/E PROM [passive range of motion] x 10 reps qd [every day]." The physician order dated 1/2/13, read, "OK to keep splint off x24 hours for splint care q [every] sat [Saturday]."	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate interventions had been implemented to minimize the risk of further injuries related to falls for 1 of 3 residents (R248) reviewed for falls. Findings include: R248 experienced 3 falls since admission 7/6/14, was no longer ambulating and the plan of care directed staff to notify rehab of a decline and to ambulate R248 with the rolling walker. During an observation on 9/16/14, at 2:00 p.m. nursing assistant (NA)-C had difficulty transferring R248 to the toilet as resident did not stand with the transfer bearing full body weight. NA-C	F 323	1) R248 revised care plan. 2) Medical Director provided mandatory education on Root cause analysis and fall prevention for licensed nursing staff, also included was the Social Services, Activities and Nursing assistants. 3) Review of resident records that may be affected by the same practice. 4) Nursing staff re-educated on post fall investigation. 5) Reviewed daily IDT meetings to include comprehensive assessment of resident status.	10/28/14

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F 323	Continued From page 21 verified R248 was no longer standing very well or ambulating with the rolling walker. R248's active diagnosis from the Minimum Data Set (MDS) form dated 7/13/14, listed, but is not limited to, Non-Alzheimer's Dementia and unspecified hearing loss. R248's Brief Interview for Mental Status (BIMS) dated, 7/13/14, indicated resident was unable to complete the interview which indicated cognition severe impairment. The plan of care dated 9/3/14, addressed using a pocket talker or writing on a white board for communication. Speak to resident clearly and directly. R248's functional status dated 7/13/14, indicated walking in room did not occur and walking in the corridor was coded for extensive assistance and one person physical assist to walk. Balance was listed as not steady and to walk with staff assist and a walker. The plan of care dated 7/16/14 read; "Mobility; impaired physical mobility related to (r/t) impaired balance, general deconditioning, low endurance/fatigues easily, confusion/impaired". The approaches read; "Observe for worsening/decline in ROM (range of motion)/mobility, refer to rehab services, as needed. Staff bear weight with assist of 1. Uses rolling walker when ambulating with staff". The physical therapy discharge note dated 7/17/14, after 9 therapy visits read; "Function at d/c (discharge): ambulate with r/w (rolling walker) up to 40' CGA (contact guard assist), but resident had been refusing to ambulate with therapy (The last 5 times), transfer Mod A (moderate assist),	F 323	Incident/Accident reports are reviewed at the monthly QA meeting. IDT will be responsible for ongoing compliance.	

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F 323	Continued From page 22 bed mobility Min A (minimum assist) and tolerated sitting LE (lower extremity) strengthening. Resident's progress limited by refusal to participate. Resident to remain in LTC (long term care) facility. Resident was not placed on ambulation program due to refusal to ambulate with therapy." The current undated, nursing assistant assignment sheet, under mobility and ROM read; "Transfer assist of 1." There was no ambulation addressed on the assignment sheet. R248 experienced an unwitnessed fall in the bedroom on 7/30/14, at 7:57 a.m. observed sitting on the floor with legs outstretched in front of her. The notes read; "Patient stated I fell." The interdisciplinary team (IDT) notes read, "Had therapy after admission-chooses not to follow recommendations, along with diagnosis of dementia. Safety measures implemented post found on floor." The second unwitnessed fall occurred on 8/19/14, at 3:30 p.m. observed kneeling on matt next to bed. The IDT notes read, "Will re-evaluate current pain and sleep patterns." The third unwitnessed fall occurred 9/1/14, at 7:35 p.m. in the hallway with injury/bruising to head. The IDT note read, "Will re-evaluate current pain and sleep patterns." During an interview with R248,using microsoft word large type to communicate, when asked about walking with the rolling walker, R248 stated, "Standing is important to me for going to the bathroom but I don't care to walk as much anymore." When interviewed on 9/18/14, at 8:00 a.m., the registered nurse RN-B verified the three falls did	F 323		

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F 323	Continued From page 23 not address any precipitating event to help prevent future falls which included the activity R248 experienced prior to the fall. Information was not available related to the precipitating factors associated with the resident including toileting, use of antipsychotic medications on Seroquil, anxiety level prior to falls and not having appropriate foot wear at the time of the falls. The RN-B did not know why R248 was not wearing shoes, or no longer ambulating with the use of the rolling walker. There was no referral made to therapy following the falls. RN-B verified there had not been enough investigation/information to make a root cause analysis of R248's three falls. RN-B verified she did not know where to find the information pertaining to the IDT recommendation to re-evaluate pain and sleep patterns. The Fall Prevention policy dated 4/14/13, under "Post Fall Investigation." read: "The facility incident reporting process includes a means for investigating falls to assist the staff to identify contributing or causative factors. The Interdisciplinary Team meets routinely to complete a root cause analysis of all documented resident falls or circumstances when a resident has been found on the floor."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a	F 325		10/28/14

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F 325	Continued From page 24 nutritional problem. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive plan of care regarding weight loss for 1 of 3 residents (R191) reviewed for nutrition. Findings include: Document review on 9/16/14, revealed Progress Notes showing that R191 was admitted on 5/9/14, from a local hospital following a hip fracture, and discharged to an assisted living facility on 6/26/14. The Weights and Vitals Summary listed the resident's weight as 114.1 lbs. on 5/9/14, 97.2 lbs. on 6/18/14, and 98.2 lbs. on 6/25/14--a weight loss of 14% from admission to discharge. The Order Summary Report indicated the physician's diet order for this resident was regular. A Nutritional Assessment, completed by the dietary manager on 5/21/14, described the resident as having a diagnosis of weight loss and having been placed on a nutritional supplement for nutritional support and weight management. This assessment specified that R191 was near the bottom of her ideal body weight range and was at moderate/high nutritional risk. The permanent plan of care for this resident contained no focus or problem related to nutrition. The only directions for staff related to nutrition in the temporary plan of care were to provide a	F 325	Res R191 discharged from facility on 6/26/14, so a care plan will not be developed at this time. All care plans for any newly admitted resident during the period of June 2014 to September 30, 2014 will be reviewed to assure nutritional and dietary needs are addressed on the comprehensive care plan. On 10/6/14 a supplemental department-specific procedure for developing and updating care plans within appropriate timeframes to comply with RAI requirements was created. This was reviewed in addition to the facility Policy and Procedure for RAI Process Interdisciplinary Care Plan with Nutrition Services clinical staff Registered Dietitians (RD s) and Diet Technicians, Registered (DTR s) with responsibilities for clinical charting on 10/8/14. An audit of current resident nutritional care plans will be done by the Dietary Director every 2 weeks beginning the week of 10/13/14 for the next quarter in collaboration with the MDS coordinators to assure practice is following the newly created department specific procedure. Results of the nutritional department care	

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F 325	Continued From page 25 regular diet and set-up and assist as needed. When interviewed on 9/18/14, at 12:30 p.m. the dietary manager stated that a permanent care plan should have been completed for this resident regarding nutrition.	F 325	plan audits will be reported by the Dietary Director at the QA meetings. Further actions may be taken pending results of the audits.	
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		10/1/14

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 ______	09/18/2014

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 356	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure nursing staffing hours were posted with the actual hours worked. This had the potential to effect all 165 residents who resided in the facility. Findings include: During observations on 9/15/14, at 12:00 p.m., the facility's daily nursing staff schedule was posted on a framed board in the main hallway by the front entrance. The actual worked hours for the licensed and the unlicensed nursing staff were not included in the posting. During observations on 9/16/14, 9/17/14, and 9/18/14, at 10:30 a.m. the nursing staff schedule was noted not to have actual hours worked for the licensed and unlicensed nursing staff. On 9/18/14, at 10:45 a.m., the director of nursing (DON) indicated the staffing person posted the form every day. The DON verified the staffing forms did not indicate the total actual hours worked by all nursing staff.	F 356	1) Posted form included Job category and total hours during survey process. Posting of nursing staff hours updated to include shifts. Responsible person: Director of Nursing/Assistant Director of Nursing.	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		10/31/14

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F 371	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to follow equipment sanitation in a manner that minimized the development of foodborne illness, which had the potential to affect 162 of the 165 residents in the facility. Findings include: During the full kitchen tour observation on 8/18/14, at 9:30 a.m. 8 of 16 shallow baking sheets on a drying rack contained areas of white, brown, or black residue on the interior of the pans, which would come in contact with food. The dietary manager was on the tour, agreed that the pans were soiled, and removed them from the drying rack to be cleaned or thrown away. Two of these pans also had significant areas of pitted metal on the interior. Interview with the dietary manager, at this time, stated that she would throw those pans away and may need to order new baking sheet pans for the facility.	F 371	Pitted and stained pans were discarded on 9/18/14. The Dietary Director placed an order with food vendor Sysco for 24 new sheet pans on 9/18/14. The new pans were delivered on 9/24/14 per Sysco Invoice #409240606. The new pans were washed and put into circulation on 9/24/14. On 10/3/14 the Dietary Director had a meeting with the facility Ecolab representative regarding the cleaning products and process to be used on the sheet pans and other pans to minimize or prevent unacceptable levels of residue or staining from recurring. The following recommendations from Ecolab will be implemented upon receipt of the products anticipated by 10/14/14: 1) changing the cleaning product used in the pot & pan washing sink where the sheet and other pans are washed to APEX Pot & Pan Soak, 2) getting a different style of scrub brush (Vikan round bristle brush), and 3) using the Greaselift RTU spray product on pans before washing as needed. 4) the sanitizing process in the 3-compartment sink will be switched from a heat sanitizing final step to a chemical quat sanitizer. The Ecolab rep will place the order for these products and set up the APEX Pot & Pan Soak and Quat Sanitizer system stations when the products arrive in the facility. 5) Once the system stations are in place dietary staff	

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F 371	Continued From page 28	F 371	will be inserviced on the correct use of the new products. Note: The Ecolab rep placed the order for the APEX Pot & Pan Soak and Quat Sanitzer products and system stations on 10/6/14.	
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	F 441		10/28/14

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F 441 Continued From page 29
professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to implement procedures to prevent the spread of infection for handwashing during diabetic glucometer procedures for resident (R21 and R37) and during resident care for R60 & R108, and cleaning of the mechanical lift remote control for R60 and R108, and using foam eggcrate (non cleanable surface) for positioning R60.

During continuous observation on 9/15/14, at 4:31 p.m. licensed practical nurse (LPN)-C was observed to remove R21's individual glucometer from the medication cart, walked into the resident's room and donned a pair of gloves without washing hands, performed a finger stick to obtain blood for the glucometer reading, walked back into the hallway where the medication cart was, put the lancet into the contaminated container, removed contaminated gloves, disposed of them into the med cart waste receptacle. LPN-C stated, "I am going to wash my hands before I do the insulin." LPN-C went into the resident bathroom turned on faucet, ran hands under the water, obtained foam soap from the dispenser, rubbed palms together for 6 seconds, rinsed hands, paper towel dried hands and went back to the med cart to draw up the

F 441

1) Individual nursing staff re-educated on policies and procedures.

2) Nursing staff re-education including competency demonstration of proper hand washing, use of alcohol hand sanitizer, glove use. Staff re-educated on disintecting shared equipment after use.

Random audits will be conducted 3 per week times 4 weeks by Director of Nursing/Assistant Director of Nursing/Nurse educator/Nurse Managers.

Results will be reported to the QA committee monthly who will determine when the audits can be discontinued.

Responsible person: Director of Nursing/Assistant Director of Nursing/Nurse educator/Nurse Managers.

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F 441	Continued From page 30	F 441		

insulin for R21. LPN-C returned to R21 with the insulin injection. donned a pair of gloves, gave the insulin, removed gloves in the bathroom, set the contaminated insulin syringe on the sink. Turned on the faucets, obtained foam soap from the dispenser, rubbed palms together for 6 seconds, rinsed hands and dried with a paper towel. LPN-C picked up the contaminated insulin syringe from the sink and returned to the medication cart to dispose of the syringe. Without using any alcohol gel LPN-C proceeded to go through the medication cart to get the individual glucometer machine for R37's blood sugar. LPN-C donned a pair of gloves from the bathroom and realized did not bring in a lancet so returned to the medication cart in the hallway, using keys with gloved hands opened the medication cart to retrieve a lancet, returned to the resident, removed gloves without washing hands or using alcohol gel and donned another pair of gloves to draw blood for the glucometer. LPN-C took a box of gloves out of R37's bathroom and put them on the medication cart for use, stating, "I ran out of gloves so I will use these." LPN-C donned a pair of gloves to use to draw up the insulin, knocked on the resident door, went into the room to give the insulin, changed gloves without washing hands or using alcohol gel, gave the insulin in the abdomen, left the bedroom wearing the gloves, went to the med cart removed gloves, disposed of them in the med cart waste receptacle then returned to the resident bathroom to wash hands for 8 seconds and did not rub the back of hands, between fingers, or fingernails.

During continuous observation of cares on 9/15/14, at 5:30 p.m. LPN-C and nursing assistant (NA)-B entered the bedroom to get up R108 for the evening meal. Without washing

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F 441	Continued From page 31 hands or using alcohol gel, both staff members donned gloves. R108 needed oxygen tubing replaced to nostrils, vital signs taken by LPN-C, R108 needed pants pulled up as they were below the brief at thigh level. The mechanical sling was under R108 and LPN-C and NA-B proceeded to use the mechanical lift to get R108 up into the large recliner type chair on wheels for supper. Both staff removed contaminated gloves from cares for R108. LPN-C went into the bathroom and removed gloves and without soap rinsed hands for 4 seconds, dried with a paper towel and left the room. NA-B removed gloves and without washing hands picked up the portable liquid oxygen tank to go to the oxygen transfill room. LPN-C moved the mechanical lift to the utility room and did not sanitize the mechanical control that had been contaminated by gloves used for cares of R108. During continuous observation of cares on 9/15/14, at 6:30 p.m. NA-A and NA-B entered the bedroom of R60 for evening cares. Neither staff sanitized hands before donning gloves. Both staff proceeded to assist resident with removing clothes. NA-B left the room without washing hands. NA-B continued with undressing clothes, washing face, but then stood and waited for NA-B to return to assist with the mechanical lift transfer. NA-A wearing contaminated gloves and holding the walky talky wire attempted to communicate with NA-B to return for assistance. NA-B returned after 6 minutes and without washing hands donned a pair of gloves to assist with the mechanical lift transfer to bed. When R60 was in bed NA-B was finished assisting. NA-B removed gloves and without sanitizing hands left the room. NA-A continued with R60's cares wearing the same gloves proceeded to remove the saturated	F 441		

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F 441	Continued From page 32	F 441		

incontinence brief and perform perineal cleansing. NA-A removed gloves and without sanitizing hands donned another pair of gloves to continue with turning R60 from side to side to apply clean brief, adjusted bed linen, and put a foam eggcrate style wedge under R60's ankles. There were multiple white and brown stains on the foam eggcrate style wedge and NA-A was not sure of the cleaning procedure for the wedge. NA-A took the basin of water and emptied the basin into the bathroom sink and without cleaning out the basin left it sit in the bathroom on the hand rail. NA-A removed the trash bag with the incontinence brief, tied the bag and put a clean bag into the trash receptacle, gathered the linen into a plastic bag, removed gloves in the bathroom and without sanitizing hands took the plastic linen and trash bag to the utility room. NA-A removed the mechanical lift from R60's room and took the lift back to the utility room without sanitizing the controls.

During observation of cares for R60 on 9/16/14, at 1:20 p.m., NA-C and NA-D both came into the bedroom and without sanitizing hands donned gloves and proceeded to transfer R60 to bed and perform cares for incontinence and positioning. Both nursing assistants removed gloves after cares and did not sanitize hands.

Interview with the director of nursing (DON) on 9/17/14, at 1:00 p.m., verified the facility handwashing procedure requires staff to sanitize hands before and after removing gloves. The DON validated staff education stresses that the use of gloves does not eliminate the need for hand hygiene. Furthermore, the DON stressed the facility expects the staff to sanitize the mechanical lift controls before storing the

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F 441	Continued From page 33 equipment. A review of the facility policy dated 2/19/13, and titled Hand Hygiene Hand washing Hand Rubs, under Indications for Handwashing and Handrubbing, directed staff to sanitize hands before having direct contact with patients and after removing gloves. The policy further stressed that handwashing is to vigorously rub hands together for 15 seconds covering all surfaces of hands and fingers. If using the alcohol based hand rub to apply liberally and to rub hands together covering all surfaces of hands and fingers and to continue to rub until hands are dry. The Policy dated 3/23/13, titled Cleaning of Reusable Equipment read, "Reusable equipment includes mechanical lifts, stand up lifts." and to clean with the facility approved disinfectant wipes.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on document review, and interview, the facility failed to establish procedures to ensure that potable and non-potable water was available to essential areas when loss of normal water supply. This had the potential to affect 165 residents in the facility. Findings include:	F 466	Ramsey County Care Center has established protocol and procedures to ensure that water is available when there is a loss of normal water supply. Procedures include potable and non-potable water, storage of potable and non-potable water, distribution of water and estimates for water for both residents	10/28/14

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F 466	Continued From page 34 During review of the facility policy dated 1/1/13, and titled Emergency Water Supply, revealed it did not contain provisions for storing both potable and non-potable water, description of a method for distributing the water and calculations for estimating the gallons of water required daily to meet the needs of the residents and staff. On 9/17/14, at 1:22 p.m., during an interview with the administrator regarding the water policy and the lack of provision for storage, both potable and non potable, distribution and estimated volume for residents in the facility. The administrator said the volume written of 5000 gallons is what the company said they would provide but that the individual resident use was not calculated.	F 466	and staff. The Administrator and Environmental Services Director will monitor and direct the protocol and procedures.	

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

F5352022

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	**09/17/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY 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 to be 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. 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 167 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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.

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: September 30, 2014

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5352023

Dear Mr. Fritzke:

The above facility was surveyed on September 15, 2014 through September 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124   Fax: (651) 215-9697