



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
CMS Certification Number (CCN): 245352

October 11, 2018

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

Dear Administrator:

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 5, 2018 the above facility is certified for:

164 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

A handwritten signature in black ink that reads 'Kamala Fiske-Downing'.

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
October 11, 2018

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

RE: Project Number S5352027, H5352049

Dear Administrator:

On September 5, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective September 10, 2018. (42 CFR 488.422)

Also on September 5, 2018, we informed you that the following enforcement remedy was being imposed:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 29, 2018.

This was based on the deficiencies cited by this Department for a standard survey completed on August 10, 2018 that included an investigation of complaint number H5352049. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On October 5, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on October 4, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on August 10, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of October 5, 2018. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on August 10, 2018, as of October 5, 2018.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective October 5, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter from September 5, 2018.

Ramsey County Care Center

October 11, 2018

Page 2

- Discretionary Denial of payment for new Medicare and Medicaid admissions effective October 29, 2018 be rescinded as of October 5, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify you of their determination regarding the imposed remedies and appeal rights.

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

Feel free to contact me if you have questions.

Sincerely,



Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PDFO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00846

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245352		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: <u>2</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint	
2.STATE VENDOR OR MEDICAID NO. (L2) 1699760785		5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (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	
6. DATE OF SURVEY 08/10/2018 (L34)		8. ACCREDITATION STATUS: <u> </u> (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other		FISCAL YEAR ENDING DATE: (L35) 12/31	
11. LTC PERIOD OF CERTIFICATION From (a) : To (b) :		10.THE FACILITY IS CERTIFIED AS: A. In Compliance With <u>And/Or Approved Waivers Of The Following Requirements:</u> Program Requirements <u> </u> 2. Technical Personnel <u> </u> 6. Scope of Services Limit Compliance Based On: <u> </u> 3. 24 Hour RN <u> </u> 7. Medical Director <u> </u> 1. Acceptable POC <u> </u> 4. 7-Day RN (Rural SNF) <u> </u> 8. Patient Room Size <u> </u> 5. Life Safety Code <u> </u> 9. Beds/Room X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: B* (L12)			
12.Total Facility Beds 164 (L18)		14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 19 SNF ICF IID 164 (L37) (L38) (L39) (L42) (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)	
13.Total Certified Beds 164 (L17)					

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

17. SURVEYOR SIGNATURE <u>Mary Heim, HFE NE II</u> (L19)		Date : 09/24/2018		18. STATE SURVEY AGENCY APPROVAL <u>Kamala Fiske-Downing, Sr. Health Program Rep</u> (L20)		Date: 10/11/2018	
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY <u> </u> 1. Facility is Eligible to Participate <u> </u> 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 : <u> </u>	
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 <u>00</u> INVOLUNTARY 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination <u>OTHER</u> 04-Other Reason for Withdrawal 07-Provider Status Change 00-Active	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 03001 (L28) (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 All Minnesotans

Electronically delivered

September 5, 2018

Ramsey County Care Center
Attn: Administrator
2000 White Bear Avenue
Maplewood, MN 55109

RE: Project Numbers S5352027, H5352049

Dear Administrator:

On August 10, 2018, 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. In addition, at the time of the August 10, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5352049. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

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

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

Appeal Rights - the facility rights to appeal imposed remedies;

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), and emergency preparedness deficiencies (those preceded by an "E" tag), i.e., the plan of correction should be directed to:

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

For all surveys completed after September 1, 2016, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when one or more of the following circumstances exist:

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **OR**
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; **OR**
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles); **OR**
- A facility is classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

Note: the "current" survey is whatever Health and/or LSC survey is currently being performed, i.e., standard, revisit, or complaint.

Your facility meets one or more criterion and remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective September 10, 2018. (42 CFR 488.422)

The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective October 29, 2018.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective October 29, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective October 29, 2018.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Ramsey County Care Center is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective August 10, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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 remedy be imposed:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE

If substantial compliance with the regulations is not verified by October 29, 2018 (80 days 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 discretionary 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 February 10, 2019 (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.

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

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

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections

Ramsey County Care Center

September 5, 2018

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Minnesota Department of Public Safety

State Fire Marshal Division

445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us

Telephone: (651) 430-3012

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in black ink that reads "Kamala Fiske-Downing". The signature is written in a cursive, flowing style.

Kamala Fiske-Downing

Licensing and Certification Program

Minnesota Department of Health

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

PRINTED: 10/15/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2018
NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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
E 000	Initial Comments	E 000			
	A survey for compliance with CMS Appendix Z, Emergency Preparedness Requirements, was conducted from 8/6-8/10/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.				
F 000	INITIAL COMMENTS	F 000			
	A recertification survey was conducted 8/6, 8/7, 8/8, 8/9 and 8/10/18. An investigation of complaint #H5352049 was also completed during the survey and found to be substantiated at F610.				
	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 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7)	F 554			10/5/18
	§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 1 of 1 resident (R80)		This plan and response to CMS 2567 is written solely to maintain certification in		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/2018

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.

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

PRINTED: 10/15/2018
FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2018
NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 554	Continued From page 1 reviewed for self administration of medications, had been appropriately assessed and deemed appropriate to self administer medications prior to doing so. Findings include: Record review revealed a physician's order dated 5/29/18, for R80 to receive Lantus insulin 8 units daily by injector pen; a physician's order dated 7/5/18, indicated R80 was to receive NovoLog insulin by sliding scale three times daily; and a physician's order dated 6/16/18, indicated R80 was to receive Oxycodone 100 mg (milligrams)/5 ml (milliliters), 0.75 ml every 3 hours for pain. R80's July 2018 Medication Administration Record (MAR) indicated the facility had sent medications with the resident during therapeutic leaves from the facility: Oxycodone was sent with R80 on July 3, 5, 6, 12, 13, 17, 19, 27, 29, and 31, 2018; the Lantus insulin injector pen was sent on leave with the resident on July 27, 2018; and the NovoLog insulin injector pen was sent on leave of absence with R80 on July 17, 19, and 27, 2018. The August 2018 MAR indicated the facility had sent meds with the resident on therapeutic leave: Oxycodone was sent with R80 on August 1, 2, 4, 6, 7, 8, and 9, 2018, the Lantus insulin injector pen was sent on leave of absence with the resident on August 2, 2018; the NovoLog insulin injector pen was sent on leave of absence with the resident on August 2, and 8, 2018. Review of R80's record revealed no assessment of the resident's ability to self-administer medications, nor orders from the physician for the resident to self-administer any medications.	F 554	Medicare and Medical Assistance programs. These written responses do not constitute an admission of non-compliance with any requirement or an agreement with any findings. We wish to preserve the right to dispute these findings in their entirety should any remedies be imposed without jeopardizing the right to challenge the validity of the F-Tags and without admitting that any non-compliance with this regulation exists. We have implemented the following measures: It is the policy of Ramsey County Care Center to ensure the residents have the right to self-administer medications if the interdisciplinary team, as defined by 483.21 (b)(2)(ii), has determined this practice is clinically appropriate. RN completed a self-administration of medication assessment (SAMS) for R80, prior to the exit of the state survey team. Nurse managers reviewed Release of Responsibility and Event Calendar logs to identify all residents who have left facility for therapeutic leave of absence or medical appointments since June 1, 2018. The individual records of the identified residents are being reviewed to determine if a SAMS was current and up to date, needed to be completed, or required further review/update. By October 5, 2018 all residents that have left the facility for a therapeutic leave of absence or medical appointment within the past 90 days will have a current SAMS per facility		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245352	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/10/2018
NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109		
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F 554	Continued From page 2 During interview on 8/8/18 at 2:25 p.m., registered nurse (RN)-B, the nurse manager for R80's unit, stated she was unsure whether R80 had an assessment for self-administration of medications. When interviewed again, on 8/10/18 at 10:50 a.m., RN-B verified R80 had not previously had a self-administration of medication assessment completed, and stated she'd asked a nurse to complete one "yesterday (8/9/18)". RN-B stated the assessment had been completed and verified R80 was shown capable of self-administering insulin and oral medications. RN-B confirmed R80 had taken insulin and oxycodone with him during therapeutic leaves from the facility. When RN-B was asked by the surveyor about physician approval for R80 to self-administer medications, RN-B stated the process was to complete the self-administration of medication assessment first, then provide the assessment information to the physician, to obtain the self-administration of medication order. RN-B confirmed there was no physician order for R80 to self-administer medications yet. The facility's policy for Self Administration of medications, dated 11/3/16, included: "1...e. Those requesting to self-administer medications will be assessed by the interdisciplinary team members as to ability to perform this task within twenty-one-(21) days of admission. II. Assessment a. The licensed nurse will initiate the Assessment for Self-Administration of Medications in the resident/patient Electronic Health Record (EHR). b. A Physician's Order is required for specific medications that are self-administered."	F 554	policy and procedure. The facility policy and procedure for Medications: Self Administration was reviewed and revised to require the SAMS be completed for all new residents within 21 days of admission. The nurse managers will be responsible to initiate the SAMS for all current residents during their next MDS assessment period and all new admissions. All licensed nurses will be re-educated on this policy and procedure update by October 5, 2018. Nurse Manager or designee will complete random weekly SAMS Audits. All findings will be reviewed by the Quality Assurance Committee to determine the frequency for future audits. Person responsible: DON or designee		

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F 561 F 561 SS=D	Continued From page 3 Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f) (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 4 residents (R89, R111 and R125) reviewed for preferences related to care, had been given choices related to bathing preferences.	F 561 F 561	It is the policy of Ramsey County Care Center to ensure the resident has the right to self-determination and the facility must promote and facilitate resident self-determination through support of resident choice.		10/5/18

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F 561	Continued From page 4 Findings include: R89's most recent Minimum Data Set (MDS) assessment dated 6/25/18, indicated R89 was moderately cognitively impaired and required physical assistance from one staff to bathe. During interview with R89 on 8/6/18 at 7:02 p.m., R89 stated she would like to bathe at least two-three days each week, but was currently only scheduled to have a bath once a week. R89 stated, "There are so many people here they have to go by their schedule." R89 stated no one had ever asked her how many times she would like a bath each week. The Transitional Care NAR [nursing assistant] assignment sheet, indicated R89 was scheduled for a bath on Fridays. A bathing report, dated 6/25 to 8/9/18, indicated R89 had received staff assistance with bathing weekly: 7/6, 7/13, 7/20 and 8/3/18. R111's most recent MDS, dated 7/3/18, revealed R89 was cognitively intact. R111 required assistance of one staff to transfer, in order to bathe. During interview on 8/6/18, at 4:41 p.m. R111 stated he was only allowed one shower a week. R111 stated he had told staff he wanted two to three showers a week, but was currently only receiving one shower each week. A bathing report, dated 6/26 to 8/10/18, indicated R111 had received staff assistance with bathing weekly: 6/28, 7/5, 7/19 and 8/2/18.	F 561	Bathing preferences were reviewed with R89, R111, and R125. Ramsey County Care Center has informed residents of their right to self-determination for individual preferences and choices related to bathing. This right was also reviewed with current residents and resident representatives at the Neighborhood Meetings and The Friends and Family Connection on September 12, 2018. The comprehensive nursing admission assessment has been updated to include a section designated to resident bathing preferences. The Things to Know informational document is reviewed with all residents/resident representatives upon admission, and has been updated in order to notify new admissions of this right. Social Service staff are responsible for reviewing the Things to Know document with residents/resident representatives. Social Service staff were re-educated regarding this update on September 12, 2018. Nursing staff will be re-educated on this right and educated on the updates to the Admission Assessment by October 5, 2018. To sustain this practice nurse manager or designee will review preferences and choices related to bathing with residents and families during weekly care conferences and chart their preferences.		

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F 561	Continued From page 5 The transitional care NAR Assignments form, undated, revealed R111 was scheduled for bathing on Thursdays. R125's most recent MDS, dated 7/17/18, revealed R125 was cognitively intact and required staff assistance with set up for bathing. On 8/7/18, at 8:36 a.m. R125 reported she was not getting as many showers as she wanted each week. R125 stated "I would rather shower everyday. You can't. Everyone else needs to shower." However, R125 stated she felt "it would be reasonable for the staff to help with two to three showers each week." The Transitional Care NAR Assignments, undated, indicated R125 was scheduled to bathe on Mondays. The bathing report, dated 6/11 to 8/9/18, indicated staff had provided R125 assistance with bathing: 6/11, 6/18, 6/25, 7/2, 7/10, 7/16, 7/23, 7/30 and 8/5/18. On 8/9/18 at 1:40 p.m. the transitional care registered nurse manager (RN)-B, confirmed there was no system to determine, and document, resident bathing preferences. RN-B stated residents were assigned a weekly bath day without being asked how frequently they wanted to be bathed. The facility's policy, Bathing: Bed Bath, Shower, Apollo Tub, MasterCare Tub, ARJO Shower Chair revised 8/24/04, indicated: "Residents are offered a tub bath at least weekly to promote optimum hygiene. The facility will honor and accommodate resident specific requests for timing, frequency	F 561	Person responsible: DON or designee		

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F 561	Continued From page 6 and type of bathing".	F 561			
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to conduct a thorough investigation related to an allegation of rough treatment for 1 of 1 resident (R95) reviewed for abuse and mistreatment. Findings include: An Incident Report submitted to the State agency dated 7/24/18, revealed concerns from R95's family member (F)-A indicating "she felt staff members were being 'rough' with cares causing [R95] increased pain."	F 610	It is the policy of Ramsey County Care Center to provide residents with a safe and secure environment free from maltreatment and thoroughly investigate all allegations of abuse and maltreatment. R95 has discharged from the facility. Investigations in progress and new investigations in response to allegations of abuse or maltreatment have included interviews of 5 other residents who may have experienced or been impacted by the alleged behavior.		10/5/18

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F 610	Continued From page 7 An investigation report, submitted to the State agency dated 7/31/18, revealed R95 was admitted to the facility on 6/25/18, following hospitalization for a fractured right shoulder. The report indicated R95 would complain of pain with movement, and indicated a follow up interview with (F)-A on 7/26/18, where she expressed concerns including: "staff did not know how to transfer or position [R95] and that she had to show staff." Investigative documents revealed interviews had been conducted with three staff, all from the same shift. Only two nursing assistants (NAs) had been interviewed, NA-B and NA-C, who had worked with R95 on 7/24/18. There was no evidence the nursing assistants had been questioned regarding allegations R95 had been treated rough during cares. The investigative documents revealed no evidence other residents or resident representatives were interviewed to determine whether there were any similar concerns of "rough" treatment by staff. In addition, there were no further observations documented to determine whether staff were able to competently transfer or position other residents with similar needs on the same unit, and no evidence staff had attempted to interview R95. On 8/9/18 at 2:24 p.m., the registered nurse manager (RN)-B confirmed R95's family member (F)-A had reported staff were rough with R95, causing her pain when she was moved. RN-B stated R95 had been admitted following a shoulder fracture that would make movement with cares very difficult and painful, despite interventions put in place by the facility. RN-B reported she had documented interviews with the staff that had worked with the R95 on 7/24/18. RN-B stated although she had interviewed other staff, she had not documented those interviews.	F 610	The Investigative Process defined in the Resident Abuse Prevention Plan has been expanded to include the following: interviews of 5 other residents who may have experienced or been impacted by the alleged behavior; that additional residents may need to be interviewed depending on the circumstances. The DON or designee will continue to review all OHFC Incident Report Investigations and will ensure that the interviews are completed. The Incident Report Checklist will serve as the audit tool for the reviews. All findings will be reviewed by the Quality Assurance Committee. All licensed nurses will be re-educated on this policy and procedure update by October 5, 2018. Person responsible: DON or designee		

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F 610	Continued From page 8 RN-B reported F-A did not report a time frame when the rough treatment was occurring so she had focused on the date the allegation was made, 7/24/18. RN-B further verified she had not interviewed or observed other residents on the unit to determine whether they had experienced any rough treatment. 08/9/18 at 2:42 p.m. the director of nursing (DON) was interviewed and stated staff were supposed to follow guidelines specified in the facility's abuse prohibition policy when conducting investigations related to allegations of rough treatment. The DON also stated all interviews completed with staff and residents related to an allegation of rough treatment should have been documented. The facility's Resident Abuse Prevention Plan dated 11/2016, included: "Investigation Procedures: 1. After ensuring resident health and safety, and after the initial report is made, the nursing supervisor will interview staff involved, to gather factual information, document the investigation in writing, request staff involved to write their account of the event, and request them to sign and date the documentation. 2. The nursing supervisor or designee will interview any and all residents involved in the incident, as well as those residents who may have been impacted by the alleged behavior resulting in the investigation. 3. The nursing supervisor or designee will interview any and all other individuals who may have witnessed, been told of or otherwise have information about the alleged incident, including family members, vendors, volunteers and visitors. 4. The nursing supervisor or designee will identify all documentation to be reviewed as part of the investigation, obtain the	F 610			

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F 610	Continued From page 9 same and review it to determine (a) what occurred, (b) whether staff followed facility policies and procedures and (c) whether staff followed residents' care plans. 5. The nursing supervisor or designee will report his or her findings to the Director of Nursing. Together, they will determine if further investigation is needed."	F 610			
F 625 SS=B	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625			10/5/18

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F 625	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure bed hold information was provided to 2 of 2 residents (R82, R124) reviewed for hospitalization. Findings include: During an interview on 8/6/18, at 5:15 p.m., R82 recalled being hospitalized in June , however, was unable to recall receiving information regarding a bed hold. R82 stated when she'd returned, she did return to the same room. Review of R82's progress notes from 1:25 p.m. 6/26/18, indicated a staff registered nurse (RN)-F had spoken to a triage nurse line whereby it had been decided to send R82 to the hospital for evaluation and treatment of shortness of breath. The progress notes indicated R82 was transferred to the hospital on 6/26/18 and returned on 6/30/18. On 8/8/18, at approximately 10:00 a.m. the unit social worker (SW)-C, stated the nursing department handled all paperwork for bed holds. On 8/8/18, at 12:58 p.m. RN-E stated the facility's bed hold procedure was for bed hold information to be provided at the time of admission for all residents. RN-E stated the information was initialed by family members and placed in the medical record. Then when residents are sent to the hospital, the facility would send bed hold information with the patient as part of the paperwork. RN-E verified the nursing staff used a worksheet to check off what was sent with the resident when transferred to a hospital. RN-E	F 625	It is the policy of Ramsey County Care Center to provide a written notice regarding bed-hold information for persons transferring to a hospital or for a therapeutic leave. The Bed-Hold/Readmission Policy and procedure has been updated. The Business Office will send out a written letter informing resident representatives of the bed hold policy. Licensed Nurses, Social Workers and the Business Office representatives will be re-educated on the policy and procedure by October 5, 2018. The process of providing a written notice at the time of transfer will be audited on all transfers out of the care center for 4 weeks. Audit results will be reviewed with the Quality Assurance Committee to determine the need and frequency of future audits. Person Responsible: Medical Records Technician		

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F 625	Continued From page 11 provided a copy of the worksheet staff utilized, it was a form where staff could check off what had been done, but was not retained in the medical record. RN-E verified the medical record lacked documentation of bed hold information being provided to R82 or family when R82 was transferred to the hospital. A progress note dated 6/28/18, indicated R124 had fallen and broken the right leg, requiring transport to the hospital. The note further indicated R124's family member (FM) had been informed, and indicated "all papers sent with paramedics." However, the progress notes lacked evidence of the facility providing or attempting to inform R124 or the responsible representative of bed hold information at the time of transfer to the hospital. During an interview on 8/9/18, at 3:52 p.m. R124's FM was unable to recall receiving bed hold notice information when R124 was sent to the hospital. During an interview on 8/10/18, at 9:49 a.m. RN-A stated, "medical assistance residents are automatic bed holds, it is included with the packet sent to the hospital and faxed to the Ombudsman that same day." However, RN-A verified the progress notes did not reflect this had occurred. On 8/10/18, at 12:13 p.m., RN-A indicated she was still searching for documentation regarding bed hold transmittal to the Ombudsman. The facility's Bed Hold policy dated 4/6/17, included:... "At the time of a transfer to a hospital this form is sent with the resident... Social services, or designee, will document in the	F 625			

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F 625	Continued From page 12 medical record regarding the choice of a bed hold for those individuals not on medical assistance. After explaining the bed hold charges to the resident or their representative their response will be documented in the electronic health record (EHR). If on medical assistance the 18-day bed-hold will be initiated, unless resident or resident representative have indicated otherwise."	F 625			
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to plan and implement a meaningful activity program based on resident preferences in the activity assessment for 1 of 2 residents (R81) reviewed for activities. Findings include: R81 was not observed out of bed, or to participate with activities during any hours of the survey. On 8/7/18, at 11:09 a.m. R81 was observed in bed, asleep. R81 had not been seen out of bed	F 679	It is the policy of Ramsey County Care Center to provide person centered activities. Staff are expected to provide this for all residents based on their interests and abilities. R81 was receiving hospice services at the time of the survey and has since passed on. By 10/5/2018 the Resident Services Director (RSD)/Activity Director Certified (ADC) will audit all Lifestyle Assessments, care plans and documentation for all		10/5/18

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F 679	Continued From page 13 all morning. On 8/8/18, at 10:23 a.m. R81 was observed in bed. During a follow-up observation, at 2:28 p.m. R81 was observed in bed, asleep. On 8/9/18, at 11:43 a.m. R81 was observed asleep in bed. During a follow-up observation, at 1:49 p.m. R81 was in bed. At 3:35 p.m. R81 was observed in bed. The television was on. The resident did not appear to be watching as R81's eyes were closed, then briefly opened, flickered around the room, and closed again. Review of R81's medical record revealed R81 had been at the facility for many years, with the most recent admission in 2012. The medical record indicated R81 had diagnoses with the potential to affect independence and mobility, mood, and vision, including but not limited to: multiple sclerosis (MS), paraplegia, contractures, dementia, bipolar disorder, cataracts, and glaucoma. Review of R81's most current Lifestyle Assessment, effective 6/12/18, revealed an interview for activity preferences. The interview indicated it was "Very important" to R81 to listen to music R81 liked, which included classical music, and Mozart. The interview noted it was very important to be around animals, as R81 had pets at home, and grew up around animals. R81 had also responded it was very important to do things with groups of people, and very important to do favorite activities. Hobbies R81 listed as having enjoyed in the past included: a love of music, with history of both listening and performing, and also attending church groups. The assessment also noted R81 enjoyed the	F 679	residents who score a 7 or below on the Brief Interview for Mental Status (BIMS), which indicates severe cognitive impairment, and residents whose BIMS is completed by a staff assessment. Care plans will be updated as needed to reflect person centered interests/activities. Activity Programming policy and procedure was updated on 8/17/18 and all Activity Coordinators were re-educated on 8/23/18. By 10/5/18 all Nursing Assistants and Licensed Nurses will be re-education on the importance of following the activity care plan and assisting residents to preferred activities. The results of the audits will be presented to the Quality Assurance Committee for review. Based on the review it will be determined if further audits are needed. Responsible Person: Resident Services Director or designee		

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F 679	Continued From page 14 smell of flowers, and liked to have flowers around. The undated care plan printed from the current electronic medical record, included a section about activities: "[R81] has a potential for altered activity attendance/participation [related to] MS, impaired mobility, physical limitations. Enjoys church- goes to [R81's] community church most Sundays and frequently on Wednesdays. (no Wed. during summer as Bible study doesn't meet)". The activity goal identified was: "have spiritual needs met through going out to church on Sundays with [R81's spouse]." The interventions listed were as follows: "Assess for ongoing activity needs/preferences, as needed", "Invite, encourage and escort, as needed, to activities of interest such as protestant services", "Seat near speaker/group leader, as needed", "Support and encourage family involvement/visits". The care plan did not incorporate the information learned during the most recent Lifestyle Assessment, such as a love for music, fresh flowers, or animals. Review of the activity attendance report run 8/10/18, at 10:57 a.m. revealed: -August 2018: R81 was marked as "not available" for one music group, physical activity, resident council, and spiritual care activity. Documentation revealed the facility had provided music and a hand massage once. -July 2018: R81 was documented as observing trivia twice, and current events once. R81 sat in a social area three times, and went to the beauty shop once. The facility provided a hand massage. There was no documentation of music, and the facility documented R81 as not available for spiritual care three times.	F 679			

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F 679	Continued From page 15 During interview on 8/9/18, at 3:15 p.m. nursing assistant (NA)-B said R81 did not really do much for activities. NA-B said when R81 was in bed, NA-B tried to turn on the TV or radio or something, just so it was not dead silent, but NA-B was not sure if R81 truly watched or listened. NA-B stated the priority was R81's skin. NA-B said R81 had very sensitive skin and they did not like R81 to be up in a wheelchair for long because of how sensitive R81's skin was. Sometimes NA-B worried about getting R81 up in a chair, because if the facility was short staffed that day, R81 might not get back in bed in time before R81's skin would begin to break down. During interview on 8/10/18, at 9:13 a.m. social worker (SW)-D explained that R81 did go out on many Sundays with a spouse, but other than that, SW-D guessed that R81's activity attendance sheets would be blank. SW-D explained trying hand massages in the past, but was not sure if R81 liked it, so wanted to try again. SW-D had ideas to try using essential oils. SW-D explained that R81 was tube fed currently, but was not in the past, so R81 used to already be up and eating in the day room, which made it easier to involve R81 in activities. SW-D knew spiritual life was important to R81, and had the idea to see that the resident was up on Fridays to attend the protestant service if R81 desired. SW-D reviewed the most recent Lifestyle Assessment and noted that classical music was listed as being important to R81, and made a note to try some music on a personal listening device. SW-D said the staff should have taken the information from the Lifestyle Assessment to glean what was important to the resident, and pull that information into the care plan and goal planning. SW-D noted that the	F 679			

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F 679	Continued From page 16 assessment mentioned R81 enjoyed fresh flowers, and thought that could be something they could incorporate into R81's care plan as well. SW-D described walking by R81 twice the day before, and noticed R81 was in bed both times. SW-D said after seeing R81 in bed twice, she wanted to take another look at R81's activities and Lifestyle Assessment, because there seemed to be more things R81 enjoyed doing in the past. An undated, untitled activity policy and procedure included: "It is the policy of Ramsey County Care Center to provide person centered activities" and that these activities meet the resident's physical, mental, spiritual and psychosocial well-being. The procedure referenced activity programming provided seven days a week, including evenings, and weekends, and that programming was to be tailored to individual interests and abilities, whenever possible. In the Ongoing Lifestyle Assessments procedure, dated 6/12/18, "Information is used to identify and invite residents to activities of interest, volunteer opportunities independent leisure activities and community outings."	F 679			
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684			9/21/18

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F 684	Continued From page 17 by: Based on interview and document review, the facility failed to ensure respond to a resident's health related complaint in a timely manner for 1 of 1 resident (R117) who expressed concerns about her cardiac status. Although the facility has since implemented corrective action, R117 experienced actual harm, including anxiety and lengthy hospitalization, when staff failed to provide her with immediate care. Findings include: During an intial interview with R117 on 8/6/18 at 6: 37 p.m., R117 reported when she was living on the long term unit, she'd told a nurse she was having a heart attack and the nurse had responded, "No, you're not. You're talking to me" and had only provided R117 with a warm towel. R117 then stated the following night she'd told another nurse she was having a heart attack and did not feel she received a timely response so she'd called 911 for assistance and was in the hospital for several weeks due to heart problems. R117's Minimum Data Set (MDS) assessments dated 4/25/18 and 7/4/18, revealed R117 was cognitively intact. A review of R117's progress notes revealed an entry documented by licensed practical nurse (LPN)-D at 7:18 a.m. on 5/18/18. The note included: "Pt (patient) blood sugar at 1:45 a.m. (morning) 371 1 (one) unit [insulin] given per order. Pt c/o (complained of) pain to the theft had [sic-left hand] and thinks she is having a heart attack. VS (vital signs) T97.7 (temperature Fahrenheit), P89 (pulse 89 beats per minute), RR 18 (respirations per minute), B/P 157/97 (blood	F 684	Past noncompliance: no plan of correction required.		

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F 684	Continued From page 18 pressure), SATS 97 % RA (oxygen saturations on room air). Pt is alert and oriented, warm towel given with good effect. Pt reminded not to cover the A-qua K (heated water pad for comfort) with pillow for good effect. Pt slept well after." Prior notes from that night indicated the resident had received 1 unit of Humalog insulin during the night for the elevated blood sugar at 1:46 a.m. In addition, the notes indicated the resident had received Zofran 4 mg (milligrams) at 3:35 a.m. for c/o nausea which was recorded as effective, and the patient had stated she felt better. According to the record, the resident had gone to dialysis on the morning of 5/18/18. R117's Pretreatment Data Collection & Assessment report from 5/18/18, included no signs or symptoms of cardiac distress: "T. 97.6, R. 12, GI (gastrointestinal) no complaints, Cardiac (pulse) 59, Edema No visual, Mental Alert, Mobility WC (wheelchair)"...Per patient report to dialysis nurse: "Pt had shoulder pain and hand pain in the middle of the night till around 4 AM. Pt states had this pain before and it has coincided with MIs (myocardial infarction also known as heart attack). Pt stated she'd told N.H. (nursing home) RN (registered nurse) and was ignored. No pain at this time. Will monitor." The resident was at dialysis until just after 3 p.m. on 5/18/18. During R117's dialysis, there were no concerns identified related to the resident's cardiac status. The next nursing progress note for R117 dated 5/18/18 was recorded at 22:01 (10:01 p.m.), and was documented by LPN-C: "Resident claimed of symptoms of heart attack, at 9:30 p.m. Writer check [sic] her vital signs and it was 136/80 [B/P], temp 98.4, p 90, O2 sat 98% on RA. She had her regular medication with Oxycodone at 8 p.m.	F 684			

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F 684	Continued From page 19 She went for dialysis today and came back at 5 p.m., blood sugar level 311 at PM (evening) and 540 at HS (hour of sleep). Writer called the on-call [physician] at 9:45 p.m. after initial assessment, by the time on-call returned the writer's call, it was 10 p.m. Writer was on the other call with other health care provider. The supervisor picked it up and by the time writer was ready, the doctor had already dropped the phone. Writer went to the resident and explained that he is still expecting the order to send her to hospital. Resident said 'I will call 911 by myself if you don't call.' Finally [physician] gave the order to send her to hospital. She [R117] had already called 911 before that. She left on the stretcher with the paramedics. She showed no respiratory distress. She left at 10:10 p.m." R117's record indicated she'd originally been admitted 6/7/16 with diagnoses including: Diabetes, Chronic Kidney Disease, Hypertension, Coronary Artery Disease and Anxiety. In addition, the record indicated the resident had a history of numerous hospitalizations. At the time of a readmission 10/17/17, R117's diagnosis history included: coronary artery disease, NSTEMI (Non-ST-elevation myocardial infarction) in August 2017, ESRD (end-stage renal disease), HTN (hypertension) and DMI (diabetes mellitus type 1). The hospital discharge summary dated 6/27/18, indicated the resident's primary diagnoses included: 1. Coronary artery disease, unstable angina, NSTEMI. 2. S/P (status post) CAB (coronary artery bypass) 5/31/18. 3. Severe aortic stenosis. Secondary diagnoses: 1. Ischemic cardiomyopathy with severe left ventricular dysfunction. Hx multiple coronary	F 684			

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F 684	Continued From page 20 stent placements. 2. Type 1 diabetes mellitus. 3. End-stage renal disease on hemodialysis. 4. Failed kidney transplant. 5. Occlusive right IJ DVT (internal jugular deep vein thrombosis), 4 weeks coumadin therapy...6. Post-op confusion, resolving, likely metabolic encephalopathy due to acute liver injury. 7. HTN. 8. Hypothyroidism. At the time of discharge, the resident's code status was identified as Full Code. R117's hospitalization documentation from her 5/19 to 6/27/18 stay further included: "72 year old female with PMHx (prior medical history) most significant for coronary artery disease and ischemic cardiomyopathy with EF (Ejection fraction) of 30-35%, admitted to cardiology service after presenting with chest pain." (Ejection fraction refers to the amount, or percentage, of blood that is pumped (or ejected) out of the ventricles with each contraction. 35% and below is considered low.) "Patient has an extensive cardiac history and presents with chest pain; and found to have elevated troponin (elevated troponin can be an indicator of cardiac event)." The history of present illness notes indicated: "She was in her usual state of health until about midnight (5/18/18) when she developed right-sided chest pain, radiating up her shoulder and referred to her right palm. She was in bed at the time this pain started. Pain had resolved by morning, by which time she had a bout of nausea that improved with Zofran. She denies having any dyspnea (sudden shortness of breath), orthopnea (shortness of breath while lying flat), sweating, or lightheadedness during this episode. Pain did not recur with activity. She felt well enough to go to dialysis which was without complications. At about 8 PM that same day, pain recurred, located in same area, but this	F 684			

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F 684	Continued From page 21 time radiating into her back and left elbow. Nausea did not recur, but she did notice that she felt a bit warm. The second episode of chest pain occurred while she was in bed as well. She denies any headaches, lightheadedness to this episode as well. Patient has no cough, no fever or chills, no abdominal pain, no changes in bowel movements. She is compliant with all her medications. Patient states that with all the episodes of cardiac events she has had, chest pain has been different in character and location. On arrival to the ED (emergency department), she is chest pain free, and was found to have troponin of >3." R117 discharged from the hospital on 6/26/18 after having a coronary bypass grafting x 3 and endoscopic vein harvest. R117's care plan last revised 7/30/18, included: "[R117] has an alteration in health management r/t (related to) diabetes, hypertension, chronic kidney disease, CABG x 4 (coronary artery bypass graft, a type of surgery that improves blood flow to the heart), pulmonary HTN." The goal was "[R117's] vital signs will remain within normal limits through next review date to promote optimal health" Interventions included: "Medications and treatments per orders. Observe for effectiveness and for side effects." ; "Observe for progression of chronic disease and acute illness."; "POLST (provider order for life sustaining treatment; the POLST dated 10/17/17, indicated the resident wanted CPR and full medical treatment) on file." ; "Update MD/NP (medical doctor/nurse practitioner), as needed."; and "Vitals/weights/labs per order." On 8/8/18 at 8:53 a.m., the director of nursing stated he'd spoken with LPN-D on the evening of 8/7/18 regarding the resident's status 5/18/18.	F 684			

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F 684	Continued From page 22 The DON reported LPN-D had stated she'd asked R117 if she wanted to go to the hospital on 5/18/18 and R117 had refused and reported she wanted to go to dialysis. The DON verified LPN-D's documentation did not reflect this conversation. The DON stated LPN-D should have reviewed the care plan and discussed the situation with the RN supervisor since R117 was experiencing a change in condition, to help determine if it was necessary to notify the physician. The DON verified documentation did not reflect this had been done either. On 8/8/18, at 9:49 a.m., the surveyor attempted to call RN-I, the night nurse supervisor from 5/18/18, and RN-J, the day nurse from 5/18/18, without response. During interview with LPN-C on 8/8/18 at 3:00 p.m., LPN-C stated on 5/18/18, R117 had reported to both he and the RN supervisor she thought she was having a heart attack. LPN-C reported he took R117's vitals and stated R117 had not shown signs and symptoms of a heart attack such as chest pain. LPN-C reported he'd called the on call physician for an order for R117 to go to the hospital. LPN-C acknowledged that due to many calls coming in that evening, there was a delay in reaching the physician. LPN-C reported the nurse supervisor followed up with him and shortly thereafter emergency services staff arrived to take R117 to the hospital. LPN-C stated he knew he had the authority to call 911 if there was an emergency, but was hesitant because R117 was not reporting classic symptoms such as chest pain. However, LPN-C stated when R117 had stated she'd had those same symptoms a few years ago before a heart attack he'd believed her. LPN-C stated R117 was anxious and also stated he'd not been informed that R117 had reported having heart attack	F 684			

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F 684	Continued From page 23 symptoms earlier that day which would have been useful information. On 8/8/18, at 11:18 a.m, R117's physician (MD)-A reported he'd found out after R117 was hospitalized that she'd felt she was having a heart attack. MD-A stated when residents had concerns after hours, typically the on-call physician was called. MD-A reported staff should have assessed whether R117 was having chest pain, documented that and documented whether the on call physician had been notified. MD-A also stated R117 was a reliable reporter and felt the statement made to the hospital was accurate, but stated he could not determine whether staff had responded to R117's concern in a timely manner. During interview with LPN-D on 8/9/18 at 7:50 a.m., LPN-D reported on 5/18/18, R117 had reported she was having pain in her back, so she'd initially told her to use the Aqua-K pad without the pillow and had provided R117 with a warm towel. LPN-D stated she had assessed R117's vitals, and had asked her if she was short of breath or had chest pain. LPN-D stated R117 had told her she did not. LPN-D also stated R117 had not appeared clammy. LPN-D acknowledged R117 had stated she was going to have a heart attack. LPN-D stated R117 had received a bath and gotten ready for the day. LPN-D added, "if she was having pain she would not have gotten a bath." LPN-D further confirmed she had not reported to the nurse manager about R117's complaints because she saw R117 talking to the nurse manager and had assumed R117 had likely reported the pain to the nurse manager. LPN-D then stated R117 had left for dialysis that day and added, "[R117] was ok. She left on foot. If she was not ok, she would have left on a stretcher." LPN-D acknowledged she had not communicated to the dialysis staff R117's complaints of feelings	F 684			

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F 684	Continued From page 24 from the previous night shift, about her feeling like she was having a heart attack, but stated she had reported R117's concerns to the oncoming shift. LPN-D reiterated she had not reported the concerns to the physician or dialysis. A review of the facility follow up for this event, included interviews with the evening building charge, RN-K and the LPNs. Documentation of coaching sessions with LPN-C and LPN-D which occurred 5/23/18 were provided. Retraining and education regarding what to report to the physician, and how to obtain emergency care was reviewed. In addition RN-K had been interviewed. RN-K had reported she'd heard R117 report she had chest pain. RN-K's report further indicated both RN-K and LPN-C had asked R117 about pain and LPN-C had checked R117's vitals. When RN-K saw LPN-C was waiting for an order, RN-K informed LPN-C he did not need to wait for an order to call 911. However, RN-K reported R117 had already called 911, and the ambulance arrived. An undated written statement by RN-J, indicated she had not been informed of any information related to R117 by LPN-C or any night shift staff. Additional education provided for review indicated all nursing staff had received training in February 2017 related to responding to changes in resident condition, including care for potential cardiac issues. Both LPN-D and LPN-C had signed in on the attendance record. The facility's Emergency Care policy and procedure last revised 4/16/13, included: "I. Determination of an emergency situation. Examples include but are not limited to: a. Acute, potentially life threatening medical change in condition (cardiac event, massive bleeding, sudden decrease in consciousness, profound	F 684			

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F 684	Continued From page 25 respiratory distress)." "II. Call 911 a. State nature of the emergency to the dispatcher. b. Provide facility address and phone number. c. Provide any information requested by 911 dispatcher. d. Wait until the dispatcher says the call is finished." "III. Do not leave the patient unattended. b. Provide first aid/care. Every situation is different and must be evaluated at the time to determine the priority for provision of intervention." "IV. b. Notify the health care provider and obtain order related to emergency transport of resident. If unable to reach the provider/no return call from the provider-Contact the Medical Director." "V. Document in electronic health record a. Circumstances of the emergency. b. Vital signs, neuro, and any other measurable data. c. Interventions performed by staff. d. Notification of the responsible party. e. Notification of the Health Care provider."	F 684			
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with	F 688			10/5/18

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F 688	Continued From page 26 the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a walking program was implemented on a consistent basis for 1 of 1 resident (R125) reviewed for mobility. Findings include: R125's most recent Minimum Data Set (MDS) assessment dated 7/17/18, indicated R125 was cognitively intact and did not walk during the assessment reference date. On 8/7/18, at 10:20 a.m. R125 stated during interview, staff were supposed to assist her to walk daily but that was not happening. R125 stated she didn't think there was enough staff to help her. On 8/9/18, at 9:06 a.m. R125's nursing assistant (NA)-D, stated R125 had a walking program in place for the last few months but refused to walk about half the time. Licensed practical nurse (LPN)-E confirmed at that time, R125 did have a walking program, but that she rarely saw her walk. LPN-E stated R125 was out of the building a lot and would refuse to walk because of pain. LPN-E also stated she thought R125 could still walk about 50 feet because she'd seen her walking in her room sometimes. R125's care plan last revised 8/7/18, indicated: "FMP (functional maintenance plan): Ambulate 50 ft (feet) BID (twice daily) with A1 (assist of one staff) and RW (rolling walker)."	F 688	It is the policy of Ramsey County Care Center to promote and maintain the highest functional level for all residents. R125 was referred to physical therapy to reevaluate her current walking program. Therapies determined her current walking program was appropriate. The nurse managers will audit the current walking programs in place, and initiate referrals to physical therapy as indicated. The wing nurses will observe the resident's ability to complete the recommended individualized walking program on a weekly basis. For any changes in ability a therapy screen will be initiated. All audit findings will be reviewed with the facility Quality Assurance Committee, and this information will be used to determine the frequency for ongoing audits and observation by the staff nurses. Nursing Assistants will be re-educated by October 5, 2018 regarding the use of the Stop and Watch Tool to communicate changes in ability or resident refusals to the nurse. Person responsible: DON or designee		

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F 688	Continued From page 27 R125's nursing rehab follow up report from 7/9 to 8/9/18, indicated the following: Ambulate 50 ft BID with A1 and RW Task completed: "No" or "Not applicable": 37 opportunities; "Resident Refused": 11 opportunities; "Resident Not Available": 5 opportunities; Unaccounted for: 5 opportunities Yes: 4 opportunities (all after 8/1/18). On 8/9/18 at 1:26 p.m., registered nurse (RN) manager, RN-B, verified R125 had a walking program in place. However, RN-B stated staff had stopped helping R125 walk because R125 would frequently refuse. RN-B stated R125 had indicated she still wanted to participate in a walking program, but would sometimes refuse due to pain, being busy with other tasks, or would just state she could not walk. RN-B further confirmed she had not documented a periodic review of R125's participation with her walking program in order to determine efficacy or need for revision.	F 688			
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a system for consistent monitoring of a dialysis access site for 1 of 1 resident (R117) reviewed for dialysis.	F 698	It is the policy of Ramsey County Care Center to ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive		10/5/18

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F 698	Continued From page 28 Findings include: R117's most recent minimum data set (MDS), dated 7/4/18, revealed R117 was cognitively intact and received dialysis while resident was at the facility. On 8/6/18, at 6:46 p.m. R117 reported she had a dialysis access site on her upper right chest and proceeded to show the surveyor the access site. The site appeared clean, dry and intact with no obvious issues observed. On 8/9/18 at 1:09 p.m., licensed practical nurse (LPN)-B reported she regularly checked R117's dialysis access site (right chest port) to make sure there were no issues, but did not do anything with the dressing over the site. LPN-B stated there was nowhere to document that she was checking R117's access site, but stated she would document if there was a problem. LPN-B reported checking the access site should be in the care plan as it is a standard care of for residents with dialysis access sites. On 8/9/18 at 1:32 p.m., registered nurse manager (RN)-B stated there were no directions for staff to monitor R117's access site on the care plan, or on the Treatment Administration Record (TAR). RN-B stated staff should monitor for signs of redness, inflammation or infection. RN-B stated she was responsible for development of the care plan and acknowledged monitoring of the access site should have been included on the care plan. RN-B also stated typically staff have directions to document monitoring of the site on the TAR. R117's care plan, last revised on 1/30/18, identified the problem: " ESRD [end stage renal	F 698	person-centered care plan, and the residents goals and preferences. R117's Electronic Treatment Administration Record (ETAR) was updated to include a nursing order to monitor the resident's dialysis access site routinely, and requires licensed nurse signature. The clinical records for all other residents currently receiving dialysis were reviewed to ensure that access site monitoring was being documented on the ETAR routinely. The facility has a template order set for dialysis resident and this includes directions for monitoring various types of access sites. The Admission Assessment includes a section to identify the type of access site. This has been updated to include direction to add the type of access site and appropriate monitoring to the ETAR and plan of care. To sustain this practice nurse managers will be responsible for monitoring the ETAR for new and current residents who are receiving dialysis. This practice will be reviewed by the Quality Assurance Committee. Licensed nurses will be re-educated regarding the admission assessment updates by October 5, 2018. Person responsible: DON or designee		

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F 698	Continued From page 29 disease]/DIALYSIS: [[R117] is able to comprehend need for fluid restriction, catheter access site (Rt [right] chest port), fatigue, kidney failure." Goals of care included: "[R117's] access site will remain free of infection or complications through next review date to promote adequate dialysis treatments." The interventions included: "Access site care done at dialysis." There were no directions for staff to monitor R117's access site. Review of R117's July and August 2018 TARs revealed no directions or documentation related to monitoring R117's dialysis access site. The facility's policy Dialysis: Care of Residents/Patients with Hemodialysis last revised 6/19/13, included: "Additional information to be included in the residents plan of care: i. Frequency and place of hemodialysis treatments, contact person and phone # ii. How the resident is transported to the dialysis center iii. Type and monitoring the resident's circulatory access," and "For subclavian catheter type access, the catheter will be inspected by a licensed nurse every shift to ensure that the catheter is secure and there are no signs of infection. This information will be documented on the nurses' treatment record."	F 698			
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including	F 757			10/5/18

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F 757	Continued From page 30 duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents did not utilize unnecessary medications for 1 of 5 (R97) residents reviewed for unnecessary medications, who routinely used an as needed (PRN) antihistamine without monitoring or continued evaluation of indications for continued use. Findings include: On 8/9/18, at 11:03 a.m. R97 was observed in bed. R97's arms were exposed, and observed to have reddened patches, and a few red streaks that appeared to be from recent scratching. When asked about the red marks on the forearms, R97 nodded head and motioned to the reddened areas, and confirmed they itched. R97 stated she utilized a medication called Hydroxyzine (an antihistamine). R97 said the medication helped provide itch relief, but stated	F 757	It is the policy of Ramsey County Care Center that each residents drug regimen must be free from unnecessary drugs. R97's order for an as needed (prn) antihistamine was clarified and updated to reflect a stop date. All other residents with orders for prn psychotropic medications have been reviewed to ensure stop dates are in place. Nursing tasks have been expanded to include additional documentation of resident specific symptoms. A letter was composed and sent to all facility attending providers to review the requirement for a stop date on all prn psychotropic medications.		

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F 757	Continued From page 31 she was only able to take the medication once every six hours. R97 said the nurses helped by watching the clock, and if she had not requested the medication at the time it could be given again, the nurses would stop by to see how she was feeling, and would ask whether any PRN Hydroxyzine was needed. R97's current physician orders revealed an active order initiated 6/5/18, for Hydroxyzine HCL 1 (one) 25 milligram (mg) tablet to be given by mouth every six hours as needed for itching and anxiety. Review of the medication administration record revealed R97 had regularly received Hydroxyzine: 25 times in June, 87 times in July, and 31 times so far in August (up to 8/9/18). Review of the pharmacist Consultation Reports revealed on 6/11/18, the pharmacist had noted R97 had experienced recurrent falls and had indicated the use of hydroxyzine could have been a factor. The physician had documented a response on 6/12/18 indicating only: "Continue all medications." The pharmacist Consultation Report from 7/2/18 indicated the pharmacist had recommended review of the use of the hydroxyzine. The recommendation included: Please evaluate the ongoing use of the above medications. If ...PRN orders must continue, current regulations require that the prescriber document: 1. the indication for use 2. the duration of therapy 3. the rationale for the extended time period. The physician had responded 7/3/18 indicating only: "Continue PRN orders." During interview with the assistant director of nursing (ADON) on 8/10/18 at 10:10 a.m., the	F 757	To sustained this practice the consulting pharmacist will continue to review prn psychotropic medications to ensure stop dates, and documentation supporting use. In addition the DON or designee will complete weekly audits X4 weeks on prn psychotropic medications to ensure stop date compliance. All findings will be reviewed by the facility Quality Assurance Committee, and use to determine the frequency for future audits. Nurse managers will review prn psychotropic medications for stop dates in conjunction with quarterly, annual or significant change care plan reviews. All licensed nurses will be re-educated by October 5, 2018 that the facility does not accept prn psychotropic medication orders without a stop date, and any orders given without a stop date must be immediately clarified with the attending physician. Person responsible: DON or designee		

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F 757	Continued From page 32 ADON stated, "[R97's] provider is in the building often, constantly reviewing patients, communication with the provider is very open." The ADON also stated R97's provider regularly reviewed R97's chart, and would make notes in the medical record about why the PRN Hydroxyzine was currently necessary for R97. The facility's policy: Medications: Unnecessary and Gradual Dose Reductions revised 5/31/16, included: "Purpose: it is the goal of the facility to reduce the use of unnecessary medications. Only those medications that are clinically indicated in the dose and for the duration to meet his or her assessed needs should be administered....Monitoring is the ongoing collection and analysis of information and comparison to baseline data...In determining indications for use, the following should be considered to clarify the appropriateness of initiating or continuing a medication: Whether other causes for the symptoms have been ruled out...Circumstances that warrant evaluation for the resident and medication(s) may include: ...A new, persistent, or recurrent clinically significant symptom/problem. A worsening of an existing problem or condition...An irregularity identified in the pharmacist's monthly medication regimen review..."	F 757			

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F5352026

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K 000	INITIAL COMMENTS THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.K A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Ramsey County Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC)	K 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/19/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN appenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Ramsey County Care Center is a 2-story building with no basement that was constructed in 1979 and was determined to be of Type II(222) construction. The building is fully protected throughout by an automatic fire sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 164 beds and had a census of 146 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000			
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K 372			9/7/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 372	Continued From page 2 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (code section applies) This deficient practice could affect the safety of all (28) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 8/7/2018, observations and staff interview revealed the following: We found penetration in smoke barrier above ceiling located by room 100. Penetration had wires running through a 3" hole in block wall. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 372	Fire caulk was installed to seal the penetration in the smoke barrier wall. Person Responsible: Housekeeping/Laundry Director or designee.		

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs		PROVIDER # 245352	MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	DATE SURVEY COMPLETE: 8/7/2018
NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES			
K 351	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: The facility failed to comply with Life Safety Code (19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)) This deficient practice could affect the safety of all (58) the residents, staff and visitors within the smoke compartment. Findings Include: On facility tour between 09:00 AM and 01:00 PM on 8/7/2018, observations and staff interview revealed the following: Found a fire sprinkler head not attached to the fire sprinkler system. This sprinkler head was used for a hidden camera for security. Sprinkler head is in violation of LSC 19.3.5.1, NFPA 13-3.1, MSFC 901.8. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.			

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

The above isolated deficiencies pose no actual harm to the residents



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

September 5, 2018

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

Re: Enclosed State Nursing Home Licensing Orders - Project Numbers S5352027, H5352049

Dear Mr. Robinson:

The above facility was surveyed on August 6, 2018 through August 10, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5352049. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order 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 Minnesota Department of Health State Form and are being delivered 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 or rule after the

Ramsey County Care Center

September 5, 2018

Page 2

statement, "This MN Requirement 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 contact Susie Haben, Unit Supervisor at (651) 201-3794 or at susie.haben@state.mn.us.

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,



Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00846	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 08/10/2018
NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109		
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2 000	Initial Comments *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/6, 8/7, 8/8, 8/9 and 8/10/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000			

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/21/18

Minnesota Department of Health

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2 000	Continued From page 1 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 out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. 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/info.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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	2 000		

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2 000	Continued From page 2 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.	2 000			
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by:	2 302			10/5/18

Minnesota Department of Health

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2 302	Continued From page 3 Based on record review and interview, the facility failed to provide consumers with a written or electronic notification including a description of the Alzheimer's or related disorder training program, the categories of employees trained, the frequency of training, and the basic topics covered in the training. This had the potential to affect any residents in the facility who suffered from Alzheimer's or a related disorder. Findings include: Review of the facility's undated Alzheimer's Disease/Related Disorders: Required Staff Training policy revealed: "All employees are trained in Alzheimer's Disease/Related Diseases". The policy described that this training takes place initially upon hire at orientation, and annually, and highlighted the format and content of the training (introduction to Alzheimer's disease, person centered care, communication, behaviors, safe environment, activities of daily living, problem solving, and challenges, etc.). During interview on 8/10/18, at 12:00 p.m. registered nurse (RN)-G was not sure whether consumers were given written information about the facility's dementia/Alzheimer's training, and suggested asking social worker (SW)-D. During interview on 8/10/18, at 12:10 p.m. SW-D explained that staff talked about dementia in general at the family council meetings, and said they would provide general information about dementia to residents or families with interest, but confirmed they did not provide written notice to consumers specifically about the dementia training. SUGGESTED METHOD OF CORRECTION: The	2 302	Corrected		

Minnesota Department of Health

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2 302	Continued From page 4 administrator or designee could create a document describing their staff training program, categories of employees trained and the frequency of the training, as required to provide to consumers. The administrator or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302			
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure respond to a resident's health related complaint in a timely manner for 1 of 1 resident (R117) who expressed concerns about her cardiac status. R117 sustained harm when she had chest pain, was not immediately sent to the hospital, and then required a lengthy hospital stay.	2 830	Corrected		10/5/18

Minnesota Department of Health

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2 830	Continued From page 5 Findings include: During an initial interview with R117 on 8/6/18 at 6: 37 p.m., R117 reported when she was living on the long term unit, she'd told a nurse she was having a heart attack and the nurse had responded, "No, you're not. You're talking to me" and had only provided R117 with a warm towel. R117 then stated the following night she'd told another nurse she was having a heart attack and did not feel she received a timely response so she'd called 911 for assistance and was in the hospital for several weeks due to heart problems. R117's Minimum Data Set (MDS) assessments dated 4/25/18 and 7/4/18, revealed R117 was cognitively intact. A review of R117's progress notes revealed an entry documented by licensed practical nurse (LPN)-D at 7:18 a.m. on 5/18/18. The note included: "Pt (patient) blood sugar at 1:45 a.m. (morning) 371 1 (one) unit [insulin] given per order. Pt c/o (complained of) pain to the theft had [sic-left hand] and thinks she is having a heart attack. VS (vital signs) T97.7 (temperature Fahrenheit), P89 (pulse 89 beats per minute), RR 18 (respirations per minute), B/P 157/97 (blood pressure), SATS 97 % RA (oxygen saturations on room air). Pt is alert and oriented, warm towel given with good effect. Pt reminded not to cover the A-qua K (heated water pad for comfort) with pillow for good effect. Pt slept well after." Prior notes from that night indicated the resident had received 1 unit of Humalog insulin during the night for the elevated blood sugar at 1:46 a.m. In addition, the notes indicated the resident had received Zofran 4 mg (milligrams) at 3:35 a.m. for c/o nausea which was recorded as effective, and	2 830			

Minnesota Department of Health

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2 830	Continued From page 6 the patient had stated she felt better. According to the record, the resident had gone to dialysis on the morning of 5/18/18. R117's Pretreatment Data Collection & Assessment report from 5/18/18, included no signs or symptoms of cardiac distress: "T. 97.6, R. 12, GI (gastrointestinal) no complaints, Cardiac (pulse) 59, Edema No visual, Mental Alert, Mobility WC (wheelchair)"...Per patient report to dialysis nurse: "Pt had shoulder pain and hand pain in the middle of the night till around 4 AM. Pt states had this pain before and it has coincided with MIs (myocardial infarction also known as heart attack). Pt stated she'd told N.H. (nursing home) RN (registered nurse) and was ignored. No pain at this time. Will monitor." The resident was at dialysis until just after 3 p.m. on 5/18/18. During R117's dialysis, there were no concerns identified related to the resident's cardiac status. The next nursing progress note for R117 dated 5/18/18 was recorded at 22:01 (10:01 p.m.), and was documented by LPN-C: "Resident claimed of symptoms of heart attack, at 9:30 p.m. Writer check [sic] her vital signs and it was 136/80 [B/P], temp 98.4, p 90, O2 sat 98% on RA. She had her regular medication with Oxycodone at 8 p.m. She went for dialysis today and came back at 5 p.m., blood sugar level 311 at PM (evening) and 540 at HS (hour of sleep). Writer called the on-call [physician] at 9:45 p.m. after initial assessment, by the time on-call returned the writer's call, it was 10 p.m. Writer was on the other call with other health care provider. The supervisor picked it up and by the time writer was ready, the doctor had already dropped the phone. Writer went to the resident and explained that he is still expecting the order to send her to hospital. Resident said 'I will call 911 by myself if you don't	2 830			

Minnesota Department of Health

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2 830	Continued From page 7 call.' Finally [physician] gave the order to send her to hospital. She [R117] had already called 911 before that. She left on the stretcher with the paramedics. She showed no respiratory distress. She left at 10:10 p.m." R117's record indicated she'd originally been admitted 6/7/16 with diagnoses including: Diabetes, Chronic Kidney Disease, Hypertension, Coronary Artery Disease and Anxiety. In addition, the record indicated the resident had a history of numerous hospitalizations. At the time of a readmission 10/17/17, R117's diagnosis history included: coronary artery disease, NSTEMI (Non-ST-elevation myocardial infarction) in August 2017, ESRD (end-stage renal disease), HTN (hypertension) and DMI (diabetes mellitus type 1). The hospital discharge summary dated 6/27/18, indicated the resident's primary diagnoses included: 1. Coronary artery disease, unstable angina, NSTEMI. 2. S/P (status post) CAB (coronary artery bypass) 5/31/18. 3. Severe aortic stenosis. Secondary diagnoses: 1. Ischemic cardiomyopathy with severe left ventricular dysfunction. Hx multiple coronary stent placements. 2. Type 1 diabetes mellitus. 3. End-stage renal disease on hemodialysis. 4. Failed kidney transplant. 5. Occlusive right IJ DVT (internal jugular deep vein thrombosis), 4 weeks coumadin therapy...6. Post-op confusion, resolving, likely metabolic encephalopathy due to acute liver injury. 7. HTN. 8. Hypothyroidism. At the time of discharge, the resident's code status was identified as Full Code. R117's hospitalization documentation from her 5/19 to 6/27/18 stay further included: "72 year old female with PMHx (prior medical history) most	2 830			

Minnesota Department of Health

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2 830	Continued From page 8 significant for coronary artery disease and ischemic cardiomyopathy with EF (Ejection fraction) of 30-35%, admitted to cardiology service after presenting with chest pain." (Ejection fraction refers to the amount, or percentage, of blood that is pumped (or ejected) out of the ventricles with each contraction. 35% and below is considered low.) "Patient has an extensive cardiac history and presents with chest pain; and found to have elevated troponin (elevated troponin can be an indicator of cardiac event)." The history of present illness notes indicated: "She was in her usual state of health until about midnight (5/18/18) when she developed right-sided chest pain, radiating up her shoulder and referred to her right palm. She was in bed at the time this pain started. Pain had resolved by morning, by which time she had a bout of nausea that improved with Zofran. She denies having any dyspnea (sudden shortness of breath), orthopnea (shortness of breath while lying flat), sweating, or lightheadedness during this episode. Pain did not recur with activity. She felt well enough to go to dialysis which was without complications. At about 8 PM that same day, pain recurred, located in same area, but this time radiating into her back and left elbow. Nausea did not recur, but she did notice that she felt a bit warm. The second episode of chest pain occurred while she was in bed as well. She denies any headaches, lightheadedness to this episode as well. Patient has no cough, no fever or chills, no abdominal pain, no changes in bowel movements. She is compliant with all her medications. Patient states that with all the episodes of cardiac events she has had, chest pain has been different in character and location. On arrival to the ED (emergency department), she is chest pain free, and was found to have troponin of >3." R117 discharged from the	2 830			

Minnesota Department of Health

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2 830	Continued From page 9 hospital on 6/26/18 after having a coronary bypass grafting x 3 and endoscopic vein harvest. R117's care plan last revised 7/30/18, included: "[R117] has an alteration in health management r/t (related to) diabetes, hypertension, chronic kidney disease, CABG x 4 (coronary artery bypass graft, a type of surgery that improves blood flow to the heart), pulmonary HTN." The goal was "[R117's] vital signs will remain within normal limits through next review date to promote optimal health" Interventions included: "Medications and treatments per orders. Observe for effectiveness and for side effects." ; "Observe for progression of chronic disease and acute illness."; "POLST (provider order for life sustaining treatment; the POLST dated 10/17/17, indicated the resident wanted CPR and full medical treatment) on file." ; "Update MD/NP (medical doctor/nurse practitioner), as needed."; and "Vitals/weights/labs per order." On 8/8/18 at 8:53 a.m., the director of nursing stated he'd spoken with LPN-D on the evening of 8/7/18 regarding the resident's status 5/18/18. The DON reported LPN-D had stated she'd asked R117 if she wanted to go to the hospital on 5/18/18 and R117 had refused and reported she wanted to go to dialysis. The DON verified LPN-D's documentation did not reflect this conversation. The DON stated LPN-D should have reviewed the care plan and discussed the situation with the RN supervisor since R117 was experiencing a change in condition, to help determine if it was necessary to notify the physician. The DON verified documentation did not reflect this had been done either. On 8/8/18, at 9:49 a.m., the surveyor attempted to call RN-I, the night nurse supervisor from	2 830			

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2 830	Continued From page 10 5/18/18, and RN-J, the day nurse from 5/18/18, without response. During interview with LPN-C on 8/8/18 at 3:00 p.m., LPN-C stated on 5/18/18, R117 had reported to both he and the RN supervisor she thought she was having a heart attack. LPN-C reported he took R117's vitals and stated R117 had not shown signs and symptoms of a heart attack such as chest pain. LPN-C reported he'd called the on call physician for an order for R117 to go to the hospital. LPN-C acknowledged that due to many calls coming in that evening, there was a delay in reaching the physician. LPN-C reported the nurse supervisor followed up with him and shortly thereafter emergency services staff arrived to take R117 to the hospital. LPN-C stated he knew he had the authority to call 911 if there was an emergency, but was hesitant because R117 was not reporting classic symptoms such as chest pain. However, LPN-C stated when R117 had stated she'd had those same symptoms a few years ago before a heart attack he'd believed her. LPN-C stated R117 was anxious and also stated he'd not been informed that R117 had reported having heart attack symptoms earlier that day which would have been useful information. On 8/8/18, at 11:18 a.m, R117's physician (MD)-A reported he'd found out after R117 was hospitalized that she'd felt she was having a heart attack. MD-A stated when residents had concerns after hours, typically the on-call physician was called. MD-A reported staff should have assessed whether R117 was having chest pain, documented that and documented whether the on call physician had been notified. MD-A also stated R117 was a reliable reporter and felt the statement made to the hospital was accurate, but stated he could not determine whether staff had	2 830			

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2 830	Continued From page 11 responded to R117's concern in a timely manner. During interview with LPN-D on 8/9/18 at 7:50 a.m., LPN-D reported on 5/18/18, R117 had reported she was having pain in her back, so she'd initially told her to use the Aqua-K pad without the pillow and had provided R117 with a warm towel. LPN-D stated she had assessed R117's vitals, and had asked her if she was short of breath or had chest pain. LPN-D stated R117 had told her she did not. LPN-D also stated R117 had not appeared clammy. LPN-D acknowledged R117 had stated she was going to have a heart attack. LPN-D stated R117 had received a bath and gotten ready for the day. LPN-D added, "if she was having pain she would not have gotten a bath." LPN-D further confirmed she had not reported to the nurse manager about R117's complaints because she saw R117 talking to the nurse manager and had assumed R117 had likely reported the pain to the nurse manager. LPN-D then stated R117 had left for dialysis that day and added, "[R117] was ok. She left on foot. If she was not ok, she would have left on a stretcher." LPN-D acknowledged she had not communicated to the dialysis staff R117's complaints of feelings from the previous night shift, about her feeling like she was having a heart attack, but stated she had reported R117's concerns to the oncoming shift. LPN-D reiterated she had not reported the concerns to the physician or dialysis. A review of the facility follow up for this event, included interviews with the evening building charge, RN-K and the LPNs. Documentation of coaching sessions with LPN-C and LPN-D which occurred 5/23/18 were provided. Retraining and education regarding what to report to the physician, and how to obtain emergency care was reviewed.	2 830			

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2 830	Continued From page 12 In addition RN-K had been interviewed. RN-K had reported she'd heard R117 report she had chest pain. RN-K's report further indicated both RN-K and LPN-C had asked R117 about pain and LPN-C had checked R117's vitals. When RN-K saw LPN-C was waiting for an order, RN-K informed LPN-C he did not need to wait for an order to call 911. However, RN-K reported R117 had already called 911, and the ambulance arrived. An undated written statement by RN-J, indicated she had not been informed of any information related to R117 by LPN-C or any night shift staff. Additional education provided for review indicated all nursing staff had received training in February 2017 related to responding to changes in resident condition, including care for potential cardiac issues. Both LPN-D and LPN-C had signed in on the attendance record. The facility's Emergency Care policy and procedure last revised 4/16/13, included: "I. Determination of an emergency situation. Examples include but are not limited to: a. Acute, potentially life threatening medical change in condition (cardiac event, massive bleeding, sudden decrease in consciousness, profound respiratory distress)." "II. Call 911 a. State nature of the emergency to the dispatcher. b. Provide facility address and phone number. c. Provide any information requested by 911 dispatcher. d. Wait until the dispatcher says the call is finished." "III. Do not leave the patient unattended. b. Provide first aid/care. Every situation is different and must be evaluated at the time to determine the priority for provision of intervention." "IV. b. Notify the health care provider and obtain order related to emergency transport of resident. If unable to reach the provider/no return call from	2 830			

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2 830	Continued From page 13 the provider-Contact the Medical Director." "V. Document in electronic health record a. Circumstances of the emergency. b. Vital signs, neuros, and any other measurable data. c. Interventions performed by staff. d. Notification of the responsible party. e. Notification of the Health Care provider." SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for cardiac conditions and residents on dialysis to assure they are receiving the necessary treatment/services to prevent complications. The director of nursing or designee could provide education to all licensed nurses on recognizing and responding to a cardiac event and providing care for residents on dialysis. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to better ensure management of dialysis and cardiac events. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830			
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities.	2 885			10/5/18

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2 885	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a walking program was implemented on a consistent basis for 1 of 1 resident (R125) reviewed for mobility. Findings include: R125's most recent Minimum Data Set (MDS) assessment dated 7/17/18, indicated R125 was cognitively intact and did not walk during the assessment reference date. On 8/7/18, at 10:20 a.m. R125 stated during interview, staff were supposed to assist her to walk daily but that was not happening. R125 stated she didn't think there was enough staff to help her. On 8/9/18, at 9:06 a.m. R125's nursing assistant (NA)-D, stated R125 had a walking program in place for the last few months but refused to walk about half the time. Licensed practical nurse (LPN)-E confirmed at that time, R125 did have a walking program, but that she rarely saw her walk. LPN-E stated R125 was out of the building a lot and would refuse to walk because of pain. LPN-E also stated she thought R125 could still walk about 50 feet because she'd seen her walking in her room sometimes. R125's care plan last revised 8/7/18, indicated: "FMP (functional maintenance plan): Ambulate 50 ft (feet) BID (twice daily) with A1 (assist of one staff) and RW (rolling walker)." R125's nursing rehab follow up report from 7/9 to	2 885	Corrected		

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2 885	Continued From page 15 8/9/18, indicated the following: Ambulate 50 ft BID with A1 and RW Task completed: "No" or "Not applicable": 37 opportunities; "Resident Refused": 11 opportunities; "Resident Not Available": 5 opportunities; Unaccounted for: 5 opportunities Yes: 4 opportunities (all after 8/1/18). On 8/9/18 at 1:26 p.m., registered nurse (RN) manager, RN-B, verified R125 had a walking program in place. However, RN-B stated staff had stopped helping R125 walk because R125 would frequently refuse. RN-B stated R125 had indicated she still wanted to participate in a walking program, but would sometimes refuse due to pain, being busy with other tasks, or would just state she could not walk. RN-B further confirmed she had not documented a periodic review of R125's participation with her walking program in order to determine efficacy or need for revision. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' on staff assisted walking programs, based on residents' comprehensively assessed needs. The DON or designee could conduct audits of residents on staff assisted walking programs to ensure their needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 885			
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing	21435			10/5/18

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21435	Continued From page 16 home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, record review and interview, the facility failed to plan and implement a meaningful activity program based on resident preferences in the activity assessment for 1 of 2 residents (R81) reviewed for activities. Findings include: R81 was not observed out of bed, or to participate with activities during any hours of the survey. On 8/7/18, at 11:09 a.m. R81 was observed in bed, asleep. R81 had not been seen out of bed all morning. On 8/8/18, at 10:23 a.m. R81 was observed in bed. During a follow-up observation, at 2:28 p.m. R81 was observed in bed, asleep. On 8/9/18, at 11:43 a.m. R81 was observed asleep in bed. During a follow-up observation, at 1:49 p.m. R81 was in bed. At 3:35 p.m. R81 was observed in bed. The television was on. The	21435	Corrected		

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21435	Continued From page 17 resident did not appear to be watching as R81's eyes were closed, then briefly opened, flickered around the room, and closed again. Review of R81's medical record revealed R81 had been at the facility for many years, with the most recent admission in 2012. The medical record indicated R81 had diagnoses with the potential to affect independence and mobility, mood, and vision, including but not limited to: multiple sclerosis (MS), paraplegia, contractures, dementia, bipolar disorder, cataracts, and glaucoma. Review of R81's most current Lifestyle Assessment, effective 6/12/18, revealed an interview for activity preferences. The interview indicated it was "Very important" to R81 to listen to music R81 liked, which included classical music, and Mozart. The interview noted it was very important to be around animals, as R81 had pets at home, and grew up around animals. R81 had also responded it was very important to do things with groups of people, and very important to do favorite activities. Hobbies R81 listed as having enjoyed in the past included: a love of music, with history of both listening and performing, and also attending church groups. The assessment also noted R81 enjoyed the smell of flowers, and liked to have flowers around. The undated care plan printed from the current electronic medical record, included a section about activities: "[R81] has a potential for altered activity attendance/participation [related to] MS, impaired mobility, physical limitations. Enjoys church- goes to [R81's] community church most Sundays and frequently on Wednesdays. (no Wed. during summer as Bible study doesn't	21435			

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21435	Continued From page 18 meet)". The activity goal identified was: "have spiritual needs met through going out to church on Sundays with [R81's spouse]." The interventions listed were as follows: "Assess for ongoing activity needs/preferences, as needed", "Invite, encourage and escort, as needed, to activities of interest such as protestant services", "Seat near speaker/group leader, as needed", "Support and encourage family involvement/visits". The care plan did not incorporate the information learned during the most recent Lifestyle Assessment, such as a love for music, fresh flowers, or animals. Review of the activity attendance report run 8/10/18, at 10:57 a.m. revealed: -August 2018: R81 was marked as "not available" for one music group, physical activity, resident council, and spiritual care activity. Documentation revealed the facility had provided music and a hand massage once. -July 2018: R81 was documented as observing trivia twice, and current events once. R81 sat in a social area three times, and went to the beauty shop once. The facility provided a hand massage. There was no documentation of music, and the facility documented R81 as not available for spiritual care three times. During interview on 8/9/18, at 3:15 p.m. nursing assistant (NA)-B said R81 did not really do much for activities. NA-B said when R81 was in bed, NA-B tried to turn on the TV or radio or something, just so it was not dead silent, but NA-B was not sure if R81 truly watched or listened. NA-B stated the priority was R81's skin. NA-B said R81 had very sensitive skin and they did not like R81 to be up in a wheelchair for long because of how sensitive R81's skin was. Sometimes NA-B worried about getting R81 up in	21435		

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21435	Continued From page 19 a chair, because if the facility was short staffed that day, R81 might not get back in bed in time before R81's skin would begin to break down. During interview on 8/10/18, at 9:13 a.m. social worker (SW)-D explained that R81 did go out on many Sundays with a spouse, but other than that, SW-D guessed that R81's activity attendance sheets would be blank. SW-D explained trying hand massages in the past, but was not sure if R81 liked it, so wanted to try again. SW-D had ideas to try using essential oils. SW-D explained that R81 was tube fed currently, but was not in the past, so R81 used to already be up and eating in the day room, which made it easier to involve R81 in activities. SW-D knew spiritual life was important to R81, and had the idea to see that the resident was up on Fridays to attend the protestant service if R81 desired. SW-D reviewed the most recent Lifestyle Assessment and noted that classical music was listed as being important to R81, and made a note to try some music on a personal listening device. SW-D said the staff should have taken the information from the Lifestyle Assessment to glean what was important to the resident, and pull that information into the care plan and goal planning. SW-D noted that the assessment mentioned R81 enjoyed fresh flowers, and thought that could be something they could incorporate into R81's care plan as well. SW-D described walking by R81 twice the day before, and noticed R81 was in bed both times. SW-D said after seeing R81 in bed twice, she wanted to take another look at R81's activities and Lifestyle Assessment, because there seemed to be more things R81 enjoyed doing in the past. An undated, untitled activity policy and procedure included: "It is the policy of Ramsey County Care Center to provide person centered activities" and	21435			

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21435	Continued From page 20 that these activities meet the resident's physical, mental, spiritual and psychosocial well-being. The procedure referenced activity programming provided seven days a week, including evenings, and weekends, and that programming was to be tailored to individual interests and abilities, whenever possible. In the Ongoing Lifestyle Assessments procedure, dated 6/12/18, "Information is used to identify and invite residents to activities of interest, volunteer opportunities independent leisure activities and community outings." SUGGESTED METHODS OF CORRECTION: The activity director or designee could develop, review, and /or revise policies and procedures for individualized activities and provide education to the staff. The activity director or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435			
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in	21535			10/5/18

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21535	Continued From page 21 part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure residents did not utilize unnecessary medications for 1 of 5 (R97) residents reviewed for unnecessary medications, who routinely used an as needed (PRN) antihistamine without monitoring or continued evaluation of indications for continued use. Findings include: On 8/9/18, at 11:03 a.m. R97 was observed in bed. R97's arms were exposed, and observed to have reddened patches, and a few red streaks that appeared to be from recent scratching. When asked about the red marks on the forearms, R97 nodded head and motioned to the reddened areas, and confirmed they itched. R97 stated she utilized a medication called Hydroxyzine (an antihistamine). R97 said the medication helped provide itch relief, but stated she was only able to take the medication once every six hours. R97 said the nurses helped by watching the clock, and if she had not requested	21535	Corrected	

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NAME OF PROVIDER OR SUPPLIER RAMSEY COUNTY CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109		
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21535	Continued From page 22 the medication at the time it could be given again, the nurses would stop by to see how she was feeling, and would ask whether any PRN Hydroxyzine was needed. R97's current physician orders revealed an active order initiated 6/5/18, for Hydroxyzine HCL 1 (one) 25 milligram (mg) tablet to be given by mouth every six hours as needed for itching and anxiety. Review of the medication administration record revealed R97 had regularly received Hydroxyzine: 25 times in June, 87 times in July, and 31 times so far in August (up to 8/9/18). Review of the pharmacist Consultation Reports revealed on 6/11/18, the pharmacist had noted R97 had experienced recurrent falls and had indicated the use of hydroxyzine could have been a factor. The physician had documented a response on 6/12/18 indicating only: "Continue all medications." The pharmacist Consultation Report from 7/2/18 indicated the pharmacist had recommended review of the use of the hydroxyzine. The recommendation included: Please evaluate the ongoing use of the above medications. If ...PRN orders must continue, current regulations require that the prescriber document: 1. the indication for use 2. the duration of therapy 3. the rationale for the extended time period. The physician had responded 7/3/18 indicating only: "Continue PRN orders." During interview with the assistant director of nursing (ADON) on 8/10/18 at 10:10 a.m., the ADON stated, "[R97's] provider is in the building often, constantly reviewing patients, communication with the provider is very open." The ADON also stated R97's provider regularly	21535			

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21535	Continued From page 23 reviewed R97's chart, and would make notes in the medical record about why the PRN Hydroxyzine was currently necessary for R97. The facility's policy: Medications: Unnecessary and Gradual Dose Reductions revised 5/31/16, included: "Purpose: it is the goal of the facility to reduce the use of unnecessary medications. Only those medications that are clinically indicated in the dose and for the duration to meet his or her assessed needs should be administered....Monitoring is the ongoing collection and analysis of information and comparison to baseline data...In determining indications for use, the following should be considered to clarify the appropriateness of initiating or continuing a medication: Whether other causes for the symptoms have been ruled out...Circumstances that warrant evaluation of the residnet and medication(s) may include: ...A new, persistent, or recurrent clincially significant symptom/problem. A worsening of an existing problem or condition...An irregularity identified in teh pharmacist's monthly medication regimen review..." SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policy and procedures for use of PRN psychoactive medications to ensure it includes the requirements of the federal regulations for PRN use, and could audit residents receiving PRN psychotropic medications to ensure compliance with documentation including rationale for extended use, and duration for the PRN order. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535			

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21565	Continued From page 24	21565			
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on document review and interview, the facility failed to ensure 1 of 1 resident (R80) reviewed for self administration of medications, had been appropriately assessed and deemed appropriate to self administer medications prior to doing so. Findings include: Record review revealed a physician's order dated 5/29/18, for R80 to receive Lantus insulin 8 units daily by injector pen; a physician's order dated 7/5/18, indicated R80 was to receive NovoLog insulin by sliding scale three times daily; and a physician's order dated 6/16/18, indicated R80 was to receive Oxycodone 100 mg (milligrams)/5 ml (milliliters), 0.75 ml every 3 hours for pain. R80's July 2018 Medication Administration Record (MAR) indicated the facility had sent medications with the resident during therapeutic leaves from the facility: Oxycodone was sent with R80 on July 3, 5, 6, 12, 13, 17, 19, 27, 29, and 31, 2018; the Lantus insulin injector pen was sent on leave with the resident on July 27, 2018; and the NovoLog insulin injector pen was sent on leave of absence with R80 on July 17, 19, and 27,	21565	Corrected		10/5/18

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21565	Continued From page 25 2018. The August 2018 MAR indicated the facility had sent meds with the resident on therapeutic leave: Oxycodone was sent with R80 on August 1, 2, 4, 6, 7, 8, and 9, 2018, the Lantus insulin injector pen was sent on leave of absence with the resident on August 2, 2018; the NovoLog insulin injector pen was sent on leave of absence with the resident on August 2, and 8, 2018. Review of R80's record revealed no assessment of the resident's ability to self-administer medications, nor orders from the physician for the resident to self-administer any medications. During interview on 8/8/18 at 2:25 p.m., registered nurse (RN)-B, the nurse manager for R80's unit, stated she was unsure whether R80 had an assessment for self-administration of medications. When interviewed again, on 8/10/18 at 10:50 a.m., RN-B verified R80 had not previously had a self-administration of medication assessment completed, and stated she'd asked a nurse to complete one "yesterday (8/9/18)". RN-B stated the assessment had been completed and verified R80 was shown capable of self-administering insulin and oral medications. RN-B confirmed R80 had taken insulin and oxycodone with him during therapeutic leaves from the facility. When RN-B was asked by the surveyor about physician approval for R80 to self-administer medications, RN-B stated the process was to complete the self-administration of medication assessment first, then provide the assessment information to the physician, to obtain the self-administration of medication order. RN-B confirmed there was no physician order for R80 to self-administer medications yet.	21565			

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21565	Continued From page 26 The facility's policy for Self Administration of medications, dated 11/3/16, included: "1...e. Those requesting to self-administer medications will be assessed by the interdisciplinary team members as to ability to perform this task within twenty-one-(21) days of admission. II. Assessment a. The licensed nurse will initiate the Assessment for Self-Administration of Medications in the resident/patient Electronic Health Record (EHR). b. A Physician's Order is required for specific medications that are self-administered." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review applicable policies and procedures to ensure residents' are assessed timely with self administration of medications, then inservice staff and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21565			
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such	21830			10/5/18

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21830	Continued From page 27 conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the resident's health care decisions. For purposes of this paragraph, "reasonable efforts" include: (1) examining the personal effects of the resident; (2) examining the medical records of the resident in the possession of the facility; (3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and (4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in	21830			

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21830	Continued From page 28 accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 4 residents (R89, R111 and R125) reviewed for preferences related to care, had been given choices related to	21830	Corrected	

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21830	Continued From page 29 bathing preferences. Findings include: R89's most recent Minimum Data Set (MDS) assessment dated 6/25/18, indicated R89 was moderately cognitively impaired and required physical assistance from one staff to bathe. During interview with R89 on 8/6/18 at 7:02 p.m., R89 stated she would like to bathe at least two-three days each week, but was currently only scheduled to have a bath once a week. R89 stated, "There are so many people here they have to go by their schedule." R89 stated no one had ever asked her how many times she would like a bath each week. The Transitional Care NAR [nursing assistant] assignment sheet, indicated R89 was scheduled for a bath on Fridays. A bathing report, dated 6/25 to 8/9/18, indicated R89 had received staff assistance with bathing weekly: 7/6, 7/13, 7/20 and 8/3/18. R111's most recent MDS, dated 7/3/18, revealed R89 was cognitively intact. R111 required assistance of one staff to transfer, in order to bathe. During interview on 8/6/18, at 4:41 p.m. R111 stated he was only allowed one shower a week. R111 stated he had told staff he wanted two to three showers a week, but was currently only receiving one shower each week. A bathing report, dated 6/26 to 8/10/18, indicated R111 had received staff assistance with bathing weekly: 6/28, 7/5, 7/19 and 8/2/18.	21830			

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21830	Continued From page 30 The transitional care NAR Assignments form, undated, revealed R111 was scheduled for bathing on Thursdays. R125's most recent MDS, dated 7/17/18, revealed R125 was cognitively intact and required staff assistance with set up for bathing. On 8/7/18, at 8:36 a.m. R125 reported she was not getting as many showers as she wanted each week. R125 stated "I would rather shower everyday. You can't. Everyone else needs to shower." However, R125 stated she felt "it would be reasonable for the staff to help with two to three showers each week." The Transitional Care NAR Assignments, undated, indicated R125 was scheduled to bathe on Mondays. The bathing report, dated 6/11 to 8/9/18, indicated staff had provided R125 assistance with bathing: 6/11, 6/18, 6/25, 7/2, 7/10, 7/16, 7/23, 7/30 and 8/5/18. On 8/9/18 at 1:40 p.m. the transitional care registered nurse manager (RN)-B, confirmed there was no system to determine, and document, resident bathing preferences. RN-B stated residents were assigned a weekly bath day without being asked how frequently they wanted to be bathed. The facility's policy, Bathing: Bed Bath, Shower, Apollo Tub, MasterCare Tub, ARJO Shower Chair revised 8/24/04, indicated: "Residents are offered a tub bath at least weekly to promote optimum hygiene. The facility will honor and accommodate resident specific requests for timing, frequency	21830			

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21830	Continued From page 31 and type of bathing". SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830			