



Protecting, Maintaining and Improving the Health of Minnesotans

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility:

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

Report #: H5352041

Date: May 31, 2013

Date of Visit: April 19, 2013
Time of Visit: 9:15 a.m.-4:15 p.m.

By: Lynn Fossen, R.N., Special Investigator

- Type of Facility:**
- Nursing Home
 - SLF
 - Hospital
 - HHA
 - ICF/IID
 - Other: _____
 - Home Care Provider/Assisted Living
 - Home Care

- Facility Self Report
- Complaint

Allegation(s): It is alleged that neglect occurred when a resident was provided food that was the wrong consistency. The resident coughed up a quarter size potato, began to show symptoms of aspiration and had audible wheezes bilaterally, at which time the resident was sent to the hospital.

An unannounced visit was made at this facility and an investigation was conducted under:

- Federal Regulations for Hospital Conditions of Participation (42 CFR, Part 482)
- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- Federal Regulations for HHA (Home Health Agencies) (42 CFR, Part 484)
- Federal Regulations for CAH (Critical Access Hospital) (42 CFR, Part 485)
- Federal Regulations for EMTALA (42 CFR Part 489)
- State Licensing Rules for Boarding Care Homes (MN Rules Chapter 4655)

- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- State Licensing Rules for Home Care (MN Rules Chapter 4668)
- State Statutes for Maltreatment of Minors (MN Statutes, section 626.556)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

Conclusion:

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

- Abuse Neglect Financial Exploitation was:
- Substantiated Not Substantiated Inconclusive based on the following information:

Based on a preponderance of evidence, neglect occurred when staff served the resident food that was the wrong consistency. The resident choked, developed aspiration pneumonia and died.

The resident had a history of esophageal strictures which placed the resident at risk for choking episodes. The resident had a history of aspirating food. The resident required food that could be swallowed without chewing (pureed) because the resident did not have teeth. The physician ordered a pureed diet. The resident required milk cartons to be opened, straws placed in the glass and once this was completed the resident ate independently. The resident ate all meals in the day room. The resident was oriented only to self. The resident routinely utilized oxygen on an as needed basis.

The dietary department prepared a regular consistency food tray instead of a pureed consistency food tray. Dietary staff stated that the tray ticket was blank in the area that lists the texture for each food item served during the noon meal which resulted in the resident receiving a regular consistency meal instead of a pureed consistency meal. The noon meal consisted of a roll, green bean casserole, au gratin potato, baked ham and lemon pie. Nursing staff delivered the regular consistency meal to the resident instead of a pureed consistency meal. The resident began to eat the meal and while the resident was eating began to choke and coughed up a half quarter size potato. The facility notified the nurse practitioner and the resident's family. The resident experienced difficulty breathing with low oxygen saturation levels ranging from 79%-90% on room air. The resident was returned to bed with the head of the bed elevated, encouraged to deep breathe and cough and was administered oxygen at 2 liters by nasal cannula. A nebulizer treatment was also administered. The resident had a large emesis of thick white phlegm. The resident refused supper and continued to expel phlegm but experienced no shortness of breath. A chest x-ray was obtained and the nurse practitioner was updated with the results and initiated new orders. The orders included scheduled nebulizer treatments and administration of lasix by mouth. After midnight the resident's oxygen saturation levels dropped to 85-87% with oxygen on at 2 liters. The resident had crackles in all lobes of the lungs. By early morning, the resident was minimally responsive and having difficulty breathing. The resident's temperature was 100.5, pulse 123, respirations 36 and oxygen saturation level was 68% on 2 liters of oxygen via nasal cannula. The resident was given a nebulizer treatment. The resident's family and nurse practitioner were updated and the resident was transferred by

ambulance to the hospital for treatment.

When the resident arrived at the emergency department the laboratory results revealed an elevated white blood count which was consistent with pneumonia. The emergency department physician discussed the resident's advance directives with the family and the resident was admitted to the hospital for further monitoring and treatment for aspiration pneumonia with resulting sepsis. The resident's treatment plan consisted of comfort measures. The resident experienced acute respiratory failure and died that evening.

Interview with the facility Nurse Practitioner confirmed that the resident was given the wrong texture of food and the resident aspirated.

The death certificate revealed the cause of death was sepsis.

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the individual(s) and/or facility is responsible for the

Abuse Neglect Financial Exploitation. This determination was based on the following:

Although the facility had policies and procedures in place to ensure that residents were not given the incorrect food texture, staff did not follow the policy. The tray tickets did not have the consistency listed for each food item served which resulted in the resident receiving a regular diet texture instead of a pureed diet texture.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) – Compliance Not Met

The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B), were not met.

Deficiencies are issued on form 2567: Yes No If no, specify: _____

(The 2567 will be available on the MDH website.)

State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) – Compliance Not Met

The requirements under State Licensing Rules for Nursing Homes (MN Rules Chapter 4658) were not met.

State licensing orders were issued: Yes No If no, specify: _____

(State licensing orders will be available on the MDH website.)

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met

The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557). No state licensing orders were issued.

State Statutes Chapters 144 & 144A – Compliance Met

The facility was found to be in compliance with State Statutes for Chapters 144 & 144A. No state licensing orders were issued.

Facility Corrective Action:

The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated

"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:

Document Review: The following records were reviewed during the investigation:

- | | |
|--|--|
| <input checked="" type="checkbox"/> Medical Records | <input checked="" type="checkbox"/> Care Guide |
| <input checked="" type="checkbox"/> Medication Administration Records | <input checked="" type="checkbox"/> Treatment Sheets |
| <input checked="" type="checkbox"/> Facility Incident Reports | <input checked="" type="checkbox"/> Physician Progress Notes |
| <input checked="" type="checkbox"/> ADL (Activities of Daily Living) Flow Sheets | <input checked="" type="checkbox"/> Laboratory and X-ray Reports |
| <input checked="" type="checkbox"/> Physician Orders | <input checked="" type="checkbox"/> Social Service Notes |

Nurses Notes

Meal Intake Records

Activities Reports

Weight Records

Therapy and/or Ancillary Services Records

Assessments

Skin Assessments

Care Plan Records

Other pertinent medical records:

Hospital Records

Ambulance/Paramedics

Medical Examiner Records

Death Certificate

Police Report

Additional facility records:

Resident/Family Council Minutes

Personnel Records/Background Check, etc.

Staff Time Sheets, Schedules, etc.

Facility In-service Records

Facility Internal Investigation Reports

Facility Policies and Procedures

Call Light Audits

Other, specify: Hospital records progress notes and hospital records/death note

Number of additional resident(s) reviewed: 5

Were residents selected based on the allegation(s)? Yes No N/A Specify: _____

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

Yes No N/A Specify: _____

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s): Yes No N/A Specify: _____

If unable to contact complainant, attempts were made on:

Date/time: _____ Date/time: _____ Date/time: _____

Interview with family: Yes No N/A Specify: _____

Did you interview the resident(s) identified in allegation: Yes No N/A Specify: Resident is deceased.

Did you interview additional residents: Yes No

Total number of resident interviews: 5

Interview with staff: Yes No N/A Specify: _____

Tennessee Warning given as required: Yes No

Total number of staff interviews: 8

Physician interviewed: Yes No

Nurse Practitioner interviewed: Yes No

Interview with Alleged Perpetrator(s): Yes No N/A Specify: Facility is the AP and multiple facility staff were interviewed.

Attempts to contact: Date/time: _____ Date/time: _____ Date/time: _____

If unable to contact was subpoena issued: Yes , date subpoena was issued _____ No

Were contacts made with any of the following:

- Emergency personnel
- Police Officers
- Medical Examiner
- Other: Specify

Observations were conducted related to:

- Wound Care
- Medication Pass
- Meals
- Personal Care
- Dignity/Privacy Issues
- Restorative Care
- Nursing Services
- Safety Issues
- Facility Tour
- Infection Control
- Cleanliness
- Injury
- Use of Equipment
- Transfers
- Incontinence

Call Light

Other: Correct diets being delivered to residents

Was any involved equipment inspected: Yes No N/A

Was equipment being operated in safe manner: Yes No N/A

Were photographs taken: Yes No Specify: _____

xc: Division of Compliance Monitoring - Licensing & Certification
Minnesota Board of Examiners for Nursing Home Administrators
Minnesota Board of Nursing
Ramsey County Medical Examiners
Maplewood City Police Department
Ramsey County Attorney
Maplewood City Attorney

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

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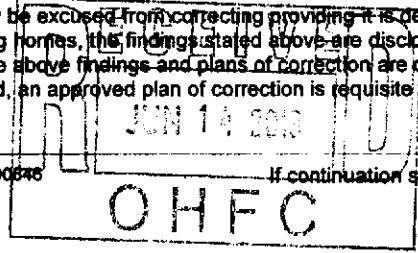
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F 000	INITIAL COMMENTS	F 000		
F 309 SS=G	<p>An abbreviated standard survey was initiated to investigate case #H5352041. As a result, the following deficiency is issued.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide a pureed diet for 1 of 5 (R1) residents reviewed who had a physician's ordered diet. This resulted in R1 choking and developing aspiration pneumonia.</p> <p>Findings include: R1's medical record was reviewed. R1's physician orders dated 1/8/2012 revealed an order for a dysphasia puree level 1 diet or national dysphasia diet level 1 (NDD1) due to esophageal stricture and edentia (no teeth). R1's care plan dated 1/17/12 and in effect on 3/31/13 revealed a dietary intervention of a NDD1 puree diet.</p> <p>The facility internal investigation dated 3/31/13 revealed staff did not follow R1's care plan of providing R1 with a pureed diet during the lunch</p>	F 309	<p>F000 This Plan of Correction is a written credible assertion of substantial compliance with the federal and state requirements for nursing facilities and/or skilled nursing facilities participating in the federal Medicare or Minnesota Medical Assistance programs.</p> <p>Nothing set forth in this Plan of Correction or any other communication is to be or should be construed as an admission by Ramsey County Care Center, or any employee, representative or agent of Ramsey County Care Center, of the validity or accuracy of any of the deficiencies cited by the Minnesota Department of Health relative to the survey, certification and enforcement effort at issue.</p> <p>Further, please note that any and all documents transmitted or otherwise provided by Ramsey County Care Center in relation to this Plan of Correction, as well as any and all other communications in writing or otherwise by or on behalf of Ramsey county Care Center are and shall be construed to be WITHOUT PREJUDICE to the rights, remedies, claims, defenses of Ramsey County Care Center, at law and /or equity, all of which are not waived and all of which are reserved and retained by , for and on behalf of Ramsey County Care Center.</p> <p>It is the policy of Ramsey County Care Center that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 6/13/13
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any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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F 309	<p>Continued From page 1</p> <p>meal on 3/31/13. Although R1 had an order for a pureed diet, R1 received a regular diet which included a roll, green bean casserole, au gratin potato, baked ham and lemon pie and was observed to be eating from the tray independently. A nursing assistant then assisted R1 by feeding R1 lemon cream pie and mashed potatoes. Half way through the meal the facility staff realized that R1 had received the wrong diet consistency and removed the tray, replacing it with a pureed lunch which consisted of lemon pie, baked ham, au gratin potatoes, green bean casserole, roll, margarine, 2% milk and coffee.</p> <p>Progress notes dated 3/31/13 at 1:00 p.m. were reviewed and revealed that R1 was served a regular consistency lunch tray instead of a pureed consistency lunch tray. R1 began to eat independently from the regular consistency lunch tray and was observed to be throwing up phlegm. R1 was encouraged to cough and after 30 seconds coughed up a half quarter size potato. R1 utilized oxygen as needed and was given oxygen at 2 liters. Oxygen saturation level ranged from 79%-90% on room air. R1 was observed to be short of breath, crying but denying pain. R1's vital signs were monitored and the nurse practitioner was notified. R1 was returned to bed with the head of the bed elevated. R1 was encouraged to deep breath and cough. A nebulizer treatment was administered. The resident had a large emesis of thick white phlegm.</p> <p>Progress notes dated 3/31/13 6:55 p.m. were reviewed and revealed that R1 refused supper. R1's vital signs were temperature 96.6, pulse 80, respirations 18, blood pressure 112/60 and</p>	F 309	<p>F 309</p> <p>It is the policy of Ramsey County Care Center to provide therapeutic diets per MD orders to all residents.</p> <p>The diet for resident R1 was corrected immediately and replaced with the proper diet. Ramsey County Care Center investigated the incident involving R1. Upon completion of this investigation, all staff involved received corrective actions and have been re-educated on dysphagia diets.</p> <p>All residents with dysphagia diets were reviewed for accuracy and care plans were updated as needed. Appropriate notifications to family and medical personnel were completed.</p> <p>Color coding for diets and diagrams of dysphagia diets were reviewed and posted for Nutrition Services and Nursing staff.</p> <p>Nutrition Services and Nursing staff were educated and retrained as to the appropriate diets.</p> <p>Policies and procedures pertaining to meal service were reviewed and updated. Revised policies will be reviewed by the Medical Director.</p> <p>Diet Techs review meal tickets after each printing to assure that the terminology regarding pureed consistency is present before the food item identified. Meal tickets are organized so that the NDD1s, 2s and 3s trays are called out and filled first on the tray line.</p>	

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F 309

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oxygen saturation 96% with oxygen on room air. Lung sounds had crackles. R1 continued to expel clear phlegm but experienced no shortness of breath or respiratory distress. A chest x-ray was obtained.

Progress notes dated 3/31/13 at 8:48 p.m. were reviewed and revealed that R1's vital signs were temperature 97.7, pulse 85, respirations 16, blood pressure 140/80 and oxygen saturation at 96% with oxygen at 2 liters. Lung sounds had crackles in the upper lobes. A nebulizer treatment was given and R1 stated it was helpful. R1 continued to spit out clear phlegm and experienced no shortness of breath. The chest x-ray results were reported to the nurse practitioner and orders obtained for scheduled nebulizer treatments and scheduled lasix to be administered daily with additional dose that night and in the a.m.

Progress notes dated 3/31/13 at 11:34 p.m. were reviewed and revealed that R1 had an emesis after taking the lasix. The nurse practitioner was notified and ordered to repeat the lasix dose by mouth now.

Progress notes dated 4/1/13 at 1:45 a.m. were reviewed and revealed R1's oxygen saturation levels to be fluctuating between 85%-87% with oxygen on at 2 liters per nasal cannula. Lung sounds revealed crackles in all lobes with increased secretions and congestion. Review of the chest x-ray completed on 3/31/13 revealed pulmonary edema.

Progress notes on 4/1/13 at 6:08 a.m. were reviewed and revealed R1 was minimally responsive and having difficulty breathing due to

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A computerized menu program is scheduled to replace the existing program. New features will minimize errors and ensure accuracy. The implementation date of this new software is yet to be determined.

Standing orders for "special occasion meals for texture modification will be clarified and presented to all medical providers by September, 2013.

Director of Nutrition Services and designees conduct daily audits of the dining rooms to monitor the accuracy of meals served.

DON and or designee will complete random dining room audits to assure that nursing staff are reviewing the meal tickets and to assure that the food served matches the diet ordered.

Results of monitoring will be reported to QA for 6 months.

Director of Nutrition Services and DON will be responsible for maintaining compliance.

The facility alleges that it will be in substantial compliance by July 2nd, 2013.

July 2, 2013



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F 309	<p>Continued From page 3</p> <p>an aspiration episode during the lunch meal on 3/31/13. The resident's vital signs were temperature 100.5, pulse 123, respirations 36 and oxygen saturation level was 68% on 2 liters of oxygen via nasal cannula. R1 was given a nebulizer treatment and transferred by ambulance at 6:18 a.m. to the emergency department for treatment. When the ambulance arrived R1's oxygen saturation level was improved, rising to 78% on 4 liters of oxygen. R1 was placed on a oxygen mask at 15 liters. R1's oxygen saturation level only increased to 80% so R1 was placed on CPAP (continuous positive airway pressure) which raised the oxygen saturation level to 93%.</p> <p>Review of the emergency department notes dated 4/1/13 6:34 a.m. revealed that R1 had a history of esophageal stricture and previous aspiration pneumonia. R1 presented with moderate respiratory distress that required high flow oxygen. R1's laboratory results revealed an elevated white blood count which was consistent with pneumonia. R1's advance directives were discussed and R1 was admitted for further monitoring/treatment and comfort measures.</p> <p>Review of R1's hospital discharge summary dated 4/2/13 at 8:16 a.m. revealed the diagnosis of acute respiratory failure due to sepsis with bacterial anaerobes due to aspiration.</p> <p>Review of the hospital progress notes dated 4/1/13 at 6:45 p.m. revealed that R1 died on 4/1/13 at 6:00 p.m. with cause of death listed as pneumonia.</p> <p>The Certificate of Death dated 4/1/13 listed the</p>	F 309		

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Continued From page 4
immediate cause of death as sepsis.

Review of R1's tray ticket utilized on 3/31/13 (the day R1 choked) revealed the top left of the tray ticket listed the diet order NDD1, the top center of the tray ticket listed R1's name and the top right of the tray ticket listed Pureed NDD1. Below R1's name was a list of each food item served and the amount to serve. To the left of each food item the texture for each food item was blank. The food items listed were lemon pie, baked ham, au gratin potatoes, green bean casserole, roll, margarine, 2% milk and coffee.

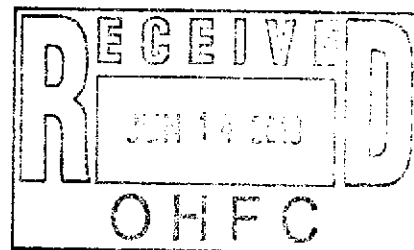
Interview with the facility nurse practitioner (NP)-I on 5/1/13 at 1:00 p.m. revealed that R1's pneumonia was acute due to aspiration that occurred at the facility when R1 was served a regular diet texture instead of a pureed diet texture during lunch on 3/31/13.

Interview with food service worker (FSW)-F on 4/19/13 at 3:00 p.m. confirmed that (FSW)-F read R1's tray ticket as a regular diet and dished regular food instead of pureed food.

Interview with the interim dietary director (IDD)-E on 4/19/13 at 2:25 p.m. revealed that R1 got the wrong texture of food on 3/31/13 at lunch time. (IDD)-E further stated that the tray tickets in use on 3/31/13 were holiday tray tickets, not the tray tickets normally used and lacked the detail that staff were accustomed to reading.

Interview with the facility cook (C)-G on 4/19/13 at 3:15 p.m. revealed that tray tickets used on 3/31/13 did not have the consistency listed for each food item served.

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F 309	<p>Continued From page 5</p> <p>Interview with dietary technician (DT)-H on 4/19/13 at 3:30 p.m. revealed that in her role as technician she prepares the tray tickets and normally the tray tickets list the texture for each food item served. The tray tickets at this meal on 3/31/13 were blank for each food item served which resulted in staff serving and delivering a regular meal to R1. (DT)-H stated staff were accustomed to reading the texture for each food item served and when the area was blank staff served R1 a regular tray instead of a pureed tray.</p> <p>An undated policy, Liberalized Geriatric Diet identified the pureed diet as a texture modified diet used for those residents who have difficulty chewing and/or swallowing. All foods are prepared to the consistency of pudding or mashed potatoes.</p>	F 309		

Minnesota Department of Health

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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:
A complaint investigation was initiated to investigate complaint #H5352041. The following correction order is issued.

When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,

2 000

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Minnesota Department of Health

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

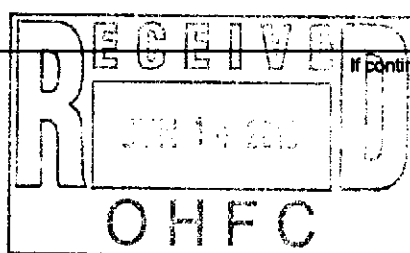
TATE FORM

6899

X2BH11

TITLE

(X6) DATE



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 05/30/2013
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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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(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) COMPLETE DATE
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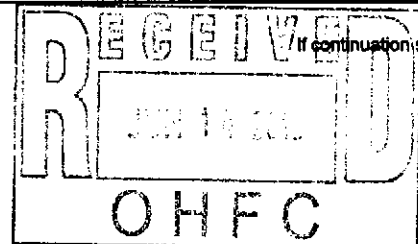
2 000	Continued From page 1 Division of Compliance Monitoring, Office of Health Facility Complaints; 85 East Seventh Place, Suite 220, St. Paul, Minnesota 55164-0970.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding 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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
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	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 2</p> <p>resident must remain in bed or the resident prefers to remain in bed.</p> <p>This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to provide a pureed diet for 1 of 5 (R1) residents reviewed who had a physician's ordered diet. This resulted in R1 choking and developing aspiration pneumonia.</p> <p>Findings include:</p> <p>R1's medical record was reviewed. R1's physician orders dated 1/8/2012 revealed an order for a dysphasia puree level 1 diet or national dysphasia diet level 1 (NDD1) due to esophageal stricture and edentia (no teeth). R1's care plan dated 1/17/12 and in effect on 3/31/13 revealed a dietary intervention of a NDD1 puree diet.</p> <p>The facility internal investigation dated 3/31/13 revealed staff did not follow R1's care plan of providing R1 with a pureed diet during the lunch meal on 3/31/13. Although R1 had an order for a pureed diet, R1 received a regular diet which included a roll, green bean casserole, au gratin potato, baked ham and lemon pie and was observed to be eating from the tray independently. A nursing assistant then assisted R1 by feeding R1 lemon cream pie and mashed potatoes. Half way through the meal the facility staff realized that R1 had received the wrong diet consistency and removed the tray, replacing it with a pureed lunch which consisted of lemon pie, baked ham, au gratin potatoes, green bean</p>	2 830		



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2 830	<p>Continued From page 3</p> <p>casserole, roll, margarine, 2% milk and coffee.</p> <p>Progress notes dated 3/31/13 at 1:00 p.m. were reviewed and revealed that R1 was served a regular consistency lunch tray instead of a pureed consistency lunch tray. R1 began to eat independently from the regular consistency lunch tray and was observed to be throwing up phlegm. R1 was encouraged to cough and after 30 seconds coughed up a half quarter size potato. R1 utilized oxygen as needed and was given oxygen at 2 liters. Oxygen saturation level ranged from 79%-90% on room air. R1 was observed to be short of breath, crying but denying pain. R1's vital signs were monitored and the nurse practitioner was notified. R1 was returned to bed with the head of the bed elevated. R1 was encouraged to deep breath and cough. A nebulizer treatment was administered. The resident had a large emesis of thick white phlegm.</p> <p>Progress notes dated 3/31/13 6:55 p.m. were reviewed and revealed that R1 refused supper. R1's vital signs were temperature 96.6, pulse 80, respirations 18, blood pressure 112/60 and oxygen saturation 96% with oxygen on room air. Lung sounds had crackles. R1 continued to expel clear phlegm but experienced no shortness of breath or respiratory distress. A chest x-ray was obtained.</p> <p>Progress notes dated 3/31/13 at 8:48 p.m. were reviewed and revealed that R1's vital signs were temperature 97.7, pulse 85, respirations 16, blood pressure 140/80 and oxygen saturation at 96% with oxygen at 2 liters. Lung sounds had crackles in the upper lobes. A nebulizer treatment was given and R1 stated it was helpful. R1 continued to spit out clear phlegm and experienced no</p>	2 830		

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2 830	<p>Continued From page 4</p> <p>shortness of breath. The chest x-ray results were reported to the nurse practitioner and orders obtained for scheduled nebulizer treatments and scheduled lasix to be administered daily with additional dose that night and in the a.m.</p> <p>Progress notes dated 3/31/13 at 11:34 p.m. were reviewed and revealed that R1 had an emesis after taking the lasix. The nurse practitioner was notified and ordered to repeat the lasix dose by mouth now.</p> <p>Progress notes dated 4/1/13 at 1:45 a.m. were reviewed and revealed R1's oxygen saturation levels to be fluctuating between 85%-87% with oxygen on at 2 liters per nasal cannula. Lung sounds revealed crackles in all lobes with increased secretions and congestion. Review of the chest x-ray completed on 3/31/13 revealed pulmonary edema.</p> <p>Progress notes on 4/1/13 at 6:08 a.m. were reviewed and revealed R1 was minimally responsive and having difficulty breathing due to an aspiration episode during the lunch meal on 3/31/13. The resident's vital signs were temperature 100.5, pulse 123, respirations 36 and oxygen saturation level was 68% on 2 liters of oxygen via nasal cannula. R1 was given a nebulizer treatment and transferred by ambulance at 6:18 a.m. to the emergency department for treatment. When the ambulance arrived R1's oxygen saturation level was improved, rising to 78% on 4 liters of oxygen. R1 was placed on a oxygen mask at 15 liters. R1's oxygen saturation level only increased to 80% so R1 was placed on CPAP (continuous positive airway pressure) which raised the oxygen saturation level to 93%.</p>	2 830		



Minnesota Department of Health

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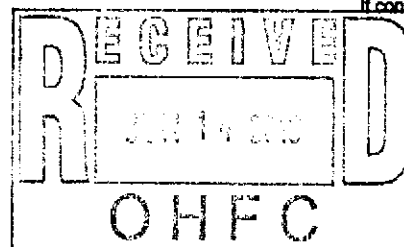
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2 830	<p>Continued From page 5</p> <p>Review of the emergency department notes dated 4/1/13 6:34 a.m. revealed that R1 had a history of esophageal stricture and previous aspiration pneumonia. R1 presented with moderate respiratory distress that required high flow oxygen. R1's laboratory results revealed an elevated white blood count which was consistent with pneumonia. R1's advance directives were discussed and R1 was admitted for further monitoring/treatment and comfort measures.</p> <p>Review of R1's hospital discharge summary dated 4/2/13 at 8:16 a.m. revealed the diagnosis of acute respiratory failure due to sepsis with bacterial anaerobes due to aspiration.</p> <p>Review of the hospital progress notes dated 4/1/13 at 6:45 p.m. revealed that R1 died on 4/1/13 at 6:00 p.m. with cause of death listed as pneumonia.</p> <p>The Certificate of Death dated 4/1/13 listed the immediate cause of death as sepsis.</p> <p>Review of R1's tray ticket utilized on 3/31/13 (the day R1 choked) revealed the top left of the tray ticket listed the diet order NDD1, the top center of the tray ticket listed R1's name and the top right of the tray ticket listed Pureed NDD1. Below R1's name was a list of each food item served and the amount to serve. To the left of each food item the texture for each food item was blank. The food items listed were lemon pie, baked ham, au gratin potatoes, green bean casserole, roll, margarine, 2% milk and coffee.</p> <p>Interview with the facility nurse practitioner (NP)-I on 5/1/13 at 1:00 p.m. revealed that R1's pneumonia was acute due to aspiration that occurred at the facility when R1 was served a</p>	2 830		

Minnesota Department of Health

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2 830	<p>Continued From page 6</p> <p>regular diet texture instead of a pureed diet texture during lunch on 3/31/13.</p> <p>Interview with food service worker (FSW)-F on 4/19/13 at 3:00 p.m. confirmed that (FSW)-F read R1's tray ticket as a regular diet and dished regular food instead of pureed food.</p> <p>Interview with the interim dietary director (IDD)-E on 4/19/13 at 2:25 p.m. revealed that R1 got the wrong texture of food on 3/31/13 at lunch time. (IDD)-E further stated that the tray tickets in use on 3/31/13 were holiday tray tickets, not the tray tickets normally used and lacked the detail that staff were accustomed to reading.</p> <p>Interview with the facility cook (C)-G on 4/19/13 at 3:15 p.m. revealed that tray tickets used on 3/31/13 did not have the consistency listed for each food item served.</p> <p>Interview with dietary technician (DT)-H on 4/19/13 at 3:30 p.m. revealed that in her role as technician she prepares the tray tickets and normally the tray tickets list the texture for each food item served. The tray tickets at this meal on 3/31/13 were blank for each food item served which resulted in staff serving and delivering a regular meal to R1. (DT)-H stated staff were accustomed to reading the texture for each food item served and when the area was blank staff served R1 a regular tray instead of a pureed tray.</p> <p>An undated policy, Liberalized Geriatric Diet identified the pureed diet as a texture modified diet used for those residents who have difficulty chewing and/or swallowing. All foods are prepared to the consistency of pudding or mashed potatoes.</p>	2 830		



Minnesota Department of Health

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2 830	<p>Continued From page 7</p> <p>A Suggested Method of Correction: The Dietary Director and Director of Nursing could review and revise as needed pertinent policies and procedures, educate staff on the policies and procedures and monitor to ensure compliance.</p> <p>Time Period for Correction: Thirty (30) days</p>	2 830		



Protecting, Maintaining and Improving the Health of Minnesotans

Post Correction Order Follow-Up/Federal Certification Review Report
PUBLIC DATA

Facility:

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

Report #: H5352041

Date: July 22, 2013

Date of Visit: July 18, 2013
Time of Visit: 11:00 a.m.

By: Stephanie Richard, R.N.
Special Investigator

Nature of Visit

An unannounced visit was made in order to follow-up federal deficiency and one state licensing order which were issued on June 3, 2013, as the result of an investigation which had been completed on May 30, 2013.

The status of the order is as follow:

1 MN Rule 4658.0520 Subp. 1 - Corrected

See Attached 2567B for status of federal deficiency.

xc: Minnesota Department of Health -Licensing & Certification Division

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number 245352	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/18/2013
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Name of Facility RAMSEY COUNTY CARE CENTER	Street Address, City, State, Zip Code 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109
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This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form)

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 07/18/2013	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By <u>KL/sd</u>	Date: <u>07/31/13</u>	Signature of Surveyor: <u>31242</u>	Date: <u>07/18/13</u>
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>5/30/2013</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number 00846	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 7/18/2013
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Name of Facility RAMSEY COUNTY CARE CENTER	Street Address, City, State, Zip Code 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>20830</u>	Correction Completed 07/18/2013	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # <u>MN Rule 4658.0520 Subp. 1</u>		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	
ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed	ID Prefix _____	Correction Completed
Reg. # _____		Reg. # _____		Reg. # _____	
LSC _____		LSC _____		LSC _____	

Reviewed By _____	Reviewed By <u>KL/sd</u>	Date: <u>07/31/13</u>	Signature of Surveyor: <u>31242</u>	Date: <u>07/18/13</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>5/30/2013</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		