

### Office of Health Facility Complaints Investigative Report PUBLIC

Facility Name: Ramsey County Care	Center		Report Number: H5352046	Date of Visit: December 19, 2016
Facility Address: 2000 White Bear Ave	nue		Time of Visit: 10:00 a.m. to 4:30 p.m.	Date Concluded: June 28, 2017
Facility City: Maplewood			Investigator's Name and Jessica Sellner, RN, Specia	
State:	ZIP:	County:		
Minnesota	<u> </u>	Ramsey		

#### Allegation(s):

It is alleged that a resident was neglected when the alleged perpetrator failed to follow the resident's care plan. As a result, the resident had a fall and sustained a left femur fracture.

- Federal Regulations for Long Term Care Facilities (42 CFR Part 483, subpart B)
- State Licensing Rules for Nursing Homes (MN Rules Chapter 4658)
- State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- State Statutes Chapters 144 and 144A

#### Conclusion:

Based on a preponderance of evidence, neglect occurred when the alleged perpetrator (AP) failed to follow the resident's plan of care. The AP failed to unplug the power to the electric reclining chair as instructed in the resident's care plan. The resident raised the chair using the remote control and fell out of the chair. The resident was sent to the hospital and diagnosed with a left femur fracture.

The resident had moderate cognitive impairment, required extensive assistance from staff with transfers, and had a history of falls. The resident's care plan indicated the resident had poor safety judgment, and staff were directed to unplug the power to the reclining chair before giving the resident the remote control. The residents nursing assistant care sheet also directed staff to hand the resident the reclining chair remote control after unplugging the power, so the resident could not utilize the remote to adjust the chair.

Review of the resident's medical record indicated approximately 10 months prior to the residents fall, the facility met with the resident's family members to discuss the safety of the electric reclining chair. The resident had a fall out of the reclining chair after using the remote control and lifting the chair in an upright position and sliding out onto the floor. The resident had no injury. The family and facility determined the resident was able to safely sit in the reclining chair after the power was unplugged.

Staff transferred the resident using a mechanical lift into the reclining lift chair. Approximately an hour later, staff heard the resident yelling for help from his/her room. The resident was found laying on the floor in front of the recliner and complained of left leg and left hip pain. The power cord was still plugged into the

Deficiencies are issued on form 2567: X Yes

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wall and the remote control was in the resident's reach on the arm of the recliner. The chair had been lifted up to a standing position by the resident using the remote and the resident fell out of the recliner. The resident was sent to the hospital by ambulance and was diagnosed with a left femur fracture. The resident was sent back to the facility four days later on pain medication and comfort care as s/he was not a surgical candidate to repair the left femur fracture.

When interviewed, the resident was unable to recall the fall.

When interviewed, the AP who cared for the resident the day of the fall stated s/he was aware the resident's electric recliner needed to be unplugged prior to giving the resident the remote control. The AP stated the resident's care plan and nursing assistant care sheet included the intervention to unplug the reclining chair. The AP stated s/he cared for the resident in the past, and on the day the resident fell out of the recliner, the AP forgot to unplug the power to the electric reclining chair.

After the residents fall, the electric reclining chair was removed from the facility. Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557) Under the Minnesota Vulnerable Adults Act (Minnesota Statutes, section 626.557): ☐ Abuse Neglect Neglect ☐ Financial Exploitation Substantiated
 ■ ☐ Not Substantiated ☐ Inconclusive based on the following information: **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: The resident's care plan and nursing assistant care sheet directed staff to ensure the resident's electric reclining lift chair was unplugged to ensure resident safety. The nursing assistant was aware the resident's recliner was to be unplugged as s/he had provided care for the resident in the past. 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.

□ No

Facility Name: Ramsey County Care Center Report Number: H5352046 (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: x Yes □ No (State licensing orders will be available on the MDH website.) State Statutes Chapters 144 & 144A - Compliance Not Met - Compliance Not Met The requirements under State Statues for Chapters 144 &144A were not met. State licensing orders were issued: X Yes □ No (State licensing orders will be available on the MDH website.) **Compliance Notes: Facility Corrective Action:** The facility took the following corrective action(s):

### Minnesota Statutes, section 626.5572, subdivision 17 - Neglect

"Neglect" means:

**Definitions:** 

- (a) The failure or omission by a caregiver to supply a vulnerable adult with care or services, including but not limited to, food, clothing, shelter, health care, or supervision which is:
- (1) reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety, considering the physical and mental capacity or dysfunction of the vulnerable adult; and
  - (2) which is not the result of an accident or therapeutic conduct.
- (b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

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#### 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:

### **<u>Document Review</u>**: The following records were reviewed during the investigation:

- ▼ Medical Records
- X Care Guide
- | Medication Administration Records
- Nurses Notes
- **X** Assessments
- Physician Orders
- ▼ Treatment Sheets
- X Physician Progress Notes
- Social Service Notes
- Skin Assessments
- **X** Facility Incident Reports
- X Activities Reports
- Therapy and/or Ancillary Services Records
- X ADL (Activities of Daily Living) Flow Sheets

#### Other pertinent medical records:

X Hospital Records X Ambulance/Paramedics

#### Additional facility records:

- Resident/Family Council Minutes
- Staff Time Sheets, Schedules, etc.
- X Facility Internal Investigation Reports
- Call Light Audits
- Personnel Records/Background Check, etc.
- ▼ Facility In-service Records

	nts selected base	d on the allegation	(s)?	No N/A	
Specify:					
Were resider	nt(s) identified in	the allegation(s) p	resent in the facility	y at the time of th	e investigation?
• Yes C Specify:	No ON/A				
<u>Interviews:</u> '	The following in	terviews were con	ducted during the	investigation:	
Interview with Specify:	th complainant(s)	◯ Yes ◯ No	o ⊚ N/A		
If unable to c	ontact complaina	ant, attempts were	made on:		
Date:	Time:	Date:	Time:	Date:	Time:
Interview wit	th family:   Yes	○ No ○ N	/A Specify:		
Did you inter	view the resident	t(s) identified in all	egation:	. Selles (2.1)	
Yes	No N/A	Specify: Resident	was unable to reca	all incident	
Did you inter	viou additional r	!-! V		***************************************	YAARAA.
Dia you litter	view additional ri	esidents? 💿 Yes	○ No		
•	r of resident inte	•	○ No		
Total numbe		•			
Total numbe	r of resident inter th staff:   Yes	rviews: Four			
Total numbe Interview wit <b>Tennessen V</b>	r of resident inter th staff:   Yes	rviews: Four  No N/A			
Total numbe Interview wit Tennessen V Tennessen W	r of resident inte th staff:   Yes  Yarnings	rviews: Four  No No	A Specify:		
Total numbe Interview wit <b>Tennessen V</b> Tennessen W Total numbe	r of resident inter th staff:   Yes  Yarnings  Yarning given as re	rviews: Four  No N/A  equired: Yes  ws: Seven	A Specify:		
Total numbe Interview wit <b>Tennessen V</b> Tennessen W Total numbe Physician Inte	r of resident inter th staff:   Yes Yarnings Yarning given as re r of staff interview	equired:  Seven  No N/A	A Specify:		
Total numbe Interview wit Tennessen W Tennessen W Total numbe Physician Inte Nurse Practit	r of resident intersity staff:   Yarnings  Yarning given as represented to the staff interviewed:   Yes	equired:  No Yes  No No N/A  Pequired:  Yes  WS: Seven No No C: Yes  No	No Specify:		
Total numbe Interview wit Tennessen W Tennessen W Total numbe Physician Inte Nurse Practit Physician Ass	r of resident intersity staff:   Varnings Varning given as resident interviewed:   Yes ioner Interviewed	equired:   Yes  No  No  No  No  No  Yes  Yes  Yes  Yes  Yes  No  Chic Yes  Chic Yes	No Specify:	Specify:	
Total numbe Interview wit Tennessen W Tennessen W Total numbe Physician Inte Nurse Practit Physician Ass	r of resident intersity of resident intersity of staff:  Varning given as resident interviewed:  Yes ioner Interviewed:  The Alleged Perpetical interviewed in the staff interviewed.	equired:   Yes  No  No  No  No  No  Yes  Yes  Yes  Yes  Yes  No  Chic Yes  Chic Yes	No No	Specify:	
Total number Interview with Tennessen Worth Total number Physician Interview with	r of resident intersity of resident intersity of staff:  Varning given as resident interviewed:  Yes ioner Interviewed:  The Alleged Perpetical interviewed in the staff interviewed.	equired:   Yes  No  No  No  No  No  Yes  Yes  Yes  Yes  Yes  No  Chic Yes  Chic Yes	No No	Specify:	Time:
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Report Number: H5352046

Obs	ervations were conducted related to:
X	Personal Care
X	Nursing Services
X	Call Light
X	Infection Control
X	Use of Equipment
X	Dignity/Privacy Issues
X	Safety Issues
X	Transfers
X	Facility Tour
X	Injury
Was	any involved equipment inspected:  Yes  No  N/A equipment being operated in safe manner:  Yes  No  N/A e photographs taken:  Yes  No  Specify:  Chair was removed prior to on-site investigation
cc:	
Hea	Ith Regulation Division - Licensing & Certification
Min	nesota Board of Examiners for Nursing Home Administrators
The	Office of Ombudsman for Long-Term Care
Map	plewood Police Department
Ram	nsey County Attorney
Мар	plewood City Attorney



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered August 8, 2017

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

RE: Project Number H5352046

Dear Mr. Robinson:

On May 17, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective May 22, 2017. (42 CFR 488.422)

Furthermore on May 17, 2017, this Department informed you and the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies were being recommended:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on May 9, 2017. 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 June 30, 2017, the Minnesota Department of Health, Office of Health Facility Complaints completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an abbreviated standard survey, completed on May 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 9, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our abbreviated standard survey, completed on May 9, 2017, as of June 9, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective June 9, 2017.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Ramsey County Care Center August 8, 2017 Page 2

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

PRINTED: 05/10/2017 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
							С
		245352	B. WING			05/0	09/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
RAMSEY	COUNTY CARE CEN	ITER		26	000 WHITE BEAR AVENUE		
ITANISE	COUNTY CARE CEN	IIEN		M	IAPLEWOOD, MN 55109		
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F 000	INITIAL COMMENT	rs	F0	000			
F 282 SS=D	to investigate case following deficiencie enrolled in ePOC a required at the botto CMS-2567 form. EPOC will be used a	ndard survey was conducted #H5352046. As a result, the es are issued. The facility is nd therefore a signature is not om of the first page of the electronic submission of the s verification of compliance. RVICES BY QUALIFIED ARE PLAN	F 2	282			
		ive Care Plans led or arranged by the facility, comprehensive care plan,				:	
	care. This REQUIREMENT by: Based on observate review, the facility for	ich resident's written plan of  NT is not met as evidenced  tion, interview, and document ailed to implement fall ding to the plan of care for 1 of					
	Findings Include:						
	10/5/16, indicated the cognitive impairment assistance with action	um Data Set (MDS) dated he resident had moderate nt, required extensive ivities of daily living, and more falls in the prior three					
	resident was at risk mobility, severe cog	d 12/19/16, indicated the for falls related to limited gnitive impairment, and poor					
LABORATOR'	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE		TITLE		(X6) DATE

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

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F 282	safety judgement. falls included assis reclining lift chair are chair remote and uthe chair so the reserence.  R1's Nursing assist containing specific nursing assistants care) dated 10/21/1 the resident into the power to the reclining remote.  A nursing progress nursing staff heard was found on her let the electric recliner unplugged and R1 chair up and fell to the resident's bed was found on the letter unplugged and R1 chair up and fell to the resident's bed was found on the resident's bed was found on the letter unplugged and R1 chair up and fell to the resident's bed was found on the letter up and fell to the resident's bed was found on the hospital R1's hospital notes admitted to the hospital R1's hospital repair a pain control until be facility on 10/24/16 with a brace, pain reare.  A Documentation of	The care plan intervention for ting the resident into the and handing the resident the lift inplugging the power supply to ident could not utilize the stant care sheet (a sheet resident care information the carried while providing resident 16, directed staff after assisting e reclining chair to unplug the ing chair and give R1 the note dated 10/21/16, indicated R1 yelling from her room. R1 eft side on the floor in front of in the electric recliner was not used the remote to lift the the floor. The call light was on which the resident was not able noted by nursing as, eg and left hip pain," and was by ambulance.  Indicated the resident was spital on 10/21/16, for a left eresident was not a candidate and remained in the hospital for eing discharged back to the interest of the facility medications, and on end of life.  If Coaching session dated	F 28	32		
	registered nurse (F	.m. indicated NA-E met with IN)-C to discuss R1's fall. w the plan of care related to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG		E SURVEY IPLETED
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F 282	not ensuring R1's or residents reach, an source for the elect the floor in her room position, the chair we control for the lift chair. NA-E indicate recliner and "forgot" the lift chair remote "Forgot to move the "Forgot to move the 10/21/16, during the 10/21/16, at approxassisted with transfrecliner using the metal the room. NA-E room she gave R1 remote control for the recliner so the remoneraction of the recliner so the remoneraction of the recliner.  During interview on stated she has was aware the recliner was aware the recliner.  During interview on stated she assesse immediately following RN-C stated when a resident was laying recliner and the reconstition. RN-C stated unplugged to the reconstition. RN-C stated the recliner in R1's the recliner in R1's	all light was within the d failing to unplug the power ric recliner. R1 was found on a with the lift chair in the high was plugged in, and the remote thair was on the arm of the ead she assisted R1 into the dot on the light."  12/19/16, at 1:40 p.m. NA-E assigned NA for R1 on eady shift. NA-E stated on imately 1:30 p.m. NA-D erring R1 into the electric techanical lift, and then NA-D estated before leaving the the call light and hid the ene recliner on the side of the ote was, "Under [R1's] butt." dot cared for R1 in the past and the ner should be unplugged, but with the control of the liner was in the recliner. She entered R1's room the on the floor in front of the liner was in the raised the power had not been cliner as directed by R1's plan note control was on the arm of	F 2	82		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		E SURVEY PLETED
		245352	B. WING			05/0	) 09/2017
NAME OF F	PROVIDER OR SUPPLIER		T	S.	TREET ADDRESS, CITY, STATE, ZIP CODE	03/(	39/2011
RAMSEV	COUNTY CARE CEN	ITER		20	000 WHITE BEAR AVENUE		
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F 282			F 2	82			
F 323 SS=G		1)-(3) FREE OF ACCIDENT	F3	23			
	(d) Accidents. The facility must en	sure that -					
		vironment remains as free rds as is possible; and					
	, ,	eceives adequate supervision ices to prevent accidents.					
	appropriate alternat bed rail. If a bed or must ensure correc	e facility must attempt to use tives prior to installing a side or side rail is used, the facility it installation, use, and a rails, including but not limited ments.					
	(1) Assess the residence from bed rails prior	dent for risk of entrapment to installation.					
		s and benefits of bed rails with dent representative and obtain rior to installation.					
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced					
	Based on observat review, the facility fa interventions were i 1 of 5 residents, R1 assessed as safe to after staff unplugge	cion, interview, and document ailed to ensure fall implemented as assessed for , reviewed for falls. R1 was o sit in a electric reclining chair d the power so the resident emote control to raise the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	TIPLE CONSTRUCTION PING			E SURVEY PLETED
	245352	B. WING				C
NAME OF PROVIDER OR SUPPLIER	243332	B. WING			05/	09/2017
NAME OF FROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2000 WHITE BEAR AVENUE	DE		
RAMSEY COUNTY CARE CENT	ГЕR 		MAPLEWOOD, MN 55109			
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD	BE	(X5) COMPLETION DATE
power to the reclinin remote control to rai floor. This resulted it was sent to the hosp femur fracture.  Findings Include:  R1's Annual Minimum 10/5/16, indicated the cognitive impairment assistance with active experienced two or months.  R1's care plan dated resident was at risk is mobility, severe cognisafety judgement. The falls included after at electric reclining chaspower so the resident control to adjust the directed to hand the was unplugged.  R1's Nursing assistants can care) dated 10/21/16 power to the reclining remote.  R1's nursing progressindicated nursing and discussed the safety	staff failed to unplug the g chair and R1 used the se the chair and fell to the in actual harm for R1 who bital and diagnosed with a left m Data Set (MDS) dated e resident had moderate	F3	323			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>	TIPLE CONSTRUCTION  NG	СОМ	E SURVEY PLETED
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	PROVIDER OR SUPPLIER	ITER		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109	1 03/	03/2011
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F 323	position, which cause the chair. After discresident would be precliner, however, source.  A nursing progress nursing staff heard was found on her let the electric recliner, unplugged and R1 chair up and fell to the resident's bed was not reach. R1 was not reach. R	the chair in the elevated sed the resident to tip out of cussion, it was determined the crovided the remote for the staff would unplug the power note dated 10/21/16, indicated R1 yelling from her room. R1 eft side on the floor in front of. The electric recliner was not used the remote to lift the the floor. The call light was on which the resident was not able oted by nursing as, eg and left hip pain," and was	F 32			
	control for the lift ch chair. NA-E indicate	vas plugged in, and the remote pair was on the arm of the ed she assisted R1 into the 'to unplug the power supply to				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	FIPLE CONSTRUCTION  NG	COW	E SURVEY PLETED
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F 323	the lift chair remote "Forgot to move the "Forgot to move the "The facility follow u 10/25/16, indicated NA-D transfer R1 in the mechanical lift. for R1 she always to chair or in the side stated she had not electric lift chair but light.  The facility investige on 10/21/16, R1 was by two nursing assing the mechanic transferred to the re NA-E stayed with R tucked the remote control. power for the electric chair up and slid out the remote control. During interview on stated she was the 10/21/16, at approxassisted with transfered in transfered with transfered to the remote control for the cliner using the model of the remote control for the control	. NA-E also indicated she, e call light."  p interview with NA-E dated on 10/21/16, she assisted ato the electric recliner using NA-E indicated when caring ucked the remote behind the pocket of the chair. NA-E unplugged the power to the stated she gave R1 the call ation dated 10/28/16, indicated as assisted into the lift recliner stants (NA), NA-D and NA-E, cal lift. After R1 was ecliner, NA-D left the room and 1 to adjust her recliner. NA-E control for the chair into the as R1 agreed she didn't need NA-E did not unplug the ic recliner and R1 lifted the	F 3:	23		

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 ' '	NG		PLETED
		245352	B. WING		1	C /00/0047
	PROVIDER OR SUPPLIER	CONTRACTOR OF THE CONTRACTOR O	D. Willed	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE MAPLEWOOD, MN 55109	<u>(</u> 05/	(09/2017
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F 323	the recliner.  During interview or stated she assess immediately following RN-C stated when resident was laying recliner and the reconstion. RN-C state unplugged to the reconstion of care, and the reconstruction of care, and the reclining chair in the unplugging it and the stated she met with after the resident for stated R1 enjoyed utilize the remote callow the resident to should unplug the premote control. For falls from the reclining staff were instructed stated after R1 fell because staff did not stated.	n 12/19/16, at 2:15 p.m. RN-C ed R1 on 10/21/16, ing the fall from the recliner. she entered R1's room the join the floor in front of the cliner was in the raised ited the power had not been ecliner as directed by R1's plan mote control was on the arm of	F 3:	23		



#### PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

August 8, 2017

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

Re: Enclosed Reinspection Results - Complaint Number H5352046

Dear Mr. Robinson:

On June 30, 2017 an investigator from the Minnesota Department of Health, Office of Health Facility Complaints, completed a reinspection of your facility, to determine correction of licensing orders found during the investigation completed on May 9, 2017. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Kate JohnsTon, Program Specialist

Program Assurance Unit

Licensing and Certification Program

Health Regulation Division

Minnesota Department of Health

kate.johnston@state.mn.us

Telephone: (651) 201-3992 Fax: (651) 215-9697



cc: Licensing and Certification File

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ C B. WING 00846 05/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE **RAMSEY COUNTY CARE CENTER** MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) 2 000 Initial Comments 2 000 \*\*\*\*\*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 conducted to investigate complaint #H5352046. As a result, the following correction orders are issued. The facility has agreed to participate in the electronic receipt

Minnesota Department of Health

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

of State licensure orders consistent with the Minnesota Department of Health Informational

Bulletin 14-01, available at

TITLE

(X6) DATE

FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: C B. WING 00846 05/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE RAMSEY COUNTY CARE CENTER MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) 2 000 Continued From page 1 2 000 http://www.health.state.mn.us/divs/fpc/profinfo/inf obul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. 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. 2 565 MN Rule 4658.0405 Subp. 3 Comprehensive 2 565 Plan of Care: Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced Based on observation, interview, and document review, the facility failed to implement fall interventions according to the plan of care for 1 of 5 residents, R1, reviewed for falls.

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months.

Findings Include:

R1's Annual Minimum Data Set (MDS) dated 10/5/16, indicated the resident had moderate cognitive impairment, required extensive assistance with activities of daily living, and experienced two or more falls in the prior three

PRINTED: 05/11/2017 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: C B. WING 00846 05/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE RAMSEY COUNTY CARE CENTER MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 565 Continued From page 2 2 5 6 5 R1's care plan dated 12/19/16, indicated the resident was at risk for falls related to limited mobility, severe cognitive impairment, and poor safety judgement. The care plan intervention for falls included assisting the resident into the reclining lift chair and handing the resident the lift chair remote and unplugging the power supply to the chair so the resident could not utilize the remote. R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff after assisting the resident into the reclining chair to unplug the power to the reclining chair and give R1 the remote. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the

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care.

facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life

A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with

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stated she assessed R1 on 10/21/16,

the recliner in R1's reach.

immediately following the fall from the recliner. RN-C stated when she entered R1's room the resident was laying on the floor in front of the recliner and the recliner was in the raised position. RN-C stated the power had not been unplugged to the recliner as directed by R1's plan of care, and the remote control was on the arm of

**OUEU11** 

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION A. BUILDING: \_ С B. WING 00846 05/09/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE

#### 2000 WHITE BEAR AVENUE **RAMSEY COUNTY CARE CENTER**

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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
2 565	Continued From page 4	2 565		
	A policy regarding following the plan of care was requested but not provided.			
	SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review policy and procedures on implementing fall interventions according to the plan of care. The director of nursing or designee could conduct random audits of staff providing resident care to ensure cares are being provided according to the plan of care.			
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.			
21850	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights	21850		:
	Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others.			
	This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility staff failed to ensure residents			

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remote.

was unplugged.

R1's Nursing assistant care sheet (a sheet containing specific resident care information the nursing assistants carried while providing resident care) dated 10/21/16, directed staff to unplug the power to the reclining chair and give R1 the

OUEU11

Minnesota Department of Health (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: С B. WING 05/09/2017 00846 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 2000 WHITE BEAR AVENUE **RAMSEY COUNTY CARE CENTER** MAPLEWOOD, MN 55109 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **DEFICIENCY**) 21850 Continued From page 6 21850 R1's nursing progress note dated 12/29/15, indicated nursing and R1's family member discussed the safety of the resident electric recliner. The resident had a fall the prior day from the electric recliner due to using the remote control and putting the chair in the elevated position, which caused the resident to tip out of the chair. After discussion, it was determined the resident would be provided the remote for the recliner, however, staff would unplug the power source. A nursing progress note dated 10/21/16, indicated nursing staff heard R1 yelling from her room. R1 was found on her left side on the floor in front of the electric recliner. The electric recliner was not unplugged and R1 used the remote to lift the chair up and fell to the floor. The call light was on the resident's bed which the resident was not able to reach. R1 was noted by nursing as, "Screaming of left leg and left hip pain," and was sent to the hospital by ambulance. R1's hospital notes indicated the resident was admitted to the hospital on 10/21/16, for a left femur fracture. The resident was not a candidate for surgical repair and remained in the hospital for pain control until being discharged back to the facility on 10/24/16. R1 returned to the facility with a brace, pain medications, and on end of life care. A Documentation of Coaching session dated 10/21/16, at 3:25 p.m. indicated NA-E met with registered nurse (RN)-C to discuss R1's fall. NA-E failed to follow the plan of care related to not ensuring R1's call light was within the residents reach, and failing to unplug the power source for the electric recliner. R1 was found on

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the floor in her room with the lift chair in the high

(X3) DATE SURVEY

Minnesota Department of Health STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED						
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		00846	B. WING			C <b>09/2017</b>						
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RAMSEY COUNTY CARE CENTER 2000 WHITE BEAR AVENUE												
MAPLEWOOD, MN 55109												
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21850	Continued From page 7		21850									
·	position, the chair was plugged in, and the remote control for the lift chair was on the arm of the chair. NA-E indicated she assisted R1 into the recliner and "forgot" to unplug the power supply to the lift chair remote. NA-E also indicated she, "Forgot to move the call light."											
	10/25/16, indicated NA-D transfer R1 ir the mechanical lift. for R1 she always t chair or in the side stated she had not	p interview with NA-E dated on 10/21/16, she assisted nto the electric recliner using NA-E indicated when caring ucked the remote behind the pocket of the chair. NA-E unplugged the power to the stated she gave R1 the call										
	on 10/21/16, R1 was by two nursing assisusing the mechanic transferred to the re NA-E stayed with R tucked the remote coside of the recliner at the remote control. power for the electric chair up and slid out During interview on stated she was the 10/21/16, during the	ecliner, NA-D left the room and 1 to adjust her recliner. NA-E control for the chair into the as R1 agreed she didn't need NA-E did not unplug the ic recliner and R1 lifted the it to the floor.  12/19/16, at 1:40 p.m. NA-E assigned NA for R1 on e day shift. NA-E stated on										
	assisted with transfirecliner using the mileft the room. NA-E room she gave R1 tremote control for the recliner so the remote control to the remote control for the recliner so the remote control for the recliner so the remote control for the remote con	imately 1:30 p.m. NA-D erring R1 into the electric sechanical lift, and then NA-D stated before leaving the the call light and hid the ne recliner on the side of the ote was, "Under [R1's] butt." d cared for R1 in the past and										

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPI	2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY				
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED					
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00846			B. WING		05/09/2017					
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21850	was aware the reclishe forgot on 10/21 sheet directed staff the recliner.  During interview on stated she assesse immediately following RN-C stated when resident was laying recliner and the reconsition. RN-C state unplugged to the reconsition. RN-C state recliner in R1's when interviewed on member (FM)-H state significantly since the longer walks, sits in not cognitive. FM-H reclining chair in the unplugging it and the 10/21/17.  When interview on stated she met with after the resident feestated R1 enjoyed to utilize the remote coallow the resident to should unplug the premote control. FM falls from the reclinic staff were instructed stated after R1 fell to should after R1 fell to staff were instructed stated after R1 fell to should unplug the premote control.	iner should be unplugged, but /16. NA-E stated R1's care to unplug the power source to 12/19/16, at 2:15 p.m. RN-C at R1 on 10/21/16, ang the fall from the recliner. She entered R1's room the on the floor in front of the eliner was in the raised ted the power had not been acliner as directed by R1's plan mote control was on the arm of reach.  on 5/1/17, at 10:20 a.m. family ated R1 had declined he fall on 10/21/16, and no a regular wheelchair, and is 1 stated R1 had fallen from the elepast, but staff had been here were no further falls until 5/1/17, at 10:40 a.m. FM-I the facility in December 2015, all out of the recliner. FM-I the recliner but was not safe to control, so it was decided to so it in the recliner but staff power so R1 could not use the I-I stated there were no further er since December 2015, after d to unplug the power. FM-I from the recliner on 10/21/16, but unplug the power, the	21850							
	SUGGESTED MET	HOD OF CORRECTION: The								

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