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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8E56

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00757

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245353**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231243300**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMILIA ROSE CARE CENTER LLC**
(L4) **11800 XEON BOULEVARD**
(L5) **COON RAPIDS, MN** (L6) **55448**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/27/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor 06/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 06/27/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
10/13/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/07/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
06/17/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245353
June 27, 2016

Mr. Mark Broman, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

Dear Mr. Broman:

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 June 13, 2016 the above facility is certified for or recommended for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 27, 2016

Mr. Mark Broman, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353025

Dear Mr. Broman:

On May 26, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on May 12, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 27, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on May 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 13, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 12, 2016, effective June 13, 2016 and therefore remedies outlined in our letter to you dated May 26, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245353 Y1	A. Building B. Wing Y2	6/27/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0176	Correction	ID Prefix F0272	Correction
Reg. # 483.10(b)(5) - (10), 483.10(b)(1)	Completed	Reg. # 483.10(n)	Completed	Reg. # 483.20(b)(1)	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	06/13/2016
ID Prefix F0278	Correction	ID Prefix F0282	Correction	ID Prefix F0309	Correction
Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	06/13/2016
ID Prefix F0364	Correction	ID Prefix F0369	Correction	ID Prefix F0373	Correction
Reg. # 483.35(d)(1)-(2)	Completed	Reg. # 483.35(g)	Completed	Reg. # 483.35(h)	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	06/13/2016
ID Prefix F0441	Correction	ID Prefix F0501	Correction	ID Prefix	Correction
Reg. # 483.65	Completed	Reg. # 483.75(i)	Completed	Reg. #	Completed
LSC	06/13/2016	LSC	06/13/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	BF/KJ	06/27/2016	10562	06/27/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 8E56

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00757

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245353**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231243300**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMILIA ROSE CARE CENTER LLC**
(L4) **11800 XEON BOULEVARD**
(L5) **COON RAPIDS, MN** (L6) **55448**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/12/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

10.THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements

Compliance Based On:

X 1. Acceptable POC

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

And/Or Approved Waivers Of The Following Requirements:

___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Brenda Fischer, Unit Supervisor 06/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 06/15/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_____ 1. Facility is Eligible to Participate
_____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
10/13/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 06/17/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 26, 2016

Mr. Mark Broman, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353025

Dear Mr. Broman:

On May 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing & Certification
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7338
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by June 21, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by June 21, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by August 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by November 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those

preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and	F 156		6/13/16

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

Electronically Signed | 06/03/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 2 of 3 residents (R29, R34) were provided the required notices of Medicare non-coverage upon termination of covered services. Findings include: R29's Notice of Medicare Non-Coverage dated 5/2/16, identified R29's services under Medicare would be ending on 5/2/16. R29 signed the document on 4/29/16. R29's progress notes dated 5/1/16 to 5/11/16, identified R29 remained at the facility after her Medicare services ended. R29's medical record was reviewed. No documentation was located identifying R29 had	F 156	The facility will ensure that required notices to inform residents who discharged from Medicare, of their right to an expedited review and/or the estimated costs for non-covered services. A corrective action could not be done for R34, as she was discharged from the facility. R29 received a Notice of Medicare Non-Coverage on 5/23/16 for LPD of 5/25/16. An ABN was issued to R29 on 6/3/16. All Medicare residents were identified as having the potential to be affected. Residents having the potential to be affected are identified on the Daily Census Report. (See Attachment #1) A Policy and Procedure for the Medicare/Managed Care Required Notices was reviewed and revised. (See	

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F 156	Continued From page 3 been provided a Skilled Nursing Facility Advanced Beneficiary Notice (SNFABN) as required. R34's progress note dated 4/26/16, identified R34 discharged from the facility to home. R34's medical record was reviewed. No documentation was located identifying R34 had been provided a Notice of Medicare Non-Coverage as required. During interview on 5/11/16, licensed social worker (LSW)-A stated R29 remained in the facility after her Medicare coverage ended due to lack of a discharge plan. LSW-A was, "100 percent sure" R29 did not receive a SNFABN, adding the social services department, "just started doing the denials." LSW-A stated R34 had been here under Medicare A for therapy services, and discharged home after therapy decided she no longer needed the skilled service. Further, LSW-A stated R34's Notice of Medicare Non-Coverage was unable to be located, and there was, "no documentation that it was given." A facility policy on liability notice(s) was requested, but none was provided.	F 156	Attachment #2) To make certain that the new policy is implemented and sustained, a daily audit of ABN of Non Coverage (See Attachment #3) and a Med B End of Coverage (See Attachment #4) will be done for 3 months. Discrepancies will be reported to the Administrator and corrected immediately. The audit results will be reported at QA.	
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced	F 176		6/13/16

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F 176	Continued From page 4 by: Based on observation, interview and document review, the facility failed to comprehensively assess and care plan the ability to safely self administer nebulizer treatments for 1 of 1 residents (R147) observed to place the nebulizer mask on the top of her head during treatment. Findings include: R147's Prospective Payment System (PPS) Minimum Data Set (MDS) dated 4/20/16, identified R147 had severe cognitive impairment. During observation on 5/11/16, at 8:41 a.m. R147 was laying in bed with her eyes closed. R147 had a running nebulizer machine on her bedside dresser connected to a mask which was placed directly on top of her head in her hair. There was some clear fluid medication remaining in the vial attached to the mask. At 8:57 a.m. (16 minutes later) nursing assistant (NA)-E walked over to R147 in bed and asked, "Are you ready to get up?" NA-E stated she was not sure who placed the nebulizer mask on R147, or how long it had been running. NA-E added, "Maybe she [R147] did it." At 9:00 a.m. trained medication aide (TMA)-D entered R147's room and stated to R147, "You still have medicine in there." TMA-D added, "You took it off again." When interviewed on 5/11/16, at 9:09 a.m. TMA-D stated she placed the nebulizer mask on R147's nose and mouth, "a little after eight [8:00 a.m.]." R147 had taken the mask off several times, but TMA-D did not have time to sit with her to make sure she received all the medication safely. "If I had time to sit with her, I would of." Further, TMA-D stated she was unaware if R147	F 176	The facility will ensure that an individual resident may self-administer drugs if the IDT has determined that this practice is safe. A corrective action for R147 could not be done, as she was discharged from the facility. One other resident was identified as having the ability to administer his own drugs. A physician order for drug self administration was written on 4/22/15. The Self Administration of Medication Evaluation Tool was reviewed and revised. (See Attachment #5) The resident was re-evaluated on 6/3/16. His ability to self administer his drugs is identified on his care plan. To ensure that the deficient practice will not occur again, a Self Administration of Medication Evaluation will be done upon admission on every resident, and if the resident is deemed safe, an order from the physician will be obtained. To make sure that the Policy is implemented and sustained, the Clinical Managers will audit new admissions for completion of the Evaluation for 3 months. The audit results will be reported at QA.	

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had been assessed to be safe with self administering her own nebulizer medications, "I don't think she has been [assessed]."

R147's medical record was reviewed. No assessment of R147's ability to safely self administer nebulizer medications was identified.

R147's signed physician orders dated 5/3/16, identified an order for, "Ipratropium-Albuterol solution [medication used to help breathing] for nebulization" twice a day. R147's physician orders did not identify R147 could self administer any medications, including nebulizers.

R147's care plan dated 3/21/16, identified R147 had chronic obstructive pulmonary disease (COPD, a disease which causes trouble breathing) with an intervention of, "Medications per orders." R147's care plan did not identify if R147 was safe to self administer nebulizer medications.

During interview on 5/11/16, at 10:05 a.m. clinical manager licensed practical nurse (LPN)-C stated residents should be assessed for safety, and physician orders should be obtained prior to allowing residents to self administer medications. Further, LPN-C stated he reviewed R147's medical record and was unable to locate any assessment of R147's ability to safely self administer nebulizer medications.

When interviewed on 5/11/16, at 1:14 p.m. registered nurse (RN)-C stated resident should have, "some kind of assessment to determine their capability of doing that [self administering nebulizer medications]," and a physician's order should be obtained. Further, RN-C stated R147

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F 176	Continued From page 6 was not someone who should be self administering her own nebulizer medication, "I would say she's incapable of self administering [medications]." A facility policy on self administration of medication was requested, but none was provided.	F 176		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272		6/13/16

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F 272	Continued From page 7 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation interview and document review, the facility failed to complete the care area assessments for 1 of 5 residents (R101) within 14 days of admission. Findings include: R101 was admitted to the facility on 12/12/2015, discharged to the hospital on 12/12/15, and re-admitted back to the facility on 12/31/15. R101's admission record dated 12/12/15, identified multiple diagnoses including diabetes, major depressive disorder and constipation. R101's care area assessment's (CAA) completed 12/23/15, failed to include the triggered areas of: cognitive loss, communication, rehabilitation, urinary incontinence, psychosocial well-being, mood state, behavioral symptoms and psychotropic drug use. During interview on 5/12/2016, 10:21 a.m. MDS registered nurse (RN)-B stated, "R101 is missing her CAA's from admission" because the facility thought she was a short term resident. RN- B confirmed the identified CAA's should have been completed prior to day 14. RN-B stated	F 272	The facility will ensure that the Care Area Assessments for residents are completed within 14 days of admission. To correct the deficiency on R101, an Annual MDS will be done, with an ARD of 6/9/16 and completed with CAAs and care plans by 6/13/16. All residents who are short term admissions are at risk for not having CAAs completed in a timely manner. For future short term clients, the CAAs will be completed on or before day 14, unless a planned discharge occurs prior to day 14. An audit for timely completion of CAAs will be done on every admission for the next 3 months by the MDS Coordinator. (See Attachment #6) Results of the audit will be reported at QA.	

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F 272	Continued From page 8 completing the CAA's was important because the "CAA's drive the care plan." A facility policy titled MDS assessment dated 11/12/15, identified, "CAA's are to be completed on all full assessments by day fourteen (or within 7 days of the ARD [assessment reference date]) for delirium, visual function, communication, activities of daily living, functional rehab potential, psychotropic drug use, psychosocial well-being, cognitive loss, mood and behavior." Furthermore the policy stated the MDS coordinator was responsible to ensure the interdisciplinary team conducted timely resident assessments and reviews, "within 14 days of the resident admission to the facility."	F 272		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who	F 278		6/13/16

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F 278	Continued From page 9 willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to accurately code two Minimum Data Set's (MDS) for 1 of 1 (R12) residents reviewed for hospice care. Findings include; R12's quarterly MDS dated 1/20/16, and 4/20/16, failed to accurately identify R12 was currently receiving hospice care. Review of document titled, "Hospice Certification and Plan of Treatment" dated 2/8/16, identified R12's hospice care was started on 4/4/15, and certified through 6/6/16. On 5/12/16, at 10:14 a.m. MDS registered nurse (RN)-B identified R12's quarterly MDS's dated 1/20/16, and 4/20/16, did not accurately identify the resident was receiving hospice care. RN-B further stated, "I would hope that they [staff] are putting the correct information in the MDS and using the tool." During interview on 05/12/2016 10:58 a.m., licensed practical nurse (LPN)-A confirmed that R12's quarterly MDS assessments dated 1/20/16,	F 278	The facility will ensure that the MDS will be accurately coded for residents on hospice care. The corrective action for R12 was that the 2 corrected/modified MDS's were submitted and accepted into the QIES data base on 5/18/2016. Any resident who is currently on hospice per daily census and/or weekly IDT or admitted to hospice in the future have the potential to be affected by incorrect coding on the MDS. Monitoring of daily census and weekly IDT will be used to identify residents who are on hospice. (See Attachments #8 & 13). Current and future residents who are on hospice will have their MDS double checked to ensure coding is correct prior to closing by the MDS coordinator. A log of current hospice residents and current MDS will be maintained by the MDS coordinator. (See attachment #7) Results of MDS hospice log will be reported to QA for 3 months.	

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F 278	Continued From page 10 and 2/8/16, did not correctly identify R12 was receiving hospice care. Furthermore, LPN-A confirmed that R12's quarterly assessments were not correctly coded and stated, "If a resident is getting hospice care it should be coded correctly. I just missed those as I am new at MDS." LPN-A confirmed that MDS quarterly assessments were inaccurate. Review of facility policy titled, MDS assessment dated 11/2/15 stated the purpose of the MDS was to, "provide a comprehensive, accurate, standardized, reproducible assessment of each long term client's functional capabilities to help staff identify health problems in order to developed individualized care plans." Furthermore, "all persons who have completed any portion of the MDS MUST sign the document attesting to the accuracy of such information."	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide adaptive equipment and assistance with meals as directed by the plan of care for 1 of 2 residents (R72). Findings include: R72's quarterly minimum data set (MDS), dated	F 282	The facility will provide adaptive equipment and assistance with meals as directed by the plan of care. The corrective action for R72 included an order obtained for OT to evaluate and treat for use of adaptive equipment. Use of adaptive equipment was added to R72's plan of care, resident menu/diet slip	6/13/16

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F 282	Continued From page 11 4/7/16, indicated moderate cognitive impairment, and need for assistance with oversight/encouragement to eat with set up help only. R72 received a mechanically altered diet. R72's care plan, dated 1/12/16, directed staff to assist with meal set-up; add condiments, pour liquids, and cut food into bite size pieces. R72's care plan also identifed the resident received a mechanical soft diet. The care guide identified R72 was on a regular diet and required assist with set up. The dietary menu slip identified R72 was to receive a covered cup. On 5/10/16, at 9:37 a.m. R72 was observed to have poured hot chocolate into the cereal bowl from an uncovered coffee cup. R72 drank from the cereal bowl, spilling fluids over the front of the clothing protector, and onto the floor. The clothing protector was saturated. R72's clothing was noted to be wet where the fluid ran off the clothing protector. At 9:40 a.m. R72 was observed pouring from bowl to cup, nursing assistant (NA)-F was observed wheeling by with another resident. NA-F did not offer assistance or seek alternate assistance for R72. At 9:42 a.m. NA-D walked slowly by slowly, without offer of assistance. NA-G then approached R72 and provided her with a fresh clothing protector, removing the bowl and cup previously used. NA-G provided R72 with a fresh cup of hot chocoalte in an uncovered cup. On 5/11/16, at 8:06 a.m. NA-H assisted R72 to the dining room table for breakfast. NA-H assisted R72 with the application of a clothing protector and provided her with orange juice and coffee. The coffee cup had no lid. At 8:13 a.m. R72 was provided with a covered cup of hot chocolate with a lid by client dining assistant	F 282	and care guide. Fifteen additional residents in the facility were identified to be using adaptive equipment. All were screened by OT and orders to evaluate and treat were obtained as recommended. Use of adaptive equipment was added to residents plan of care, resident menu/diet slip and care guide. Residents using adaptive equipment will be reviewed each week at IDT. Any significant change in residents ability to feed self will be identified at morning stand up. (see Attachment # 8 and Attachment #13) To ensure that the practice for residents who use adaptive equipment is implemented and sustained, the nurse managers will perform random audits 2 times each week for 3 months to ensure compliance with adaptive equipment and that consistent documentation is recorded on the plan of care, resident menu/diet slip and care guide. Results of audits will be reported at QA. (See Attachment #9)	

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F 282	Continued From page 12 (CDA)-C, and the coffee cup without a lid was removed. On 5/11/16, at 1:17 p.m. R72 was observed without a covered coffee cup. CDA-C stated R72 was to have a covered cup for hot liquids, as listed on the bottom of the menu. The lunch menu in front of R72 identifed the need for a covered cup for hot liquids. CDA-C stated this was how the information was relayed to anyone providing dining assistance to residents. On 05/12/16, at 2:33 p.m. NA-I stated information was provided to staff regarding resident needs with use of the resident menu, as well as the care guide. On 5/12/16, at 2:39 p.m. licensed practical nurse (LPN)-A stated the information for the staff assistance needed at meal time was listed on the resident menu. On 5/12/16, at 3:31 p.m. LPN-C stated the information on the resident menu sheet would be considered to be part of the resident plan of care. LPN-C stated information was placed on the menu to provide staff with information on how to best meet the resident's needs. LPN-C was unable to state when this intervention was implemented, by whom, for what reason, or how it was relayed to staff for implementation. On 5/12/16, at 3:36 p.m. a care plan and activities of daily living policies were requested of the director of nursing and nothing was provided.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		6/13/16

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F 309	Continued From page 13 provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess behavior changes with bathing for 1 of 1 residents (R97) observed to become upset during her bath. Findings include: R97's quarterly Minimum Data Set (MDS) dated 2/4/16, identified R97 had severe cognitive impairment, required physical assistance with bathing, and displayed no behaviors. During observation on 5/12/16, at 10:20 a.m. R97 was seated in her wheelchair being assisted down the hallway toward the tub room by nursing assistant (NA)-K. R97 stated, "Please don't do this, it scares me" to NA-K as they approached the tub room. NA-K stated she was going to help R97 take her scheduled bath. R97 replied, "No, we're not." R97 stated several times she wanted to leave, "Please take us out of the other way [pointing down the hallway, away from the tub room]." NA-K replied, "You have to take a shower first." R97 again stated she wanted to leave, "Take us out of here." NA-K continued to wheel R97 into the shower room. R97 started to scream aloud, "Wait!" as she was being wheeled into the tub room, "No, No, No!" At 10:25 a.m.	F 309	The facility will ensure 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. The corrective action for R97 was that target behaviors were added to POC documentation and a behavior care plan was implemented for her. (See Attachment #10) A target behavior symptom log for NAR documentation was established for R97 and behavior interventions were added to the care guide. Nurse manager had a staff meeting on May 12, 2016 to address behavior communications. (See Attachment #11) All residents were identified to be at risk for behaviors and refusal of care. Behaviors will be reviewed daily during morning meeting and weekly IDT. (See Attachment #8 and Attachment #13) To monitor and ensure that all residents with behaviors are being identified and documented, and care plans and care guides are established or current, the nurse managers will conduct audits two	

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F 309	Continued From page 14 more audible screaming was heard from the tub room with the door closed. "Help, Help!" NA-K opened the tub room door and asked NA-D, "Can someone help me?" NA-L entered the tub room, and left shortly afterward. At 10:28 a.m. further audible screaming was heard from the tub room, with R97 shouting: "Take me out of here!" "Don't do that!" "I'm burning!" "Get me out of here!" R97's care plan dated 5/9/16, identified R97 had, "Potential for alteration in behavior" related to her dementia. It directed staff to: "Re-approach as needed", "Attempt to maintain a consistent routine," and, "Observe for precipitating factors that may lead to negative behavior." The psychosocial portion of the care plan identified staff was to be aware of the care plan areas and goals and to implement the plan of care. The care plan did not identify R97 had behaviors with bathing, nor were there any individualized interventions to reduce or eliminate behaviors with bathing. When interviewed on 5/12/16, at 11:04 a.m. NA-K stated R97 had, "A lot of screaming" with her bath and, "It sounded terrible." NA-K stated she had never worked with R97 before because she was from an outside agency, so NA-K, "was very unaware" of R97's behaviors with bathing. NA-K stated she continued to perform the bathing, despite R97 yelling and screaming, because she had worked with other dementia residents in the past. NA-K stated she "assumed from previous experience [with other residents]" that R97's behavior was "what she [R97] does." Further, NA-K stated she was unaware of any specific interventions to help decrease anxiety and behavior from R97 during her bathing. "It would have been nice to know." NA-K stated R97	F 309	times each week for 3 months.(see Attachment #12) Audit results will be reported to QA.	

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F 309	Continued From page 15 calmed down after her shower "but it took awhile." NA-K added it was, "hard with dementia [residents] to walk in and not know about them." During interview on 5/12/16, at 11:16 a.m. NA-E stated she was an employee of the facility and consistently worked with R97. R97 had been having more behaviors with her bathing in the past, "couple weeks," and now disliked taking showers and baths. "She hates taking a bath." At times, R97 would "start screaming" when brought into the tub room. Staff tried to talk to her about other things, and show her the hand shower faucet during the bathing which sometimes would help reduce her fears and behaviors. NA-E stated sometimes R97 would, "scream too much" so they were not able to complete the shower. NA-E added "Maybe she is scared of the water or something." Further, NA-E stated staff have never tried just doing bed baths instead of a shower with R97, "We just give her a shower." When interviewed on 5/12/16, at 11:22 a.m. clinical manager licensed practical nurse (LPN)-C stated he was not aware of, "any concerns with [R97]" about behaviors during bathing. LPN-C added, "Nobody's brought that to my attention." LPN-C stated R97 had not been assessed for interventions to reduce her behaviors with bathing, including alternatives to the shower such as bed bathing. LPN-C reiterated no staff had told him about concerns with R97's behavior during bathing. Facility policies on dementia care and assessment of behavior was requested, but none were provided.	F 309		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		6/13/16

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F 364 SS=D	Continued From page 16 PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide warm, palatable food for 2 of 2 residents (R208, R209) observed to receive cold hamburgers during the meal service. Findings include: R208's Brief Interview for Mental Status (BIMS) dated 5/05, identified R208 had intact cognition. R209's Social Work Services Assessment dated 5/5/16, identified R209 was, "Alert and Orientated to Person, Place and Time." During observation of the evening meal service on 5/9/16, at 5:17 p.m. dietary aide (DA)-A was preparing and serving hamburgers from a steam table on the second floor dining room. The lids from the containers in the steam table were all removed and placed on the adjacent stove, allowing the food to sit in the steam table uncovered. R208 was seated at a table eating a hamburger and stated the meal was good, "Except the meat was cold." At 5:33 p.m., DA-A prepared a room tray for R209, which was covered and delivered by a	F 364	The facility will ensure that each resident receives food prepared by methods that conserve nutritive value, flavor, and appearance; and food is palatable, attractive, and the proper temperature. The facility was unable to correct deficient practice for R208 due to discharge. The dietary tech met with R209 to discuss nutritional preferences. R209 stated that she never felt the need to have food reheated and that everything had been fine. "Food was good." (see Attachment #14) All residents were identified to have the potential of not receiving warm palatable food. Measures that were put in place to ensure that the deficient practice will not reoccur are Nutrition Service Manager or Diet Tech will continue to attend the monthly Culinary Club during Resident Council. At every meeting attendees will be asked if 1) the hot food has been hot 2) the cold food has been cold and 3) how the food is tasting. Responses will be documented and concerns addressed immediately. (see Attachments #15 and Attachment #16)	

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F 364	Continued From page 17 nursing assistant (NA). A sample tray was requested by the surveyor at that time, and DA-A prepared a hamburger from the steam table. The surveyor asked DA-A to check the temperature of the hamburger(s) being served to the residents in the dining room and with room trays, however DA-A stated she was not sure how to do that, adding she wasn't even sure where to find a thermometer. The sample hamburger was cut in half, and DA-A along with the surveyor tasted the food. The meat was cold to touch and taste, and DA-A stated the meat was cold and, "definitely could be warmer." DA-A stated the food temperature was checked in the kitchen prior to being brought up to each floor for steam table service, but to her knowledge was not checked again during the serving process. DA-A stated she stored the steam table lids on the stove top versus using them to cover the food because she was trained to do that by other staff. When interviewed about her evening meal on 5/9/16, at 5:43 p.m. R209 stated her hamburger was cool and could be, "A little bit warmer." Further, R209 stated the meals served at the facility were not consistently served warm. During interview on 5/11/16, at 12:27 p.m. the certified dietary manager (CDM) stated the food on the steam table should have been covered to, "help maintain that heat." When interviewed on 5/11/16, at 1:25 p.m. registered dietician (RD) stated the lids on the steam table should be closed to, "Keep the temperature warm," and hamburgers should be served hot as cold ones were, "not going to taste very good."	F 364	Mandatory meetings for all dietary staff will be held on June 7, 2016 and June 9, 2016 to educate them on new half covers for the steam tables, and how to use them; how to properly take food temperatures and the locations of thermometers on the units. (see Attachment #17) To ensure that the plan is implemented and sustained, the Nutrition Service Manager or Diet Tech will take temperatures weekly on random test trays and record results x3 months. Non compliance will be addressed immediately. (see Attachment #18)RD to audit test tray compliance 2 times a month for 3 months. Audit results will be reported at QA.	

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F 364	Continued From page 18 A facility policy on food palatability was requested, but none was provided.	F 364		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adaptive equipment was provided for 1 of 2 residents (R72) identified as needing adaptive dining equipment. Findings include: R72's quarterly minimum data set (MDS), dated 4/7/16, indicated moderate cognitive impairment, and need for assistance with oversight/encouragement to eat with set up help only. R72 received a mechanically altered diet. R72's care plan, dated 1/12/16, directed staff to assist with meal set-up; to add condiments, pour liquids, and cut food into bite size pieces. R72's care plan also identifed the resident received a mechanical soft diet. The care guide identified R72 was on a regular diet and required assist with set up. The dietary menu slip identified R72 was to receive a covered cup. On 5/10/16, at 9:37 a.m. R72 was observed to have poured hot chocolate into the cereal bowl from an uncovered coffee cup. R72 drank from	F 369	The facility will ensure that residents who need special eating equipment and utensils will be provided with them. The corrective action for R72 included an order obtained for OT to evaluate and treat for use of adaptive equipment. Use of adaptive equipment was added to R72's plan of care, resident menu/diet slip and care guide. Fifteen additional residents in the facility were identified to be using adaptive equipment. All were screened by OT and orders to evaluate and treat were obtained as recommended. Use of adaptive equipment was added to residents plan of care, resident menu/diet slip and care guide. Residents using adaptive equipment will be reviewed each week at IDT. Any significant change in residents ability to feed self will be identified at morning stand up. (see Attachment # 8 and Attachment #13) To ensure that the practice for residents who use adaptive equipment is implemented and sustained, the nurse	6/13/16

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F 369	Continued From page 19 the cereal bowl, spilling fluids over the front of the clothing protector, and onto the floor. The clothing protector was saturated. R72's clothing was noted to be wet where the fluid ran off the clothing protector. At 9:40 a.m. R72 was observed pouring from bowl to cup, nursing assistant (NA)-F was observed wheeling by with another resident. NA-F did not offer assistance or seek alternate assistance for R72. At 9:42 a.m. NA-D walked slowly by slowly, without offer of assistance. NA-G then approached R72 and provided her with a fresh clothing protector, removing the bowl and cup previously used. NA-G provided R72 with a fresh cup of hot chocoalte in an uncovered cup. On 5/11/16, at 8:06 a.m. NA-H assisted R72 to the dining room table for breakfast. NA-H assisted R72 with the application of a clothing protector and provided her with orange juice and coffee. The coffee cup had no lid. At 8:13 a.m. R72 was provided with a covered cup of hot chocolate with a lid by client dining assistant (CDA)-C, and the coffee cup without a lid was removed. On 5/11/16, at 1:17 p.m. R72 was observed without a covered coffee cup. CDA-C stated R72 was to have a covered cup for hot liquids, as listed on the bottom of the menu. The lunch menu in front of R72 identifed the need for a covered cup for hot liquids. CDA-C stated the menu's are updated as needed. CDA-C stated this was how the information was relayed to anyone providing dining assistance to residents. On 05/12/16, at 2:33 p.m. NA-I stated information was provided to staff regarding resident needs with use of the resident menu, as well as the care guide. NA-I stated it "tells how to	F 369	managers will perform random audits 2 times each week for 3 months to ensure compliance with adaptive equipment and that consistent documentation is recorded on the plan of care, resident menu/diet slip and care guide. Results of audits will be reported at QA. (See Attachment #19)	

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F 369	Continued From page 20 feed them on their menu" and additional information "if they need assistance, food preference, allergies, special techniques, finger foods, etc..." On 5/12/16, at 2:39 p.m. licensed practical nurse (LPN)-A stated the information for the staff assistance needed at meal time was listed on the resident menu. Upon review of resident chart, LPN-A was unable to determine when the intervention of a covered cup was put into place. LPN-A stated no recent occupational therapy evaluations had been completed for dining. On 5/12/16, at 3:31 p.m. LPN-C stated the information on the resident menu sheet would be considered to be part of the resident plan of care. LPN-C stated information was placed on the menu to provide staff with information on how to best meet the resident's needs. LPN-C was unable to state when this intervention was implemented, by whom, for what reason, or how it was relayed to staff for implementation. LPN-C stated he would look into that and provide additional information, however, nothing was provided. On 5/12/16, at 3:36 p.m. a care plan and activities of daily living policies were requested of the director of nursing and nothing was provided.	F 369		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is	F 373		6/13/16

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F 373	Continued From page 21 consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights.	F 373		

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F 373	Continued From page 22 Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility filed to ensure 3 of 5 residents (R115, R93, R113) identified as needing assistance with eating were assessed to be safe to be fed by a paid feeding assistant (PFA). Findings include: On 5/9/16, at 1:02 p.m. the director of nursing (DON) stated the facility had a PFA program and they had been trained to assist with feeding any resident in the facility. The DON further indicated the PFA's had been trained with a state approved training program by a Registered nurse (RN). The facility identified the following three residents in the facility needed assistance with eating and had been feed by a PFA: R115, R93, and R113. R115's annual Minimum Data Set (MDS) dated 1/28/16, indicated she needed extensive assistance to eat, had no swallowing disorder and received a mechanical soft diet. R115's care area assessment (CAA) dated 1/28/16, indicated she received a mechanical soft diet for better acceptance and ease of chewing. R115's care plan dated 4/29/16, indicated she had diagnoses including dementia, Parkinson's and congestive heart failure. The care plan	F 373	The facility will ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Residents R115, R93, and R113 were identified and had a meal time assistance evaluation done. (see Attachment #20) Speech therapist will screen all 3 and orders to evaluate and treat will be obtained if recommended. 15 residents in the facility were identified as needing assistance during mealtime and will have a meal time assistance evaluation done. (see Attachment #20) Speech therapist will screen all 15 residents and orders to evaluate and treat will be obtained if recommended. Nurse managers will review all identified residents' menu/diet slip, care plan and care guide to make sure they match. Any new residents' that are identified as needing assist with feeding, will be reported during morning meeting. All residents who need assistance with feeding will be discussed weekly x 3 months.(see Attachment #13 and	

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F 373	Continued From page 23 further indicated R115 needed staff assistance to eat and had impaired nutrition status due to diabetes. R115 was identified to have difficulty chewing regular textures and received a mechanical soft diet. The R115's physician order dated 5/26/15, identified a mechanical soft diet. On 4/26/16, R115's Physician Orders indicated "Three day puree diet trial. Resident choking on mechanical soft diet meat and watermelon". R115 ' s Meal Time Assistance Evaluation dated 5/9/15, indicated she needed assistance with feeding, did not need a modified textured diet and was appropriate for a paid feeding assistant. The assessment further indicated she "meets criteria" for a PFA and indicated "Client is not at significant risk of choking/aspiration with current interventions. Client may participate in the paid feeding assistant program. " On 4/28/16, a "Quarterly Nutritional assessment completed. See nutrition assessment for objective data. Res is on a mech soft diet d/t [due to] better acceptance with mech soft. She is being tried on a puree diet to see if this helps increase intake d/t noted increase of pocketing food. Nursing staff is monitoring and will recommend puree diet if she does better with this." Resident Progress Notes dated 5/3/16, indicated a quarterly interdisciplinary review "diet has changed to a pureed from mechanical. Resident is tolerating diet change well. Has had a 6 pounds weight loss, but not significant." During interview 5/9/16, at 11:12 a.m. R115's family member (FM)-K indicated R115's diet had changed to a pureed diet because she started to pocket her food. During interview 5/9/16, at 8:13 p.m. licensed practical nurse (LPN)-C stated R115 was pocketing her food and it wasn't going well. R115	F 373	Attachment #8) Interdisciplinary Team Meeting Review minutes (Attachment #8)will be reviewed at QA x 3 months.	

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F 373	Continued From page 24 coughed a lot so a three day trial of a pureed diet was trialed and she did so well the diet was changed to pureed. During observation and interview on 5/10/16, at 8:29 a.m. client dining assistant (CDA)-A was observed to feed R115. No difficulty was observed with R115 being fed. R115 had a pureed diet. CDA-A stated she assisted with feeding R115. R115 was eating "pretty good but we have to feed her baby bites". CDA-A continued to state R115 ate approximately 50% of her meal and was on a mechanical soft diet but now needed a pureed diet. On 5/10/15, at 8:31 a.m. CDA-B stated she was the one who was feeding R115 a few weeks ago when she began coughing while eating. CDA-B stated "she was coughing at 2-3 different meals" so she reported it to nursing because it was concerning to her. R93's significant change MDS dated 3/10/16, indicated she had no swallowing disorders, needed extensive assist of one to eat and received a mechanical soft diet. R93's CAA dated 3/14/16, indicated she received a pureed diet due to declining condition and spitting food out. R93's care plan dated 3/1/16, indicated she had a diagnosis of dementia which could affect intake and had difficulty chewing regular textures so received a pureed diet. R93's Physician Orders dated 5/1/16, indicated she received a pureed diet. R93's Meal Time Assistance Evaluation dated 11/18/14, indicated she needed physical assistance with eating, did not have a modified textured diet, did not have increased risk of choking/aspiration and could participate in the paid feeding assistant program. On 5/10/16, at 8:40 a.m. CDA-A was observed to	F 373		

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assist R93 with eating breakfast. R93 was observed to be fed a pureed diet with no difficulty noted.
On 5/10/16, at 8:45 a.m. CDA-A stated she helped feed R93 and she usually ate about 50% of her meals. CDA-A continued to state R93 had no coughing or choking issues while being fed.
R113's annual MDS dated 4/28/16, indicated he received extensive assistance with eating, had no swallowing difficulty and received a mechanically altered diet. R113's CAA dated 4/28/16, indicated he was receiving a mechanical soft diet due to increased difficulty chewing regular texture.
R113's care plan dated 4/29/16, indicated he had alteration in eating related to Parkinson's disease and advanced dementia and had increased difficulty chewing regular textures and received a mechanical soft diet.
R113's Physician Order Report dated 4/25/16, indicated he received a mechanical soft diet.
On 5/10/16, at 8:29 a.m. CDA-C was observed to feed R113 a mechanical soft diet. No difficulties with eating were observed.
On 5/10/16, at 8:31 a.m. CDC-C stated she usually fed R113 and she had not observed any difficulty chewing or swallowing.
On 5/12/16, at 2:00 p.m. the director of nursing (DON) stated R115 should have been seen by speech therapy (ST) before doing a trial diet change. Staff normally contact ST with diet order changes. The DON further stated if a resident's diet has changed a new Meal Time Assistance Evaluation should be completed.
On 5/12/16, at 2:48 p.m. the speech language pathologist (SLP) stated she was not contacted to observe R115 eating. Usually the facility would contact her before completing a change in someone's diet. The SLP stated nursing usually contacted the physician for a SLP order and then

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F 373	Continued From page 26 she would observe the resident. The SLP further indicated someone with a complicated feeding problem would be someone who was cognitively impaired and/or had a pureed or mechanical soft diet. Although R115, R93 and R113 had changes in their diets due to chewing or swallowing difficulty, a new assessment was not completed to ensure they could be safely fed by a paid feeding assistant. A facility policy for Paid Feeding Assistants dated 5/9/16, indicated "1. Staff attend state approved paid feeding assistant program and must pass skilled and written test within recommended guidelines. 2. Staff oriented to the floor and specific duties/tasks as designated. 3. Staff are monitored while on the unit by the nurse on-duty." No other policies were provided by the facility.	F 373		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		6/13/16

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F 441	Continued From page 27 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to implement an infection control program to track, trend and analyze infections and to prevent a gastro-intestinal (GI) outbreak which affected 16 of the 31 residents on third floor (R1, R23, R64, R97, R134, R25, R93, R146, R107, R200, R28, R142, R32, R59, R201) and 8 of 22 residents on the first floor (R5, R104, R3, R55, R35, R43, R60, R96). This failure had the potential to affect all 73 residents in the facility. Findings include: During initial tour 5/9/16, at 1:00 p.m. a note was posted on the third floor at the nurses station	F 441	The facility will establish and maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection. R1, R 23, R64, R97, R134, R125, R93, R146, R107, R200, R28, R142, R32, R59, R201, R5, R104, R3, R55, R35, R43, R60, and R96 have had no further gastrointestinal signs or symptoms since May 15, 2016. No additional residents have been identified with any gastrointestinal signs or symptoms. Systemic changes in the Infection Control	

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F 441	Continued From page 28 which indicated: "Since the start of May 2016, a number of our residents have been sick with GI [gastro- intestinal vomiting and/or having diarrhea]. Please staff, do hand washing, hand washing, hand washing. Encourage residents to drink more fluids if possible. Request for liquid diet. Keep those sick in their room whenever possible frequent checks." During the initial tour there was no indication which residents had GI symptoms or who should be isolated. Third Floor: A facility calendar for the third floor was provided by the facility on 5/10/16, at 10:00 a.m. which identified 15 resident's with GI symptoms of emesis and/or diarrhea from 5/1/16 thru 5/6/16. It identified 10 of the third floor residents with the following: On 5/1/16, at 2:45 a.m. R23 woke up around 2:00 a.m. had incontinent larger stool on the floor of her room, some are loose while some are formed. Resident also had small emesis about 75 ml (milliliters) VSS (vital signs stable), will continue to monitor the patient. The progress notes futher indicated on 5/2/16, at 4:04 p.m. R23 "Writer placed call to NP (nurse practitioner) in rel (relation) to c/o (complaints of) stomach pains and stooling. No emesis at this time." At 9:45 p.m. the progress notes indicated "A very large undigested food, tan liquid foul odorous emesis." On 05/01/16, at 9:54 p.m. R142 "Resident had large emesis with food particles and light and tan in color, approximately 190 cc (cubic centimeters) at 9:45 p.m." On 5/3/16, at 12:41 a.m. R97's progress note	F 441	Program have been implemented to include: All residents that have suspected/confirmed infectious process will be reported and discussed at morning meeting. (see Attachment #13) Residents exhibiting any signs of gastrointestinal distress will be evaluated by using the Criteria for Infection Report form-Gastrointestinal Tract Infections. (see Attachment #21) All resident exhibiting GI signs or symptoms will be recorded on a Monthly Infection Control Log to ensure tracking and trending is being completed. (see Attachment #22) To ensure that our resident care equipment is disinfected after use by potentially infectious residents, the Resident Care Equipment Use Policy and Procedure was revised. (see Attachment #23) All residents with identified infectious processes will be completely and accurately recorded on the Monthly Infection Control Log on all 3 units. (see Attachment #22) To ensure that all Monthly Infection Control Logs are complete and accurate, the Infection Control Nurse will review weekly for 3 months. If inaccurate, education will be done and omissions or discrepancies will be reported to the DON. The Infection Control nurse will complete an Infection Summary monthly and report results at QA. (see Attachment #24) To ensure that all employees with suspected infectious processes are tracked, an Employee Illness Reporting	

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F 441	Continued From page 29 identified "Client started having an emesis as she sat in recliner in TV lounge, then went to the bathroom and had diarrhea." On 5/3/16, at 4:41 a.m. R64's progress note indicated "Patient called and ask for something to eat, toast, fruit cocktail, coffee and ginger ale was given. Few minutes later, patient went to the toilet and had a BM (bowel movement) patient later has emesis twice this shift." On 5/3/16, at 5:43 a.m. R107's progress note indicated "Patient also has diarrhea once this shift." On 5/3/16 at 5:33 a.m. R93's progress notes identified "Patient had diarrhea and emesis once this shift." On 5/3/16, at 5:55 p.m. R25's progress note stated "Resident seen having emesis into the trash can next to water fountain." On 5/4/16, at 6:11 a.m. R72's progress note indicated "Client had large liquid stool at 0500 a.m. her temperature was 97.6. shower was given." On 5/5/16, at 3:13 p.m. R141's progress note indicated "Resident had x 2 x large diarrhea in this shift. VSS, BP (blood pressure) 99/86, P (pulse) 118, R (respiration) 18 ,T (temperature) 98.1 O2 (oxygen saturation) 97% RA (room air). Broth and fluids are given, message left for NP and family, will continue to monitor." On 5/6/16, at 1:30 p.m. R32's progress notes indicated "Emesis: Temp 100.6 P.88 R.20 BP118/68 Client had 3 small to moderate dark	F 441	policy and procedure was initiated. (see Attachment #25) To safeguard the health of our residents and staff members, the Attendance Record will be utilized and the CRCC Employee Infection Control Log will be maintained by the Infection Control Nurse. (see Attachment #26 and Attachment #27) Education on Infection Control, along with other preliminary survey results, were presented at the Monthly Nurses meeting on May 24, 2016 and at the Monthly NAR meeting on May 26, 2016. (see Attachments #28 and Attachment #29) The Infection Control Program was discussed and approved by the Medical Director on June 1,2016. The Infection Control Program will be reviewed at QA.	

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emesis this shift, no loose stools. Abdomen soft, does have regular bowel movements. Denies pain."

Residents who had vomiting and/or diarrhea were allowed to co-mingle with symptom free residents. Symptomatic residents were brought into the public milieu prior to being symptom free for the 72 hours recommended by the Centers for Disease Control and the Minnesota Department of Health (MDH) epidemiologist.

On 5/9/16, at 3:00 p.m. R1 was observed to be sitting in the day room at an activity. The director of nursing (DON) was talking to the residents about mothers day. R1 was in her wheelchair sitting next to the bird Avery along with several other residents. At 5:11 p.m. R1 was observed to be sitting in the dining room next to R64 eating a cookie.

On 5/10/16, at 9:46 a.m. R1 was observed in the dining room eating toast, danish and a banana.

R1's Progress Notes indicated on 5/6/16, at 1:55 p.m. "Client had small emesis after breakfast, will keep on cleat [clear] liquid, client did eat a regular breakfast and said she was feeling fine at the time." On 5/9/16, at 5:09 a.m. "Nausea and vomit, diarrhea. 98.4. Did offer juice and ginger ale, took a few sips of each." On 5/9/16, at 10:44 p.m. the progress notes indicated "Resident had a large emesis at 6:00 p.m. while nursing assistant was getting her ready for HS (bedtime). Resident gave no indication after dinner that her stomach was upset. After the 1 x emesis resident stated "Feel much better". No other episodes of emesis on evening shift. Residents temperature was 97.4 after emesis. Continue to

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F 441	Continued From page 31 monitor." R35's progress notes dated 5/7/16, indicated he had emesis and loose stools, "resident is probably getting stomach flu." The progress notes dated 5/10/16, at 6:28 p.m. included the R35's family "is insisting that he be seen in the ER [emergency room]...Daughter thinks that he is dehydrated..." R35's emergency department note dated 5/10/16, included in part, "[R35] is a 85 p.o. male who presents with a report of generalized weaknesses and confusion following several days of vomiting and diarrhea. The patients GI symptoms appear to be improving over the past day. He still has not resumed a normal diet. He arrived with hypotension [low blood pressure]. He normalized after initial intravenous fluids. After being treated for suspected dehydration, the patient did have clearing of his mental state." The note indicated R35 received 1.5 liters of intravenous fluids. R5's progress notes dated 5/10/16 indicated he no longer had any gastrointestinal symptoms. Registered nurse (RN)-A stated on 5/11/16, at 8:43 a.m. R5 had been ill with symptoms on 5/9/16, and had no symptoms for the first time on 5/10/16. R5 was observed to be in the dining room with 17 other residents on 5/11/16, at 8:50 a.m. This was less than 72 after having symptoms. R104's progress note dated 5/9/16, at 11:07 p.m. indicated she had loose stools four times during the shift. R104 was noted to be in the dining room at breakfast with 17 other residents on 5/11/16, at 8:50 a.m. This was less than 72 hours after having gastrointestinal illness symptoms.	F 441		

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When interviewed on 5/11/16, at 8:43 a.m. registered nurse (RN)-A stated she had a list of 7 residents who had gastrointestinal illness symptoms in the past few days and would be checking their vital signs. RN-A stated residents needed to stay in their room while they had symptoms, but could come out if their symptoms had resolved. The list included R104, R5, R60, R43, R55, R96, and R3. R35 was not on RN-A's list of residents who had been ill.

R60's progress notes dated 5/9/16, at 11:32 a.m. indicated she had loose stools during the shift. R60 was noted to be in the dining room with 17 other residents on 5/11/16, at 8:50 a.m. This was less than 72 hours of having symptoms.

R3's progress notes dated 5/10/16, indicated she had loose stools. R3 was observed leaving her room on 5/11/16, at 8:59 a.m. she stated she was going to breakfast and would be getting her hair done today. R3 then joined breakfast with other residents who had not been identified as having gastrointestinal symptoms, even though she had loose stools the evening before.

The EZ way stand handles on first floor were not disinfected between resident use. Residents had been ill with gastrointestinal symptoms within the past 48 hours.

R55's progress notes dated 5/9/16, included she had experienced loose stools and emesis that day. During observation on 5/11/16, at 7:52 a.m. registered nurse (RN)-A and trained medication aide (TMA)-B assisted R55 from her wheel chair to her recliner with a mechanical EZ Way standing lift. The standing lift required R55 to hang onto the handle bars as she was being lifted

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from the wheel chair. After R55 was in her recliner, she requested a towel be placed on her chest in case she vomits. R55 explained she had the vomiting and diarrhea that had been going around and she felt she could vomit again. TMA-B then brought the mechanical lift into R5's room without disinfecting the handle bars.

R5's progress notes dated 5/10/16, indicated he had not had any emesis or loose stools that day, however, RN-A stated on 5/11/16, at 8:00 a.m. he had been ill with a gastrointestinal illness with vomiting and diarrhea on 5/9/16. She was going to check his vital signs to ensure he was recovering from this illness. The EZ Way standing lift was used by TMA-B and NA-B to get him out of bed on 5/11/16, at 8:06 a.m. The handle bars were not disinfected on the lift, and the lift was brought into R43's room at 8:50 a.m.

R43's progress notes dated 5/6/16, indicated she had begun having emesis. A progress note dated 5/9/16 indicated she continued with loose stools. The EZ Way standing lift was used by TMA-B and NA-B to assist her out of bed on 5/11/16, at 8:57 a.m. The handle bars had not been disinfected before or after the transfer.

When interviewed on 5/11/16, at 9:03 a.m. TMA-B stated she did not know of any gastrointestinal illness on this unit. She had been off work for a few days and nothing was said in report from the previous shift. She had not been instructed on any extra precautions and was not aware of any resident being restricted to their rooms. She stated she had not disinfected the handles of the standing lift between residents and did not know if they were ever disinfected.

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Student nurse (SN)-A brought the EZ Way standing lift into R35's room on 5/11/16, at 9:20 a.m. and utilized it with another student nurse to get him in to the wheelchair from bed. The handles of the lift were not disinfected. R35's progress notes dated 5/11/16, indicated he had returned from the emergency room where he was sent after having vomiting and diarrhea for "several days." SN-A brought the lift out of the room at 9:25 a.m. and placed it in the bathing room. SN-A stated she did not know if the handles of the lift should be disinfected or not, and was not aware R35 had been having gastrointestinal symptoms.

Infection Control Program and Monthly Infection Control Log:

Review of the facility's Monthly Infection Control Logs from 10/1/15 to 5/12/16 indicated the following:

The third floor Monthly Infection Control Log listed the following:

On 10/30/15, R107 had an upper respiratory infection (URI). The log failed to identify organisms, antibiotic utilized, classification (if it was a community acquired or health care associated infection) and date resolved.

On 3/21/16, R145 had an URI with a date resolved of 3/31/16. No organism or classification was identified in the log.

On 4/8/16, R126 had a urinary tract infection (UTI). No organism, classification or date resolved was listed on the log.

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During interview 5/10/16, at 9:18 a.m. licensed practical nurse (LPN)-A stated he was the clinical manager for the third floor and he had been there since 7/15. He verified the above listed infections were the only ones he has had on his floor.

A facility Order Report by Category for antibiotic use on the third floor dated 11/1/15 to 4/30/16 indicated the following:

R145 was prescribed cipro for UTI on 12/29/15, and doxycycline on 3/21/16 and again on 3/31/16.

R72 was prescribed bactrim for a UTI on 2/2/16.

R64 was prescribed keflex for cellulitis on 12/23/15.

R147 was prescribed levofloxacin for community acquired pneumonia on 3/11/16.

R107 was prescribed augmentin with no diagnosis identified on 10/31/15 and on 11/1/15 was prescribed rocephin again with no diagnosis listed.

Although the facility had infection control logs for the third floor, the logs did not identify the infections for R72, R64,R147 and R107 and the logs did not indicate the culture, classification, and date resolved.

Review of the second floor Monthly Infection Control Log from 2/16 to 4/16 indicated the following:

2/16 - listed ten infections: three UTI's; four pneumonia - one aspiration, two community acquired and one infectious organism; one ear

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	245353	A. BUILDING _____ B. WING _____	05/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

(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
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infection; one skin infection, and one cystitis (infection of the bladder). The log did not indicate culture, classification and date resolved. In addition, the log did not indicate a location comparison for infections to assist with identifying clusters/trends for infections.

3/16 - listed 11 infections: five UTI, three pneumonia, two leg cellulitis - weeping bilateral extremity, and one lower respiratory infection. The log did not indicate culture, classification or date resolved. In addition the log had no tracking/trending of infections to locations.

4/16 - listed ten infections: four pneumonia, one abscessed tooth, one ear infection, two UTI, one lower respiratory infection and one upper respiratory infection. The log did not indicate date of onset, date resolved, organism, and classification. In addition the log had no tracking/trending of infections to locations.

The first floor Monthly Infection Control log from 2/16 through 4/16 indicated the following:

2/16 - identified six infections: four UTI, a lung infection and chronic obstructive pulmonary disease (a chronic lung disease not infection based). The log did not list organism, classification, or date resolved.

3/16 - listed three infections: three UTI's with one culture of E.coli (organism residing in stool that commonly causes UTI's), no other cultures, no classifications or dates resolved were identified.

4/16 - listed three infections: two UTI's, and one pneumonia. The log did not indicate cultures, classifications or dates resolved.

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During interview 5/10/16, at 10:17 a.m. licensed practical nurse (LPN)-D stated she was the staff development nurse and was taking on the infection control program. LPN-D stated no one had been tracking the infection control program. She indicated each clinical manager on the floors were documenting on the logs but no one had been analyzing the data. She indicated she planned to get them back on track and they have a plan in progress. LPN-D further indicated she would be making sure she knew if anyone had an infection and if an employee was ill. LPN-D further indicated until recently the staff were only identifying resident's on antibiotics on the log. The facility had not been tracking infectious illnesses not requiring the use of antibiotics such as GI illnesses. LPN-D futher indicated the logs were lacking the culture, classification, resolved date and they had not been tracking the location of the infections.

On 5/9/16, at 7:27 pm. nursing assistant (NA)-L stated "We had a stent of flu like a 24 hour bug that we had here." NA-L stated he hadn't received any training but that "we are to keep them in there room." NA-L further stated "we keep pretty much everyone in there room it they have nausea or vomiting until the symptoms are gone so we don't spread it to anyone it is like a 24 hour thing." NA-L further stated that R1 was sick the other day and "I think she is doing good now."

On 5/9/16, at 8:08 p.m. LPN-C stated "We have had some GI symptoms going on for the past week." LPN-C identified the facility has an infection control nurse who gives directions for staff on what to do. LPN-C stated the facility protocol had been if residents were vomiting they

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kept them in their room as much possible, and complete handwashing. Staff contacted the resident physicians and the physician's indicated staff should monitor residents on the unit. The nurses were to pass the information of residents being sick from shift to shift. LPN-C received report and reported infections to the infection control nurse. LPN-C stated there had been staff sick call's but was not sure if it was related to the symptoms the residents were having.

On 5/10/16, at 1:51 p.m. LPN-D stated they notified the residents primary physicians of the illness. The physician's felt no cultures were necessary but to check temperatures and confine residents with a clear liquid diet for as long as needed. LPN-D further indicated the NP had been in the loop. LPN-D further stated she had not contacted the medical director. LPN-D stated she had not contacted the state department of health concerning the facility's outbreak of GI symptoms.

On 5/10/16, at 4:10 p.m. with the director of nursing (DON), administrator and infection control nurse, the DON stated the the first symptom was noted on 5/1/16. The DON also stated day with most symptoms was 5/3/16 and they did not culture the residents. The DON futher indicated they attempted to isolate the residents and that no resident went longer than 24 hours with symptoms. The DON stated she had not contacted the epidemiology unit of the Minnesota Department of Health because she did not feel they had a outbreak.

On 5/12/16, at 10:30 a.m. the DON provided a letter dated 5/10/16 at 6:00 p.m. that she indicated her infection control nurse reported

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MDH epidemiology by voice message. "Calling from Camilia Rose to report/discuss our facility surveyors are here & suggested that I call to report the N (nausea),V (vomiting),diarrhea in our facility. We have been in contact with our MD's (medical doctors) providing care here & our medical director regarding this. They have provided us with their recommendations to follow as they do not consider this to be clinically significant facility acquired infection. Left message to return call with number."

On 5/12/16, at 11:02 a.m. one of the family nurse practitioners (NP) stated LPN-C had informed her in a memo on 5/4/16, and I had informed them to keep them as separated as possible when they have symptoms. The NP futher stated they don't do cultures for gastro-intestinal enteritis (infectious diarrhea) and the hospitals do not. It was a self limiting one day viral issue that they are not concerned about. The NP stated the residents on the dementia unit have the freedom to make wrong choices - they can't lock them up in their rooms.

During interview on 5/10/16, at 4:10 p.m. the medical director (MD) stated she had been the facility's medical director for, "approximately about a year and a half," and visited the facility, "once a month." The MD stated she was aware the program, "was a big issue at the last survey," however she had not been included on trying to correct it. "I haven't had a huge involvement." The previous DON started working on the program after last years state survey, however there were, "so many things to focus on" and the infection control program was not a focus. The MD stated her responsibilities as the facility medical director included, "quality control," and

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offering the facility, "a variety of guidance." Further, the MD stated the infection control program at the facility was not adequate and, "definitely needs work." However, the MD added the facility had not worked with her to address the deficient program, "I don't have a specific plan."

When interviewed on 5/12/16, at 3:31 p.m. the DON stated the medical director was used, "as a reference" for the facility with any concerns. The MD visited the facility on a monthly basis, however, the DON stated she had not specifically addressed the concerns with the inadequate infection control program with the medical director.

When interviewed on 5/13/16, at 1:00 p.m. the Minnesota Department of Health (MDH) Infectious Disease Epidemiologist, Prevention, and Control representative, epidemiologist (EP)-A, stated the facility should have reported an outbreak of infectious gastrointestinal (GI) illness to them, yet no report had been made at this point. An outbreak would be anything over their baseline for GI illness at any given time. In addition, the facilty should have taken the following steps to minimize the spread of this illness:

1. Gather data and characterize the outbreak: this would include the number of residents and staff ill with vomiting or diarrhea. For residents, this information should include the room number and floor. For staff, work station, including wing and floor. Date of onset of symptoms for each ill individual. The number of individuals who have had vomiting. The number of individuals who have had diarrhea. The number with diarrhea that have bloody diarrhea. The number of individuals

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F 441	Continued From page 41 with fever, including the highest temperature recorded for each individual. The median duration of illness and range of illness. A list of food service staff, identifying who have been ill and who have not been ill. Document special meals/patient feeding and extracurricular activities or special events that were held in past 2 weeks prior to the first illness. This information should be provided to the health department. In addition, this information should be tracked as residents or staff become ill and utilized to determine the initial ill person and how it was spread, and to assist in stopping the spread of the illness. 2. The facility should have restricted ill employees from resident care and food handling for 72 hours after their vomiting and diarrhea ended. 3. Ill residents and staff should be separated from those who have not experienced illness. If a large outbreak, consideration should be given to halting new admissions until after the outbreak has ended. Ill residents should be separated from non-ill residents for 72 hours after their last vomiting or diarrhea episode. 4. Eliminate common events until the conclusion of the outbreak. 5. Environmental surfaces should be thoroughly cleaned and sanitized. EP-A provided a "Clean-up and disinfection for Stomach Bug" handout that included the need to use a chlorine bleach solution. 6. Staff and residents should use hand washing with soap and water (instead of hand sanitizer) for all handwashing, as hand sanitizer fails to eliminate GI illness virus. During interview 5/10/16, at 1;50 p.m. housekeeping director (HD) stated the facility	F 441		

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used Oasis 531 to disinfect the residents rooms. She stated they cleaned the room surfaces, bathrooms are done twice a day and they are wiping down the handrails in the hall and table tops. The HD stated they received the Oasis 531 from Ecolab. The HD further stated she had a housekeeper call in and that she only worked Monday's and Fridays and she has not been back to work yet. The HD was not certain of her symptoms.

The Product Specification Document for Ecolab One Step Disinfectant Germicidal Detergent and Deodorant (Oasis 531) provided by Ecolab representative (ER)-A identified bacteria, viruses and fungi the product destroys. The document did not identify the capability of killing typical gastro-intestinal illness viruses such as norovirus. The document identified it as a product that may be used to pre-clean an area that required a higher level of disinfection.

The US Environmental Protection Agency Office of Pesticide Programs List G: EPA Registered Hospital Disinfectants Against Norovirus (Norwalk-like virus) dated 10/22/15, did not list the Ecolab product used by the facility as a product that killed this gastrointestinal illness.

The facility's Infection Control Transmission-Based Precautions policy dated 2015 from Pathway Health Services-Infection Control Manual indicated under Surveillance and Outbreak Management "2. An outbreak is defined as a. three cases of clinically significant, facility acquired infections caused by the same organism occurring in the same general area within a period of seven (7) days (2,3,4,) OR b. twice the normal number of these infections per month

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F 441	Continued From page 43 observed for a period of three (3) consecutive months." The policy futher indicated "An outbreak is likely to be caused by the transmission of organisms by staff and a breakdown in the use of standard precautions. Therefore, an intensive education program for staff with rigorous supervision of hand washing and use of gloves and gowns should be done. If after these procedures are done and there continues to be new cases of infection, an epidemiologist from the state or local heath department should be notified."	F 441		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to collaborate with the medical director (MD) to establish and maintain an effective infection control program to reduce potential transmission of infections to other residents in the facility. This had potential to affect all 73 residents in the facility. Findings include: Refer to F441. The facility failed to implement an infection control program to track, trend and analyze infections and to prevent a	F 501	The facility will ensure that our Medical Director is responsible and involved in the implementation of resident care polices and the coordination of medical care in the facility. To correct the deficient practice, the Medical Director and the Director of Nursing will meet monthly to discuss, evaluate to ensure that the current Infection Control policy is effective and being maintained. The Medical Director, Director of Nursing, and the Infection Control nurse met on	6/13/16

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F 501	Continued From page 44 gastro-intestinal (GI) outbreak which affected 16 of the 31 residents on third floor (R1, R23, R64, R97, R134, R25, R93, R146, R107, R200, R28, R142, R32, R59, R201) and 8 of 22 residents on the first floor (R5, R104, R3, R55, R35, R43, R60, R96). This failure had the potential to affect all 73 residents in the facility. During interview on 5/10/16, at 4:10 p.m. the medical director (MD) stated she had been the facility's medical director for, "approximately about a year and a half," and visited the facility, "once a month." The MD stated she was aware the program, "was a big issue at the last survey," however she had not been included on trying to correct it. "I haven't had a huge involvement." The previous DON started working on the program after last years state survey, however there were, "so many things to focus on" and the infection control program was not a focus. The MD stated her responsibilities as the facility medical director included, "quality control," and offering the facility, "a variety of guidance." Further, the MD stated the infection control program at the facility was not adequate and, "definitely needs work." However, the MD added the facility had not worked with her to address the deficient program, "I don't have a specific plan." When interviewed on 5/12/16, at 3:31 p.m. the DON stated the medical director was used, "as a reference" for the facility with any concerns. The MD visited the facility on a monthly basis, however, the DON stated she had not specifically addressed the concerns with the inadequate infection control program with the medical director. A facility Medical Director Agreement dated 1/14,	F 501	June 1,2016 to discuss and evaluate the Infection Control Program Plan. The current Infection Control Program was approved by the Medical Director. (see Attachments # 21, Attachment #22, Attachment #23, Attachment #24, Attachment #25, Attachment #26, Attachment #27). Medical Director reviewed and approved the May Monthly Nurses and NAR meeting minutes. (see Attachment #28 and Attachment #29) To ensure that the Medical Director and Director of Nursing continue to meet monthly to review the infection program and to implement and coordinate the medical care in the facility, the Administrator will audit the meetings monthly for 3 months. (see Attachment #30) Results of the audits will be reported at QA.	

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F 501	Continued From page 45 identified services the MD was responsible for which included, "shall guide, approve, and help oversee the development, implementation, and monitoring/evaluation of Facility's resident care polices and procedures," and, "shall review, respond to, and participate in federal, state, local, and other external surveys and inspections. To that end, Facility shall notify Physician [MD] of any such quality of care or medical issues noted during the survey or inspection. Physician shall provide input on any plan of correction ... resulting from a survey or inspection."	F 501		

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

F5353024

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on May 05, 2016. At the time of this survey Camilia Rose Care Center was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Camilia Rose Care Center is a 3-story building with no basement. The original building was constructed in 1976 and an addition was constructed to the facility in 1993 both the original building and the addition are Type I (332) construction. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 80 beds and had a census of 74 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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