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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 92J5

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 **06/24/2021** (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 :
Susie Haben, Unit Supervisor — 07/26/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Melissa Poepping, Enforcement Specialist — 07/26/2021 (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.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/09/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 26, 2021

CMS Certification Number (CCN): 245353

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

Dear Administrator:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective June 15, 2021 the above facility is certified 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
May 27, 2021

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: CCN: 245353
Cycle Start Date: May 6, 2021

Dear Administrator:

On May 6, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 6, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by November 6, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
July 26, 2021

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: CCN: 245353
Cycle Start Date: May 6, 2021

Dear Administrator:

On June 24, 2021, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 92J5

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 **05/06/2021** (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:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X 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: **B*** (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 :
Austin Fry, HFE NE II 06/21/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 07/09/2021 (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.
00131
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
May 27, 2021

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: CCN: 245353
Cycle Start Date: May 6, 2021

Dear Administrator:

On May 6, 2021, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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 6, 2021 (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).

In addition, if substantial compliance with the regulations is not verified by November 6, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	C 05/06/2021

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
E 000	Initial Comments On 5/3/21 to 5/6/21, a survey for compliance with the Centers for Medicare and Medicaid (CMS) Appendix Z Emergency Preparedness requirements was conducted during a recertification survey. Camilia Rose Care Center was found to be in full compliance with the requirements.	E 000		
F 000	INITIAL COMMENTS On 5/3/21 to 5/6/21, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH). Camilia Rose Care Center was found to be not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. In addition, multiple complaint investigations were completed at the time of the recertification survey. The following complaint(s) were found to be substantiated: H5353121C (MN65488); cited at F677. H5353122C (MN65216); with no deficiencies issued due to corrective actions taken prior to survey. H5353123C (MN63930); cited at F550. The following complaint(s) were found to be unsubstantiated: H5353119C (MN68720) H5353120C (MN66738) 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	F 000		

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

Electronically Signed | 06/05/2021

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 _____	C 05/06/2021

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	Continued From page 1 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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		6/15/21

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CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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F 550	Continued From page 2 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure soiled incontinence products were cleaned and removed to promote a dignified living space for 1 of 1 resident (R20) observed to have a soiled product left on the floor of his room which resulted in a noticeable urine odor. Findings include: R20's minimum data set (MDS) quarterly assessment dated 3/24/21, indicated no cognitive impairment, however, required extensive one assist for personal hygiene care and two assist for repositioning and bed mobility. R20's care plan revised 5/6/21, resident has a self-care deficit with activities of daily living (ADL) The care plan outlined R20 was incontinent of bowel and bladder and required assistance to meet his toileting needs. During observation and interview on 5/3/21, at 10:11 a.m. visibly soiled, white incontinence	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by provisions of federal and state law. For the purposes of any allegation that the center is not substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F550-D Residents Rights Camilia Rose Care Center strives to maintain an environment that promotes or enhances resident rights by treating each resident with respect and dignity. All activities and interactions with residents focus on assisting residents in maintaining	

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F 550	Continued From page 3 product on floor next to trash in R20's room by window. R20 stated not sure how long it has been there. There is a noticeable urine odor present in room. During interview on 5/3/21, at 10:36 a.m. nursing assistant (NA)-C and trained medication aid (TMA)-A stated that they have not changed R20's brief yet this morning as he was sleeping earlier and denied placing a wet brief on the floor. NA-C and TMA-A stated it was inappropriate for staff to leave it on the floor and stated they would clean it up right away. During interview on 5/5/21, at 12:07 p.m. registered nurse (RN)-A stated all wet incontinent products should be discarded in the residents trash and brought to the soiled utility room and should never be placed on the floor as it is not dignified and pose a risk for infection When interviewed on 5/5/21, at 12:43 a.m. licensed practical nurse manager (LPN)-C expressed soiled incontinence products should be immediately removed from the resident's room after they're changed as it was an infection control concern and causes urine odors. Further, LPN-C voiced a soiled product being left in the room was poor presentation and a dignified care issue. On 5/6/21, at 9:55 a.m. the interim director of nursing (DON) was interviewed. She explained soiled incontinence products should be removed from a resident's room and disposed of in the soiled utility room adding it was inappropriate for them to be left on the floor as it caused room odor and was a dignified care issue for the resident.	F 550	or enhancing his or her self-esteem, promoting autonomy, honoring choices and respecting each resident□s individuality. Education provided to all nursing staff on 6/4/2021 and 6/10/2021. Education will include procedure on providing ward order after all personal cares are completed and ensuring resident rights are maintained by promoting a dignified living space. Staff will refrain from leaving incontinent products on the floor. Any staff not in attendance at the staff meeting will be required to complete make up by 6/15/2021. Daily audits of resident living space will be conducted on all 3 floors to ensure resident dignity is maintained for 2 weeks or until compliance is achieved, then 3x per week for 2 weeks, then weekly thereafter X 3 months. Results of audits will be brought to the facility□s Quality Assurance Committee for review and further guidance. The Director of Nursing or designee is responsible for monitoring.	

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F 550	Continued From page 4 During interview on 5/6/21, at 11:45 a.m. R20 stated he was unsure who had left the soiled incontinence product on the floor but voiced he did not like it being left there. R20 added this was because of "dignity" and it "smells bad." Policy Quality of Life-Dignity dated 2/10/21, indicated "Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem. Staff promote, maintain and protect resident privacy, including bodily privacy treatment procedure. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents."	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the	F 578		6/15/21

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F 578	Continued From page 5 resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure wishes and directives for emergency treatment (i.e., cardio-pulmonary resuscitation) were obtain upon admission to ensure appropriate care would be provided if found without pulse or breathing for 1 of 1 resident (R12) reviewed for advanced directives. Findings include: R12's quarterly Minimum Data Set (MDS), dated 3/4/21, identified R12 had moderate cognitive impairment and required limited to extensive assistance for his activities of daily living (ADLs). Further, the MDS outlined R12 had high blood pressure, heart failure and diabetes mellitus.	F 578	F578-Req/Ref/Discontinue Tx/Formulate Advance Directive Residents have the right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advanced directive. Facility failed to ensure wishes and directives for emergency treatment were obtained upon admission to ensure appropriate care would be provided if found without pulse or breathing for R12. During standard survey on 5/5 & 5/6/2021 multiple calls were placed to POA to discuss R12□s POLST and wishes for care. No call was	

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F 578	Continued From page 6 R12's undated Face Sheet, obtained from his electronic medical record, identified R12 as "Full Code" under a section labeled, "Advanced Directives." The sheet then had spacing to record if R12's directive(s) were on file, however, this was left blank. On 5/4/21, at 5:49 p.m. R12 was interviewed and expressed he used oxygen since having COVID and being hospitalized. When questioned on actions he would want taken if he were found without a pulse or not breathing, R12 expressed he would want "whatever it takes" to keep him alive or resuscitate him. R12 stated he had not been asked or questioned on this since his admission to the nursing home. R12's progress note, dated 12/16/20, identified the staff had mailed R12's admission paperwork, including a POLST (Physician Orders for Life Sustaining Treatment) to R12's family member (FM)-D via certified mail. During the standard survey, on 5/4/21 and 5/5/21, mulitple phone calls were placed to FM-D to discuss R12's POLST and wishes for emergency care. No return call was provided. R12's medical record was reviewed and lacked evidence the mailed items, including POLST, had been received or followed up on to ensure R12's wishes and directives were assessed and accurate despite the change in care venue (i.e., hospital to nursing home). There was no evidence the facility had assessed R12 to determine what, if any, measures he or his responsible party would want implemented during an emergency situation; nor directives or	F 578	returned. On 6/4/2021, Social Services was able to reach a family member. Per family request, the POLST was reviewed with the resident. It is now updated and reflects his current wishes. Education provided to nursing staff and social services on 6/4/21 and 6/10/21 on providing written information upon admission/readmission. Included in the education procedure for follow up of when POLST mailed to families, reviewed and addressed. All residents have the potential to be affected. All resident□s charts reviewed for POLST on file and in compliance. All POLSTs reviewed during care conferences to determine if current wishes remain the same and documented. Audits to be completed weekly X4 on all new admissions/readmissions and then monthly X4. Results of audits will be brought to the facility□s Quality Assurance Committee for review and further guidance. The Director of nursing or designee is responsible for monitoring and compliance.	

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explanation on how the facility identified R12 as a full code on his Face Sheet.

On 5/4/21, at 6:48 p.m. licensed practical nurse manager (LPN)-C and social services designee (SSD)-A were interviewed. They reviewed R12's medical record and verified it lacked any completed POLST(s) or documentation from the nursing home outlining R12's wishes in the event of emergency care being needed. R12 was placed as a "full code" as he came from the hospital with those orders. They acknowledged the facility had not, according to the medical record, revisited this with R12 to ensure those remained his wishes since his admission and expressed the facility was currently in the process of changing how POLST's were completed and obtained. LPN-C and SSD-A both expressed they were unaware a completed POLST had not been returned and/or scanned into his record and SSD-A stated she was unaware who should be following up on those mailed items to ensure they are returned. During subsequent interview, on 5/5/21, at 11:59 a.m. LPN-C stated she attempted to contact R12's family member (FM)-A to discuss the code status and R12's wishes, however, had not received a return call as of then. LPN-C reiterated R12 should have had a POLST completed upon admission, per their facility' policy, and expressed "somewhere along the line it got missed."

When interviewed on 5/5/21, at 1:30 p.m. the interim director of nursing (DON) stated a POLST should be completed for each resident upon their admission to the nursing home which was their process. This was important to do so staff would have "clear direction" on R12's wishes should be require emergency care. The DON added, "We

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F 578	Continued From page 8 need to get that taken care of." A provided Advance Directives policy, dated 2/2021, identified resident's would be provided with written information upon admission regarding their right(s) to refuse or accept medical care and formulate an advanced directive, if they wished. The policy included, "Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record." However, the policy lacked any information on how or who was responsible to ensure mailed items, including POLST, were returned and addressed.	F 578		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide routine personal hygiene (i.e., shaving and nail care) for 1 of 2 residents (R20) reviewed for activities of daily living and who were dependent on staff for their care. Findings include: R20's face sheet undated, indicated diagnosis: hemiplegia and hemiparesis unspecified cerebrovascular disease affecting left non-dominate side (stroke causing paralysis of his left side), dysphagia (difficulty swallowing), age-related physical debility, and muscle	F 677	F677-D ADL Care Provided for Dependent Residents All residents have the potential to be affected. A resident who are unable to carry out ADL□s have the right to receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. R20□s care plan updated to include shave daily if resident will allow. Clean fingernails daily. Check, and cut fingernails on bath days or PRN if needed. All residents have been reviewed for proper nail care and shaving and provided as needed.	6/15/21

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F 677	Continued From page 9 weakness. R20's minimum data set (MDS) quarterly assessment dated 3/24/21, indicated no cognitive impairment, however, required extensive one assist for personal hygiene care. R20's Care area assessment (CAA) dated 2/7/21, indicated requiring extensive assistance with dressing, grooming and incontinence care. CAA further indicated a self-care deficit with activities of daily living and mobility due to hemiplegia from a prior stroke. R20's aid sheet undated, indicated shaving should be done daily and grooming with assist of one. R20's care plan revised 5/6/21, resident has a self-care deficit with activities of daily living including bathing, grooming, oral cares, ambulation, transferring, mobility, bowel and bladder. History of cerebrovascular accident (CVA) (stroke). Care plan approach included shave daily if resident will allow, check fingernails daily if needed to be cleaned then clan and if needs cut them created 5/6/21. Care plan revised on 2/2/21, indicated "I can verbally ask for assistance, I need 2 assistance to help me remain free from skin breakdown and respect my dignity". During observation and interview on 5/3/21, at 10:25 a.m. R20 had visible white hair on chin and neck line. R20 stated doesn't usually like wearing a beard and would like it removed and stated he was shaved over 3 days ago with his battery powered shaver. R20's finger nails on both hands visibly long. R20 indicated he usually has to ask	F 677	Education provided to all nursing staff on facility policy- Care of fingernails/toenails, shaving and activities of daily living on 6/4/2021 and 6/10/2021. To ensure the changes are effective, audits will be performed by Nurse Managers or designee that consist of visual inspection of the resident. Audits will be conducted on 5 residents on each floor 3X week X4 weeks then monthly X3. Results of the audits will be brought to the facility□s Quality Assurance Committee for review and further guidance. The Director of Nursing or designee is responsible to monitoring.	

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to have them clipped, but really would like to have them shorter.

During interview on 5/4/21, at 6:14 p.m. R20 indicated he would like to be shaved along with having his facial hair cut, however denied staff asking him to assist him. R20 stated "I usually have to ask if I want to be shaved or have my nails trimmed." R20 stated he did not like having his nails long or his facial hair long. R20 denied refusing to have these cares provided. R20 stated his bath day was Tuesday evenings.

During interview on 5/5/21, at 7:30 a.m. LPN-B indicated R20 takes his bed bath in the evening and staff should be providing nail care and offering shaving. LPN-B further stated nail care and shaving should be offered as needed and if a resident refused it should be reproached after education. LPN-B further stated it is important to be provided with shaving and nail care to prevent spread of infection and appearance.

During interview on 5/5/21, at 9:52 a.m. nursing assistant (NA)-A stated men should be shaved almost every day as long as it was their preference and nail care done on bath days or as needed.

During interview on 5/5/21, at 10:21 a.m. RN-B stated all residents should be shaved and provided nail care on shower days and as needed. RN-B stated he would expect residents who need to be shaved, shaved as long as it is the resident's preference.

During interview on 5/5/21, at 10:43 a.m. LPN-C stated R20 requires assistance with activities of daily living and stated it was a concern if it was

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only being done when he requested it. LPN-C stated she was unsure if he had refused shaving or nail care to be performed. LPN-C looked at Weekly Bath and Body Audit sheet and stated it indicated that he was cleaned shaved which would mean face and neck were shaved. LPN-C stated nail care should have been completed as well unless resident refused. LPN-C further indicated having being shaved and nail care can make an individual feel better. LPN-C stated it is important to have nails trimmed to prevent residents from scratching themselves and for sanitary purposes.

During observation and interview on 5/5/21, at 12:01 p.m. R20's partially shaved cheeks were shaved however under nose has approximately 1/4 inch long hairs above left lip just under nose and 1/4 inch to 1/2 inch gray/white hair from chin down to neck. Nails appear to be the same length as 5/4/21. R20 indicated he shaved his self first then staff assisted him with shaving the rest of the way but doesn't feel they shaved him very well. R20 further stated that no one had clipped his nails.

R20's progress notes dated 5/5/21, licensed practical nurse (LPN)-A stated "shaved the patient and clipped the patients finger nails this evening on p.m. (evening) shift. Patient tolerated the shave and nail clipping well

During interview on 5/5/21, at 12:07 p.m. Registered nurse (RN)-A stated R20 should be shaved and provided nail care on his bath days and shaving should be offered more frequently. RN-A observed R20's facial hair and nails. RN-A stated that is not an appropriate shave or nail care. RN-A stated a clean shave is whole face

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and neck. RN-A reviewed bath sheet and stated it looks like they indicated they did it, however should not be charting on something they didn't do.

During interview on 5/6/21, at 9:55 a.m. director of nursing stated according to their policy shaving should be provided daily and nail care with baths and as needed as long as resident allows. DON stated shaving a resident partially is not ok, unless it was the resident's preference as it could be an issue with dignity. Would expect if the weekly bath day body audit form indicated a clean shave she would expect this to be completed which includes cheeks, chin, and neck, under nose and would not be acceptable to have only a partial shave. DON further stated if the bath day body audit indicated nail care was completed she would expect staff to have done this.

During observation and interview on 5/6/2, at 11:45 a.m. R20 face and neck has no facial hair and nails appear to be trimmed. R20 stated that staff assisted him last evening and he feels much better having this done.

Policy Shaving the Resident, dated 2/10/21, indicated "The purpose of this procedure is to promote cleanliness and to provide skin care. Begin at the sideburns and work downward over the cheek, chin, lips, and nose. Keep the skin tight as you shave. Rinse the razor after each stroke. Use an upward stroke under the chin and jaw. Documentation: If the resident refused the treatment, the reasons why the intervention taken."

Policy Fingernails/Toenails, care of policy revised 2/2018, "The purposes of this procedure are to

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F 677	Continued From page 13 clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Unless otherwise permitted, do not trim he nails of diabetic residents or residents with circulatory impairments. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. Notify the supervisor if the resident refuses the care." Policy Activities of Daily living (ADLs), supporting dated 2/10/21 Resident will provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLS). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review the facility failed to ensure the necessary coordination of service and adequate	F 684	Quality of Care Notebooks labeled Mary T Hospice initiated with monthly calendars to reflect	6/15/21

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F 684	Continued From page 14 communication between the hospice agency and the facility for 1 of 2 resident (R1) reviewed for hospice services. Findings include: R7's quarterly Minimum Data Set (MDS) dated 4/22/21, included severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, toilet use and personal hygiene; total dependent of one person assistance with bathing. Hospice care was identified on MDS. R1's Physician Order Report dated 5/6/21 identified an order for hospice to evaluate and treat which was dated 7/21/20. R1's care plan dated 4/21/20, included, "Resident admitted to Mary T Hospice for dx [diagnosis] of Atherosclerotic Heart Disease of Native Coronary Artery with unspecified Angina Pectoris. The care plan directed a Hospice Nurse to visit one time per week and prn [as needed]; Social Service to visit on scheduled/prn basis; offer/provide Hospice Aide visits one time per week; offer/provide Mary T Hospice Chaplain visits two to four times a month; offer/provide Massage Therapy visits two to four times a month." R1's nurse worksheet, identified he was on hospice services but failed to identify scheduled visits or coordinated tasks hospice would provide. R1's last hospice progress note was dated 2/10/21 and did record services provided at that time. R1's record lacked evidence of progress notes since 2/10/21 to date.	F 684	nursing services, social services, spiritual care, chaplain, and massage. If a visit requires rescheduling, hospice will notify nursing supervisor and social worker via email. All hospice paperwork will be scanned into Matrix under the hospice tab. Nursing and social worker will complete a progress note in R1's chart with every visit. R1's plan of care reviewed and updated to reflect current status. New policy on Hospice Services created to improve collaboration and communication service lines. Education provided to all nursing staff on 6/4 and 6/10/2021 on new facility policy to ensure the necessary coordination of services and adequate communication between the hospice agency and the facility. Audits of visit progress notes and monthly calendar will be conducted by DNS/designee weekly x4 then monthly x3. Results of the audits will be brought to the facility's QAPI Committee for review and further guidance. The Director of Nursing is responsible for monitoring.	

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When interviewed on 5/5/21, at 8:15 a.m. registered nurse (RN)-D stated he was not aware of hospice schedule for visits and looked at "hospice binder" and could not locate the calendar which indicates when hospice visits R1. RN-D said hospice would document their visits in the R1's electron medical record; RN-D reviewed R1's progress notes and stated the last progress note from hospice was on 2/10/21. RN-D said coordination of care is hard with hospice when visits are unknown and progress notes are not completed.

When interviewed on 5/5/21, at 9:00 a.m. registered nurse (RN)-C stated hospice visits should be documented in R1's electronic medical record in the progress notes. RN-C reviewed R1's progress notes and identified the last hospice visit documented on 2/10/21. RN-C confirmed R1 is receiving hospice services and stated hospice is expected to document after each visit to collaborate care.

When interviewed on 5/6/21, at 9:01 a.m. nursing assistant (NA)-H stated she was unaware when hospice visits are scheduled.

When interviewed on 5/6/21, at 9:59 a.m. RN-C stated the facility staff doesn't know when hospice comes to visit due to not receiving a schedule from hospice regarding their visits. Normally, hospice would provide this information and put in a binder however the binder was empty. RN-C further stated the plan of care does identify the visit frequency however the separate calendar should be provided in the binder to direct specific schedule visits per week to collaborate care.

When interviewed via phone call on 5/6/21 at

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F 684	Continued From page 16 3:19 p.m. hospice case manager stated "there is no specific day of the week we go, our schedule changes all the time". Hospice case manager stated she does not recalled where the binder was on the unit and not aware of what should be in the binder. Hospice care manager said when a hospice discipline visits a progress note would be shared with the facility to collaborate care. Hospice care manager identified that the hospice progress notes had not been shared with the facility since 2/10/21 and was not sure why. Requested facilities policy on hospice services and none was provided.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a safe environment for 1 of 1 resident (R3) who was bitten by a visitor's dog which resulted in a puncture on the hand and required interventions of an antibiotic and tetanus shot. Findings include: R3's annual Minimum Data Set (MDS) dated 2/4/21, identified R3 with sever impaired	F 689	F689-D Free of Accident Hazards/Supervision/Devices CRCC strives to maintain an environment of safety for all residents, staff, and visits. Education was provided to all nursing staff on 6/3/2021 and 6/10/2021. Education will include reviewing the pet policy. Education will be provided regarding the location of the pet vaccination records and where to locate the schedule for visitors	6/17/21

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F 689	Continued From page 17 cognition, extensive assistance needed with bed mobility, transfer, dressing, eating, toilet use, personal hygiene and total dependence with bathing. R3's care plan dated 5/5/21, identified psychosocial well-being as a vulnerable adult: R3 was at risk of abuse/neglect by others related to: residing in a skilled nursing facility, dependence upon others to meet her needs, cognitive impairment, and communication impairment. Goal identified as R3 would receive person-center long term care in a safe and dignified manner during stay. R3 would remain free from harm through next care review. Approach identified staff to intervene and assist R3 in situations where her safety was at risk. When interviewed on 5/6/21, at 12:55 p.m. social service director (SS)-B stated she was contacted by staff after R1 had been bitten by a visitor's dog. SS-B investigated the incident and discovered the visitor was an employee of the facility's organization and the dog was not approved by the facility to visit. When interviewed on 5/6/21, at 1:11 p.m. registered nurse (RN)-B stated he assessed R1's bite which showed two punctures on her left hand. RN-B said he called the doctor and received orders for antibiotics and a tetanus shot due to not knowing the history of the dog. RN-B said the family was also updated on the incident. RN-B stated he had not seen the dog in the facility before. When interviewed on 5/6/21, at 1:20 p.m. registered nurse (RN)-C stated she assessed the dog bite the day after the incident and no signs of	F 689	including their pets. Education will also be provided on how to assist visitors with accessing the building at the main front doors. Additional department supervisors will complete education by 6/15/21. The Pet Policy & Pet Visitation Agreement will be added to resident admission packets to ensure resident/responsible parties are aware of the facility pet policy. Shared MaryT Inc. services,(MaryT Hospice, MaryT Home Health, MaryT Maintenance and MaryT Quality Services have received a copy of Camilia Rose pet policy and pet visitation policy to ensure that those staffs are aware of the Camilia Rose pet policy and visitation procedures. Audit will include a random sample of visitors and any pets entering, with verification of vaccination records. Audits will be completed 2x a week x4 weeks then monthly x3 monnths. The Life Enrichment Director or designee will be responsible for monitoring. The QAPI committee will oversee the process for compliance.	

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F 689	Continued From page 18	F 689		

infection was noted. RN-C stated the owner of the dog was an employee of the facility's organization and used her employee code to get into the building without being screened by staff. RN-C stated the facility pet policy was not followed as the dog was not approved for the visit and R3's safety was at risk.

When interviewed on 5/6/21, at 1:28 p.m. administrator stated myself and the director of social services were the designated reporters for incidents occurring at the facility. The administrator stated visitors were required to schedule a time so they could be screened before visiting a resident but the owner of this dog worked for our organization and had a code to unlock the doors; this visit was not scheduled. The administrator stated the pet policy was not followed and the dog was not approved to enter the facility. The administrator stated the pet policy was developed to protect our vulnerable adults and keep them safe and this incident caused one of our residents' injury. Lastly, the administrator stated the dog would not be allowed in the facility again.

Though the facility addressed the incident specifically, based on interview and incident report review, the facility failed to address the systematic failure and address policies and employees throughout sister facilities, to ensure protection for their residents from similar incidents.

When interviewed via phone call on 5/7/21, at 8:39 a.m. visitor (V) stated she was the owner of the dog and was holding the dog when R3 was petting the dog. V stated the dog growled at R3 and bit her; staff was then notified. V stated she

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F 689	Continued From page 19 was unaware the facility had a dog policy and that the dog was not approved to come to the facility. V stated she worked for the facility's organization and had a code to unlock the door which was used the day of the incident. V verified she was not working but was visiting other residents with her dog. V stated her dog was not normally aggressive. V did confirm she was informed she was no longer able to bring her dog back to the facility. Though the facility addressed the incident specifically, based on interview and incident report review, the facility failed to address the systematic failure and address policies and employees throughout sister facilities, to ensure protection for their residents from similar incidents. Pet and Animal Visitation Policy dated 3/1/21 specified "all pets and animal visits need to have advance approval. The owner or handler must provide copies of all vaccinations, including rabies vaccination certificate, and other exams in advance. A visitation agreement form must be signed for each pet and animal prior to the initial visit."	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		6/15/21

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F 690	Continued From page 20 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and develop interventions to promote urinary continence for 1 of 2 residents (R12) reviewed for bowel and bladder elimination. Further, the facility failed to comprehensively assess and demonstrate adequate justification for the continued use of an indwelling catheter for 1 of 2 residents (R41) reviewed who used a catheter.	F 690	F690-D Bowel/Bladder Incontinence, Catheter, UTI Facility failed to comprehensively assess and develop interventions to promote urinary incontinence for R12 for bowel and bladder elimination. Bladder assessment for R12 and in conjunction with a 3 day tracking form was completed to identify voiding pattern. All residents who are cognitive and incontinent will be	

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F 690	Continued From page 21 Findings include: TOILETING ASSESSMENT: R12's quarterly Minimum Data Set (MDS), dated 3/4/21, identified R12 had moderate cognitive impairment, required extensive assistance with toileting, and consumed a daily diuretic medication. Further, R12 was recorded as being frequently incontinence of urine, however, had never been attempted or placed on a toileting program (i.e., scheduled or prompted voiding). When interviewed on 5/3/21, at 11:53 a.m. R12 stated he seemed to "got to pee all the time" which made him "wet all the time." R12 expressed he had poor bladder control and stated he was "not sure" if he was on a bladder re-training program or scheduled toileting. R12's most recent Elimination - Camilia Rose Care Center TENA/SCA Bladder Observation, dated 3/4/21, outlined R12 was incontinent of urine demonstrated by his clothing being soiled and/or having urgency which he was unable to suppress. R12 was assessed as having mixed urinary incontinence (a combination of stress and urge incontinence), and a section labeled, "Treatment Program," was provided which outlined several options to choose from to promote continence or, at least, help reduce his incontinence which included bladder retraining, scheduled toileting, prompted toileting, or, if R12 was not appropriate for a toileting program with spacing to record subsequent rationale. However, none of these options were selected and the section was left blank. The assessment concluded with a summary statement which read, "Patient is mostly continent but has episodes of	F 690	reassessed to ensure appropriate treatment and services are in place to promote urinary continence or reduce bladder incontinent episodes. All resident□s thereafter will be assessed through their MDS scheduling. Results from voiding trial will be added to resident□s care plan. Referral to therapy for those residents that are identified for a bladder training program. The facility failed to comprehensively assess and demonstrate adequate justification for the continued use of an indwelling catheter for R41. R41□s catheter was discontinued and is successful with elimination. All residents with catheters have the potential to be affected and were audited. Care plans reviewed and updated to reflect current urinary status. Education provided to all nursing staff on 6/4/2021 and 6/10/2021 on completing the 3 day voiding trial data collection in conjunction with the bladder assessment accurately and for reviewing care plans for new prompted or scheduled voiding. Additional education to include a comprehensive assessment and demonstrate adequate justification for continued use of an indwelling catheter upon admission or readmission. To ensure the resident who is incontinent of bladder receives the appropriate treatment and services, audits will be conducted on cognitive and incontinent residents 2X week X4 weeks then	

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F 690	Continued From page 22 incontinence as well. Patient has diagnoses of diabetes, dementia, and repeated falls. He also takes Lopressor and Lasix. Has mixed urge and stress incontinence." R12's corresponding Point of Care History, dated 2/25/21 to 3/10/21, identified R12 had a total of 12 episodes of urinary incontinence. Of those episodes, four of the 12 were recorded as happening between 5:00 a.m. and 9:30 a.m.; four were recorded as happening between 11:30 a.m. and 3:30 p.m.; and, three of the 12 episodes were recorded between 8:05 p.m. and 9:53 p.m. R12's care plan, revised 5/5/21, identified R12 had occasional bladder incontinence due to impaired mobility, diabetes and use of diuretic medication. The plan outlined several interventions to help R12 reduce his risk of skin breakdown or urinary tract infection which included having a urinal at bedside and providing extensive assistance with toileting "every shift." The care plan lacked evidence if R12 was on a prompted and/or scheduled toileting program; nor if one had ever been attempted despite having been recorded as having continent voids. On 5/4/21, at 6:36 p.m. R12 was observed from the hallway to be standing up at his bedside in his room with his pants and brief lowered. R12 was using his left hand to steady himself by holding onto his wheelchair, and was holding and voiding into a urinal held by his right hand. R12's call light was not illuminated, however, R12 did physically void into the urinal and did not have any observed soiling in his brief. The surveyor alerted nursing assistant (NA)-F to R12 needing assistance to void and prevent him from potentially falling while attempting to do so. NA-F entered R12's room and voiced aloud, "You need to call for help!"	F 690	monthly per MDS schedule until all residents have the proper voiding schedule. Administration will be updated on the audit results and compliance of voiding programs at IDT weekly meetings. QAPI committee will discuss audit findings and compliance monthly to determine if compliance has been met, and if the audit period would need an extension. All current residents with an indwelling catheter will be reviewed for current dx, clinical rationale, and voiding trials. Care plans reviewed and updated as needed. Audits will be completed weekly X4 then monthly X3 or until compliance is reached. Results of the audits will be brought to the facility□s QAPI Committee for review and further guidance. The Director of Nursing or designee is responsible for monitoring.	

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Immediately following, at 6:42 p.m. NA-F was interviewed and voiced the staff will often walk into R12's room and find him trying to void by himself using the urinal as he rarely calls for assistance despite ongoing reminders. NA-F stated he believed R12 was mostly continent, however, acknowledged he did have incontinence at times. Further, NA-F stated R12 was not on a scheduled voiding or bladder retraining program but rather staff help him just "as he needs" and when they check on him "once in awhile."

When interviewed on 5/5/21, at 9:37 a.m. NA-G stated R12 tried to be as independent as possible and usually wanted cares, including toileting, done in "his way." R12 often used the commode and NA-G stated he recently had agreed to start using an incontinence brief "at night" since he was more incontinent on that shift. NA-G expressed she felt R12 was mostly continent "during the day" but added he just "can't make it" to the bathroom on night shifts. NA-G stated she could not answer if R12's urinary continence had improved, plateaued or worsened in the past months since he was last assessed (on 3/4/21) adding, "I don't know." Further, NA-G stated R12 was not an scheduled toileting or bladder retraining programs to her knowledge.

R12's most recent Point of Care History, dated 4/29/21 to 5/5/21, identified R12 had 11 recorded episodes of urinary continence with nine episodes of urinary incontinence recorded. Of the recorded incontinent episodes, seven of the nine were recorded as happening between 10:00 p.m. and 3:00 a.m.

R12's medical record was reviewed and lacked

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evidence R12 had been comprehensively assessed for his ability to participate in a bladder training and/or scheduled toileting program despite having recorded episodes of continence. Further, the record lacked evidence the facility had identified and reassessed the need for increased and/or revised toileting interventions between 10:00 p.m. and 3:00 a.m. despite having recorded evidence and the floor staff verbalizing him having more incontinence on the night shift.

On 5/5/21, at 11:59 a.m. licensed practical nurse manager (LPN)-C explained the nurses were supposed to complete a residents' bladder assessment in conjunction with a three-day tracking form to help identify patterns. LPN-C reviewed R12's completed Bladder Observation (dated 3/4/21) and verified it lacked any intervention or treatment plan. LPN-C expressed she was unsure why it had been left blank and added, "I don't have that answer." LPN-C reviewed R12's incontinence records, including his frequent night shift incontinence, and stated R12 should be reassessed and staff should "revisit it" to help develop a plan to promote more continence. LPN-C stated the staff needed to be educated on the "proper way" to assess someone's urinary incontinence, and R12 should be assessed as some residents "are retrainable" and less urinary incontinence prompts better health and skin integrity.

When interviewed on 5/5/21, at 1:33 p.m. the interim director of nursing (DON) stated any identified toileting patterns should be recorded in their bladder assessment process as staff "would want to review that." The DON expressed they would then need to develop interventions to help promote increased continence which needed to

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be done to help reduce skin breakdown and "to prevent other problems."

A provided Urinary Continence and Incontinence - Assessment and Management policy, dated 2/2021, identified the nursing staff and physician would screen for information related to urinary incontinence as part of "the initial and ongoing" assessment processes. The policy continued, "As part of its assessment, nursing staff will seek and document details related to continence. [These include] ... voiding patterns (frequency, volume, nighttime and daytime, quality of stream, etc.)" The physician was then responsible to ensure treatable causes of incontinence were identified and acted upon, however, if the person remained incontinent then the staff would " ... initiate a toileting plan."

CATHETER:

R41's quarterly Minimum Data Set (MDS), dated 4/5/21, identified R41 had moderate cognitive impairment and required extensive assistance with his activities of daily living (ADLs). Further, the MDS outlined R41 used an indwelling catheter and had never been trialed or placed on a toileting program. R41's urinary continence was listed as, "Not rated."

On 5/4/21, at 12:58 p.m. R41 was observed laying in his room with a visible urinary drainage bag suspended from his bed rail. The bag had visible, light yellow colored urine present in the bag and attached tubing. R41 was interviewed and expressed had a catheter placed while he was hospitalized. When questioned on why it had been placed, R41 responded it was due to him

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having a leg amputation from years prior. R41 denied any concerns with recent bladder infections despite use of the catheter.

R41's AllinaHealth Discharge Summary, dated 3/22/21, identified R41 was hospitalized from 3/19/21 to 3/22/21 and listed principal diagnoses of choledocholithiasis (also called bile duct stones or gallstones in the bile duct) and urinary retention. The summary outlined R41 was, " ... also found to have urinary retention and significant obstipation. Urinary retention improved with foley [sic] placement." R41 had another diagnosis listed of acute renal failure with dictation reading, "- Continue foley [sic] - likely due to BOO [bladder outlet obstruction] causing hydronephrosis," along with, "- Consider continuing tamsulosin [medication used to treat enlarged prostate] and voiding trial."

R41's most recent TENA/SCA Bladder Observation, dated 3/26/21, identified R41 was incontinent of bladder and listed risk factors including impaired mobility, needing assistance with transfers, and a history of urinary retention. A section was provided to list any results of completed post-void residuals (PVRs), however, this was left blank and not completed. R41 was recorded as having mixed urinary incontinence (a combination of stress and urge incontinence), however, there was no selected treatment program despite spacing and options being provided to record such. Further, a section labeled, "Evaluation for Residents with Indwelling Catheters," provided options to select demonstrating the medical need or justification of using such device (i.e., terminal illness, urethral blockage), however, this was left blank and not completed. A summary was then provided of the

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assessment which read, "Resident has a Foley catheter."

R41's care plan, dated 4/30/21, identified R41 needed assistance to use the bathroom with a listed goal reading, "Resident will use the bathroom per his/her preference." The care plan directed R41 used a Foley catheter which should be emptied every shift and as needed. Further, the care plan outlined, "Resident has hx [history] of urinary tract infections per spouse."

R41's medical record was reviewed and lacked evidence R41 had been offered and/or attempted with a voiding trail as outlined by his hospital discharge summary. Further, the record lacked evidence any PVRs had been completed since R41's admission to the nursing home to help demonstrate the ongoing medical justification for placement of a Foley catheter despite R41's identified history of bladder infections on his care plan.

When interviewed on 5/6/21, at 9:55 a.m. licensed practical nurse (LPN)-E verified R41 used a Foley catheter which, to her understanding, was placed for urinary retention; and R41 was not consider to be a terminal condition patient, nor demonstrate significant pain. LPN-E stated R41 had used the catheter for several months since it had been placed at the hospital just prior to his admission to the nursing home and the staff tried to clean the catheter tubing "every shift" to reduce the risk of bladder infections. LPN-E expressed she was unaware of any completed attempts to remove the device or trial R41 on a voiding program since he admitted.

On 5/6/21, at 10:53 a.m. licensed practical nurse

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manager (LPN)-C and social services designee (SSD)-A were interviewed. LPN-C explained R41 had urinary retention which was diagnoses while he was hospitalized just prior to his admission. LPN-C reviewed R41's medical record and verified it lacked any evidence a trial voiding program or PVR(s) had been completed since he admitted. LPN-C stated she was unaware if R41's catheter had ever been attempted for removal and added, "I don't have that answer." LPN-C stated the nurses should have obtained a clarification order for the physician's intent about attempting a voiding program and expressed the medical record, and lack of PVR(s) and justification, made her question, "Does he need it [the catheter]?"

When interviewed on 5/6/21, at 12:40 p.m. the interim director of nursing (DON) verified the medical record lacked evidence a trial voiding program, nor post-admission PVR(s), had been completed to provide ongoing medical justification for R41's use of the catheter. The DON stated they needed to "re-evaluate our policies" and "re-look at our systems" to ensure appropriate resident catheter use and make sure post-hospital instructions were addressed.

A provided Urinary Incontinence - Clinical Protocol policy, dated 2/2021, identified a resident who admitted from the hospital with a newly placed indwelling catheter would be evaluated by the physician and nursing home staff for " ... the potential for removing the catheter." The physician would be responsible to address any treatable causes of urinary retention and the physician was responsible to document any clinically pertinent rationale why an indwelling catheter needed to be used.

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F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d) §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure mental health needs identified on a Preadmission Screening (PAS) were reevaluated and coordinated with the outside agency for 1 of 1 resident (R17) reviewed who required specialized services. Findings include: R17's admission Minimum Data Set (MDS), dated 3/5/21, identified R17 was less than 25 years of age, had intact cognition and required extensive assistance with her activities of daily living (ADLs). The MDS identified R17 had been evaluated by a Preadmission Screening and Resident Review (PASRR) which determined R17 to have a serious mental health disorder and/or mental retardation; and identified R17 to have autism with mental retardation. R17's Initial PAS, dated 2/26/21, identified R17 lived in a shared living space prior to her nursing home admission, and listed her anticipated length of nursing home stay as, "Less than 30 Days." Further, the PAS identified a section labeled, "Developmental Disability [DD] or Related Condition," which outlined, "Based on the information provided for this nursing home stay, it appears this person meets the criteria for DD and needs to be referred to the lead agency for further evaluation."	F 745	F745-D Provision of Medically Related Social Services All Social Services staff were educated on PAS, OBRA Level II, Care Planning & Updating County Assessments. The social workers completed an audit of all resident charts, care planning and updating County Assessments for PAS & OBRA Level II screenings on 5/5/2021. The social services department meets weekly to review all new admissions. The Social Service Director will review all OBRA II in house screenings during the meeting. The social workers document the review of the PAS & OBRA II if applicable in the social service assessment observation in the electronic medical record, Matrix. Results of the audits will be brought to the facility□s Quality Assurance Committee for review and further guidance. The Social Services Director is responsible for monitoring.	6/15/21

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R17's corresponding OBRA Level II Evaluative Report, dated 2/26/21, identified Sherburne County evaluated R17 and listed her stay in the nursing home as, "Anticipated stay less than 30 days. Plan to discharge back home." R17 was outlined as needing assistance with meal preparation, shopping and managing her schedule. A section labeled, "Specialized services ..." identified, "7. This person requires active treatment. The county/tribal nation has specified all active treatment needs in this evaluative report and confirms that these needs will be met while this person resides in the nursing facility." The report identified R17's Community Residential Services would be resumed once discharged and listed an anticipated date of discharge as, "3/17/2021."

On 5/3/21, at 1:58 p.m. R17 was interviewed while laying in bed in her room. R17 expressed she had been at the nursing home for three months after falling outside McDonald's where she worked. R17 abruptly stopped conversing and asked the surveyor how their name was spelled and then asked several questions about how to get her television fixed. R17 then stated she attends the activities at the nursing home, however, was not working at McDonald's or attending any other day programs. R17 added she enjoyed working at the McDonald's as it "keeps me out of the house," and expressed she was unsure when she'd be discharged and get to return to her job.

R17's care plan, dated 5/3/21, identified a problem statement had been developed on 5/3/21 which outlined R17 had a PAS Level II completed due to autism. The care plan listed several

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interventions to help R17 adjust to the nursing home which included introducing her to others, involve her in meaningful activities, and, "Involve County Case manager as needed." The care plan lacked any further dictation or guidance on what, if any, specialized therapy or services R17 required as outlined by her completed OBRA Level II PAS.

When interviewed on 5/4/21, at 4:40 p.m. nursing assistant (NA)-E stated R17 was "pretty independent" with her cares adding she only needed minimal assistance with bathing and would "once in awhile" ask for help or need something else throughout the day. NA-E stated R17 was not leaving the campus for any work-related programs or having an other specialized services provided to her knowledge but rather just "goes to activities in the building."

R17's medical record was reviewed and lacked evidence R17's Level II PAS, or subsequent mental health needs and/or need for specialized services, had been reevaluated despite R17 remaining in the nursing home past her originally outlined and expected less than 30-day admission. Further, there was no evidence the facility had coordinated with the county to update them so as to ensure R17's needs were being met and/or her places in off campus work programs were held and ready for resumption upon her discharge from the nursing home.

On 5/4/21, at 4:43 p.m. licensed practical nurse manager (LPN)-C and social services designee (SSD)-A were interviewed. They explained R17 admitted to the nursing home with a broken ankle from a "supportive living apartment" and remained working with physical therapy. R17's

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stay was being funded through workman's compensation and, as a result, they had been in touch with Medica to update them on her progress frequently. SSD-A and LPN-C both verified they had not revisited R17's Level II PAS, or her subsequent mental health needs outlined on such, since her admission despite both completed PAS outlining her expected stay as being less than 30 days in length and R17 remaining in the nursing home. SSD-A voiced she was unaware of what, if any, next actions needed to be taken and she would consult with her supervisor for guidance.

On 5/5/21, at 12:11 p.m. a subsequent interview was held with LPN-C and SSD-A. They contacted the Sherburne County social worker (SCSW) who re-visited and updated R17's Level II PAS with updated information. They also coordinated a "MN Choice Assessment" which needed to be done prior to R17 returning to her apartment setting when she left the nursing home. This was needed to ensure her programs and waivers were resumed upon her discharge from the nursing home. Further, SSD-A expressed she had been told R17 did not need to resume her specialized services while admitted to the nursing home according to the SCSW.

On 5/6/21, at 9:13 a.m. SCSW was interviewed and expressed he was the "covering case manager" for R17 at the time. SCSW verified R17's initial admission was expected to be less than 30 days in length and they had not been updated since her stay breached those initial 30 days to his knowledge. SCSW voiced they were going to continue to hold R17's needed specialized services given she remained in the nursing home, however, he expressed updates

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F 745	Continued From page 33 and communications from the nursing home "should be happening" so the county can arrange and coordinate services for R17, and ensure R17's needed programs are resumed as timely as able. A provided Social Services policy, dated 10/2010, identified the facility would provided needed medically-related social services to assure each resident could attain or maintain their highest level of well-being. This included, "Making referrals to social service agencies as necessary and appropriate," and participating in the planning of a resident's return to home or the community.	F 745		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in	F 755		6/15/21

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F 755	Continued From page 34 the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement a system for periodic reconciliation of controlled substance medications in 2 of 2 of the facility's emergency kit (E-Kit) boxes to prevent potential loss or diversion. Additionally, the facility failed to properly seal 1 of 2 of the facility's E-Kits after removal of a medication. Findings include: On 5/4/21, at 1:29 p.m. observed two plastic E-Kit storage containers in the locked refrigerator located in the locked second floor med room. The kits were labeled as #60 and #61. Each E-Kit was labeled with, Novolin R (a type of insulin); Novolog flex pen (a type of insulin); Novolin 70/30 (a type of insulin) and Lorazepam (a controlled substance). E-Kit #60 was not secured with a zip tie. It was noted, the vials of lorazepam remained in the container and remained sealed. One vial of insulin was missing from the container. E-Kit #61 was secured with a zip tie, no medications were missing from this container. On 5/4/21, at 1:34 p.m. licensed practical nurse (LPN)-D confirmed E-Kit #60 did not have a zip	F 755	F755-D Pharmacy Service Facility failed to establish a system of record receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation. During time of survey, area of concern identified, failure to ensure a system for medication reconciliation was adequate to ensure timely identification of loss or diversion of narcotic medications. 1 of 2 E-KITS was not secured after removal of a controlled substance. Education to be provided to licensed nursing staff/TMA on 6/4/2021 and 6/10/2021 on Emergency Pharmacy Service and Emergency E-kits policy. Education to include securing the E-kits with the tag provided by pharmacy and returning E-kit to pharmacy immediately for reconciliation. Audits: Director of Nursing/designee will audit narcotic book 2 times per week x 4 weeks, 1 time per week X3 months. Results of the audits will be brought to the	

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F 755	Continued From page 35 tie securing it and the two vials of lorazepam were in the container. She indicated she was not aware the E-Kits were in the refrigerator and did not know why E-Kit #61 was secured with a zip tie when E-Kit #60 was not secured in the same manner. LPN-D stated controlled substances were counted at the start and end of each shift, by two staff. She confirmed, because she was not aware the lorazepam was in the refrigerator, she had not counted it. LPN-D stated she had never removed medications from these E-Kits so was not aware of the process. On 5/4/21, at 1:39 p.m. registered nurse (RN)-B stated the E-Kits in the refrigerator were received from pharmacy when the facility had a unit to care for COVID positive residents. RN-B did not know when these E-Kits were delivered to the facility and confirmed there was no log to track use of these medications or to count the controlled substance in these containers. RN-B stated all controlled substances were expected to be counted with each change in shift, this included the lorazepam in the E-Kits. RN-B was not aware of the policy for securing the E-Kits after medications were removed. He stated he would need to call the pharmacist to find out. RN-B was also not aware of the procedure for making pharmacy aware of what medications were removed from the E-Kit. On 5/6/21, at 10:21 a.m. Director of Nursing (DON) stated she was not aware of what the policy said about storing the E-Kit or removed medications. She expected, if staff removed a medication from the E-Kit they would document what they took, the amount needed and the amount wasted, if needed. DON was not sure where this information should be documented.	F 755	facility□s Quality Assurance Committee for review and further guidance. Director of Nursing or designee is responsible for monitoring.	

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F 755	Continued From page 36 DON was not sure how the E-Kit should be secured after medication was removed but stated she would want to have a zip tie put on it. DON stated she expected narcotics (controlled substances) to be counted every change in shift, this included those in the E-Kit. On 5/6/21, at 12:01 p.m. consulting pharmacist (CP) stated the E-Kit should be secured. When an item was removed there should be documentation that it was removed including who it was for, and the date it was removed. This was necessary so the pharmacy was aware. After the medication was removed, staff should have secured the E-Kit with either the numbered tag provided by pharmacy or with some other means. The E-Kit, especially with controlled medications, should not be left unsecured. CP expected the narcotics, in the E-Kit, to be counted when other narcotics are counted. Facility document, Emergency Pharmacy Service and Emergency Kits dated 1/2020, indicated the kit [E-Kit] must be properly locked and sealed and must comply with all state and federal requirements. The nurse will record the date, resident name, medication name and strength used, number of doses used, ordering prescriber and signature of the nurse removing the dose in the facility emergency kit logbook. A policy and procedure for counting medications was requested but was not received.	F 755		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident	F 756		6/15/21

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F 756	Continued From page 37 must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure declined pharmacy	F 756	F756-D Drug Regimen Review	

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F 756	Continued From page 38 recommendations were supported with adequate and appropriate medical justification for 1 of 5 resident (R12) reviewed for unnecessary medication use. Findings include: R12's quarterly Minimum Data Set (MDS), dated 3/4/21, identified R12 had moderate cognitive impairment, required limited to extensive assistance to complete his activities of daily living (ADLs), and had several medical diagnoses including heart failure, high blood pressure, and diabetes mellitus. The MDS outlined R12 received a daily insulin injection, and consumed diuretic (water reducing medication) and anticoagulant (blood thinning medication) medication on a daily basis. R12's Physician Orders Report, dated 4/6/21 to 5/6/21, identified R12's current physician orders for medications and treatments. The report directed R12 should receive Lantus (a long-acting insulin) 25 units twice a day, with breakfast and supper, to treat his diabetes mellitus. The order was started on 3/11/21, and was listed as " ... Open Ended." R12's Consultant Pharmacist's Medication Review, dated April 2021, identified a repeated recommendation was made which read, "This patient is currently prescribed Insulin Glargine [Lantus] BID [twice daily]. Glargine has a 24 [hour] duration of action, and is not indicated for twice a day dosing ... Consideration - In addition, to changing the Insulin Glargine to once-daily dosing being supported by the manufacturer, it can also help reduce 'patient touches' during the current Pandemic, thereby limiting	F 756	Facility failed to ensure R12 pharmacy consultant recommendations were supported with adequate and appropriate medical justification for unnecessary medication use. R12 Lantus order changed from BID to once daily per manufacturer guidelines on 5/13/2021. This recommendation has been resolved. Education to be provided to licensed nursing staff on supporting pharmacy recommendations and physician follow up on manufacturer guidelines and a brief explanation on rejection of recommendation per regulatory guidelines on 6/4/2021 and 6/10/2021. Pharmacy recommendation guidelines reviewed with medical director to document rationale in the resident□s medical record if there is to be no change in medication regimen. These measures will be put into place, or systemic changes made, to ensure that the deficient practice will not occur. Policy and procedure review has been completed, no changes to current policy. Pharmacy consultant to review all recommendations past 60 days for compliance. Audits to be conducted monthly and PRN audits are being completed on pharmacy consultant recommendations to ensure all are completed as ordered. The results of these audits will be discussed and reviewed at QAPI Committee meetings for further recommendations. Director of Nursing or designee is responsible for	

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F 756	Continued From page 39 person-to-person exposure." The consulting pharmacist (CP) then suggested a once daily dosing of Lantus 50 units. The form then provided a section labeled, "Follow-Up or Action Taken," which allowed the physician to circle either, "Accepted," or, "Rejected." The form listed, " ... if rejected please see footnote," which identified, "* (1) Per regulatory guidelines, a brief explanation of why the recommendation is rejected is required." However, the physician only circled 'rejected' and wrote, "Keep as is." R12's medical record was reviewed and lacked any further physician rationale or explanation supporting why R12's dosing of Lantus was kept in a manner inconsistent with the manufacturer's guidelines or against the CP recommendation. On 5/6/21, at 10:33 a.m. licensed practical nurse manager (LPN)-C was interviewed and verified she was unable to locate any other supporting documentation or rationale from R12's rejected pharmacist recommendation. LPN-C voiced R12's last HgB A1C (a lab test for diabetes) was 9.7 which LPN-C added was "pretty high." LPN-C expressed the physician should have provided rationale or an explanation why the CP recommendation was rejected adding, "They're supposed to write why they're rejecting it." This was needed "to know why they're not willing to change it" and because "there has to be a reason" for refusing such recommendations. When interviewed on 5/6/21, at 11:46 a.m. the CP verified the rejection of a recommendation did require clinical reasoning to meet the regulatory guidelines. CP expressed the lack of rationale, or twice a day Lantus dosing, likely would not significantly harm R12; however, he was	F 756	monitoring.	

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F 756	Continued From page 40 potentially getting more injections than he needed to. Further, CP voiced the reduction of "patient touches" during a pandemic was a consideration which made him suggest the dosing. On 5/6/21, at 12:51 p.m. the interim director of nursing (DON) verified rejected pharmacist recommendations should have supporting rationale from the physician and voiced the nurses reviewing the recommendations "should go back" and obtain such. This was important to do as the nurses have to make sure physician orders "make sense" and nothing else required follow-up. A policy on pharmacy recommendations was requested, however, was not received.	F 756		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 05/05/2021. At the time of this survey, Camilia Rose Care Center was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

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

Electronically Signed | 06/04/2021

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K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Camilia Rose Care Center is a 3-story building without a basement that was built in 1976 and was determined to be of Type II(222) construction. There were two additions built in 1993 and 2008 that were determined to be Type II(222) construction. Residents reside on Floors 1, 2, and 3 of the facility. Floor 1 has 3 smoke compartments, and Floors 2 and 3 each have 2 smoke compartments. The facility is fully protected throughout by an automatic fire sprinkler system and has a complete fire alarm	K 000		

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K 000	Continued From page 2 system with smoke detection in the corridors and spaces open to the corridor that is monitored for automatic fire department notification. Because the original building and additions are of conforming construction, the facility will be surveyed as one building. There is an adult day-care facility located on the first floor of the nursing home that will be included in the survey due to the lack of a fire-rated separation. The facility has a capacity of 80 beds and had a census of 56 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=F	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain a level exit discharge surface in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.2.7 and 7.1.6.2. This deficient practice could affect all 80 residents. Findings include:	K 271	K271 A temporary ramp has been placed to even the grade of the exit discharge sidewalk at the first floor dining room. The maintenance director placed a temporary ramp that has evened the grade. We have contracted with a concrete vendor who will permanently fix the grade by lifting the slab to meet grade	6/15/21

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K 271	Continued From page 3 On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, it was observed on the 1st Floor in the Dining Room area that the exit door had a vertical transition to grade at the exit discharge sidewalk that was greater than one-half of an inch. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 271	height by July 15, 2021. The maintenance director is responsible to monitor and ensure completion of the project.	
K 293 SS=D	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain exit sign illumination in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.2.10 and 7.10.5.1. This deficient practice could affect any residents in the adult day center. Findings Include: On the facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, it was observed on the 1st Floor that the exit sign located in the facility's adult daycare area was not illuminated.	K 293	K293 The sign located at the entrance of the Adult Day Care has been fixed and is now illuminating. This sign has been added to the preventive maintenance schedule. The maintenance director or designee is responsible for monitoring the sign for illumination.	6/15/21

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K 293	Continued From page 4 This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 293		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain accessibility to manual initiation components of the fire alarm system in accordance with the Life Safety Code NFPA 101-2012 edition sections 9.6.1.3 and 9.6.1.5, and National Fire Alarm and Signal Code NFPA 72-2010, sections 17.14.5, 14.4.5.3.2, and 14.6. This deficient practice could affect all 80 residents. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, it was observed that the fire alarm pull station located in the kitchen hallway corridor was obstructed. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 345	K345 The fire alarm pull station has been cleared of carts. Maintenance staff have been educated on the importance of not leaving carts in front of a pull station. The administrator or designee is responsible for monitoring so that clearance is maintained. An audit of the door will be conducted 2 times a week for 4 weeks.	6/15/21

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K 345	Continued From page 5 discovery.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to test and maintain the sprinkler system in accordance with the Life Safety Code NFPA 101, 2012 edition, sections 9.7.5, 9.7.6, 9.7.7, and 9.7.8, and NFPA 25, 2011 edition, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.1.1., 5.2.1. This deficient practice could affect all 80 residents. Findings include: On facility tour between 09:00 AM and 02:00 PM	K 353	The facility's contracted sprinkler vendor will be testing the sprinkler system on June 9 and 10. The sprinkler system testing has been placed on the preventive maintenance schedule and the vendor will continue to provide the required testing. The system testing will be documented stating the date the sprinkler system last checked, who provided the system test and what the water system supply source is and kept in the preventive maintenance binder. The maintenance director is responsible for monitoring and scheduling	6/15/21

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K 353	Continued From page 6 on 05/05/2021, during a walk-through of the facility, the following observations were made: 1) In Room 3.12, the sprinkler head was fully obstructed by a data cable wiring bundle. 2) In Room 2.14, bed mattresses were stacked within less than 18 inches of the ceiling sprinkler head deflector. 3) In the Sprinkler Riser Room, the sprinkler head storage cabinet did not have enough slots or space to hold all of the spare heads properly. 4) In the Physical Therapy Storage Room, there was paint splatter found on the sprinkler head. 5) In the following locations, there were holes, gaps, and penetrations found, which could adversely affect the efficiency and effectiveness of the fire sprinkler system: a. In the 3rd-floor corridor, south exit area, and nurses station area, there were holes and gaps in the ceiling tiles. b. In the 2nd floor Beauty Shop closet, a hole in the back wall near the ceiling was approximately 1 foot by 1 foot in size, and a ceiling tile was missing. c. In the 1st-floor Janitor closet, a ceiling tile was missing. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 353	the testing in coordination with the vendor. 1. The sprinkler head obstructed in room 312 is cleared. IT staff have been educated on the requirement of maintaining clearance for the sprinkler heads. Maintenance director or designee is responsible maintaining the clearance of the sprinkler heads. 2. The mattresses have been rearranged to provide the 18 inch clearance from the ceiling. The housekeeping director has been educated on the ceiling clearance in all areas. The maintenance director or designee is responsible for monitoring the ceiling clearance of all ceilings. 3. The contracted sprinkler vendor is providing a storage unit that will hold the sprinkler heads properly. This will be provided during the June 9 and 10 service visit. The Maintenance director or designee is responsible for ensuring the heads are stored properly in the storage unit. 4. The sprinkler vendor will replace the sprinkler head located in the PT storage area that has paint on it during June 9 and 10 visit. The maintenance director or designee will monitor the sprinkler heads during their preventive maintenance rounds. 5. a. The third floor ceiling tiles have been replaced to prevent gaps in the ceiling tiles. b. The missing ceiling tiles in the beauty shop have been replaced. c. The ceiling tile missing in the 1st floor janitor closet has been replaced. The maintenance director or designee is responsible for monitoring and replacing	

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K 353	Continued From page 7	K 353	all ceiling tiles if they are doing work in the ceiling.	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to maintain portable fire extinguishers in accordance with the Life Safety Code NFPA 101 - 2012 edition, sections 19.3.5.12, 9.7.4.1, and NFPA 10 Standard for Portable Fire Extinguishers, 2010 edition, section 7.2.1.2, 7.2.4, 7.3.3. This deficient practice could affect all 80 residents. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, the following observations were made: 1) During the documentation review, no evidence was provided regarding the annual inspection of the portable fire extinguishers. 2) During the walk-through of the facility, it was observed in the Beauty Shop that the fire extinguisher had not been inspected monthly since 02/2021. This deficient practice was confirmed by the	K 355	F355 Inspection of the portable fire extinguishers will continue and the documentation will be stored in the preventive maintenance binder. The fire extinguisher in the beauty shop has been inspected and the documentation updated. The maintenance director or designee is responsible for conducting the inspections and documenting the inspections. This inspection is in the preventive maintenance schedule.	6/15/21

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K 355	Continued From page 8 Assistant Maintenance Director at the time of discovery.	K 355		
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.3.7.3 and 8.5.2.2, 8.3.5.1. This deficient practice could affect all residents in both smoke compartments. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, it was observed that on the 2nd Floor, above the ceiling at the smoke barrier door, there were penetrations in the smoke barrier wall. This deficient practice was confirmed by the Facility Maintenance Director at the time of	K 372	K372 An access panel has been installed at the 2nd floor ceiling by the smoke barrier door closing the penetration in the smoke barrier wall that was caused by repairing a leaky pipe. The maintenance director or designee is responsible for maintaining the integrity of the smoke barrier wall.	6/15/21

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K 372	Continued From page 9 discovery.	K 372		
K 511 SS=F	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper security and accessibility of electrical breaker panels in accordance with the Life Safety Code NFPA 101-2012 edition, sections 19.5.1.1 and 9.1.2, the National Electrical Code NFPA 70-2011, section 110.26, and the Health Care Facilities Code NFPA 99, section 6.3.2.2.1.3. This deficient practice could affect all 80 residents. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, unsecured electrical panels were found in the following locations: 1. 3rd Floor - resident corridor 2. 2nd Floor - resident corridor 3. 1st Floor - resident corridor	K 511	K511 The second floor electrical panel has been secured. A locksmith has been contracted to secure the 1st and 3rd floor panels. The smith will be on site to secure those panels on June 7th. The maintenance director or designee is responsible for the correction and monitoring to ensure those electrical panels remain secure.	6/15/21

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K 511	Continued From page 10 This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 511		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to conduct fire drills under varied times and conditions and document drills in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.7.1.4, 19.7.1.6, 4.7.4, and 4.7.6. This deficient practice could affect all 80 residents. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a review of the available fire drill documentation, the following was evidenced: 1. 1st Shift - Quarter 3, there was no fire drill documented. 2. 3rd Shift - Quarter 2, there was no fire drill	K 712	K712 The monthly fire drills are conducted on each shift quarterly. The transmission of the fire alarm signal is recorded on the drill documentation. The drill are in the preventive maintenance schedule. The documentation is kept in the preventive maintenance binder. The maintenance director or designee is responsible for conducting the drills, documenting the drills and documenting the transmission of the fire signal.	6/15/21

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K 712	Continued From page 11 documented. 4. 3rd Shift - Quarter 4, there was no documented transmission of the fire alarm signal. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 712		
K 761 SS=F	Maintenance, Inspection & Testing - Doors CFR(s): NFPA 101 Maintenance, Inspection & Testing - Doors Fire doors assemblies are inspected and tested annually in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Non-rated doors, including corridor doors to patient rooms and smoke barrier doors, are routinely inspected as part of the facility maintenance program. Individuals performing the door inspections and testing possess knowledge, training or experience that demonstrates ability. Written records of inspection and testing are maintained and are available for review. 19.7.6, 8.3.3.1 (LSC) 5.2, 5.2.3 (2010 NFPA 80) This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to inspect and maintain fire-rated door assemblies in accordance with the Life Safety Code NFPA 101 - 2012, sections 19.7.3.1, 19.7.6, 4.6.12, and the Standard for Fire Doors and Other Opening Protectives NFPA 80-2010, section 5.2.1. This deficient practice could affect all 80 residents. Findings include:	K 761	K761 The fire rated door assemblies are being inspected for operation, frame, door, hinges, flush bolts, lockset/hardware, fire exit hardware, door closer and other utilizing a check point fire/smoke door inspection audit for each door. The maintenance director and the assistant maintenance director are conducting these inspections. These annual	6/15/21

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K 761	Continued From page 12 On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through and document review of the facility, the following observations were made: 1. No records of having conducted or contracted an annual inspection of fire-rated door assemblies. 2. There was a basement door at the bottom of the stairs from Laundry Room with a fire rating that was wired in the open position hindering the door from self-closing. 3. There was a Laundry Room door with a fire rating that was found in a propped open state and blocked from self-closing. 4. There was a Kitchen door at the right side of the Dining Room that was found to be obstructed in the open position and would not be able to close. 5. There was a Kitchen door at the left side of the Dining Room that was found propped open not allowed to self-close. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 761	inspection checklists are placed in the preventive maintenance binder. The annual inspection is set up in the preventive maintenance schedule. The maintenance director or designee is responsible for the monitoring and for the completion of the inspection annually. The kitchen and housekeeping staff have been educated to not prop open doors or obstruct the doors from self-closing. The housekeeping/dietary director is responsible for monitoring that the doors are kept free to self close.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are	K 914		6/15/21

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K 914	Continued From page 13 tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to provide documentation to confirm that annual electrical receptacle testing at resident bed locations had been completed in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 6.3.3.2, 6.3.4.1, and 6.3.4.2. This deficient practice could affect all 80 residents. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, no records were provided during a review of the available documentation to confirm that the facility had completed annual electrical receptacle testing at resident bed locations. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 914	F914 The maintenance director and the assistant maintenance director have completed an inspection of the electrical receptacle testing at resident bed locations and have documented this inspection. The annual inspection has been placed in the preventive maintenance schedule. The maintenance director or designee is responsible for monitoring and ensuring that the testing is completed and documented annually.	
K 920 SS=F	Electrical Equipment - Power Cords and Extens	K 920		6/15/21

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K 920	Continued From page 14 CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview, the facility failed to use commercially approved electrical devices and implement them accordingly in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, sections 10.2.3 and 10.2.3.6, 10.2.4 and the National Electrical Code NFPA 70 - 2011, sections 400.8(1), and TIA 12-5. This deficient practice could affect all 80 residents. Findings include:	K 920	K920 1. The 6 plug wall adapter in use at the 3rd floor nurses station has been removed. 2. The power tap and 6 plug wall adapter that was located in room 315 has been removed 3. The extension cord used in room 206 has been removed 4. The six plug wall adapter located in the PT room has been removed.	

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K 920	Continued From page 15 On facility tour between 09:00 AM and 02:00 PM on 05/05/2021, during a walk-through of the facility, the following observations were made: 1. At the 3rd Floor Nurse's Station, there was a 6-plug wall adapter in use that was not listed with UL 1363. 2. On the 3rd floor in Room 3.15, a relocatable power tap was daisy-chained to a 6-plug wall adapter that was not listed as UL 1363. 3. On the 2nd floor in Room 2.06, an extension cord was used to power a floor lamp. 4. In the 1st floor Physical Therapy, there was a 6-plug wall adapter in use that was not listed with UL 1363. This deficient practice was confirmed by the Assistant Maintenance Director at the time of discovery.	K 920	If power tap or wall adapters are necessary to use, they will be UL 1363 listed. The maintenance director or designee are responsible for monitoring the use of these adapter if necessary and they will ensure that they are UL 1363 listed if they are used.	
K 923 SS=E	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923		6/15/21

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K 923	Continued From page 16 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper segregation of medical gas cylinders in accordance with the Health Care Facilities Code NFPA 99 - 2012 edition, section 11.6.5. This deficient practice could affect all residents on the first floor. Findings include: On a facility tour between 09:00 AM and 02:00 PM on 05/05/2021, In the 1st floor Med Gas Room, it was revealed that there was no physical separation of full and empty oxygen cylinders. This deficient practice was confirmed by the Assistant Maintenance Director at the time of	K 923	K923 A precautionary sign has been placed on the door of the oxygen cylinder storage room with the wording containing caution: oxidizing gas(es)stored within no smoking. Empty cylinders are now segregated from the full cylinders. Signage has been placed to instruct staff how to store the cylinders properly. The maintenance director or designee is responsible to monitor that the precautionary sign remains in place and to monitor the room ensuring that the full cylinders are separated from the empty cylinders. This task is added to the weekly preventive	

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K 923	Continued From page 17 discovery.	K 923	maintenance schedule.	