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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRYI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**
2.STATE VENDOR OR MEDICAID NO.
(L2) **456190000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **07/16/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Gloria Derfus, Supervisor 07/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 08/12/2014 (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
01/01/1991
(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.
00320
(L31)

30. REMARKS File Name and Location:
P:\QIS Surveys\Camden Care Center IRYI11 03132014 30951\PCR 3_All Corrected

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5544

On July 16, 2014, the Minnesota Department of Health completed a third post certification revist (PCR) to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the original survey completed March 18, 2014 and the PCR completed on May 13, 2014. We presumed, based on its plan of correction, that the facility had corrected these deficiencies as of July 6, 2014. Based on our visit, we have determined that the facility has corrected the deficiencies issued pursuant to the original survey completed March 18, 2014 and PCR, completed on May 13, 2014. Please refer to CMS form 2567B for the results of the July 16, 2014 revisit.

Effective July 16, 2014, the facility is certified for 87 skilled nursing facility beds.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED LETTER

August 15, 2014

Ms. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544023

Dear Ms. Killian-Smith:

This letter revises and should replace our letter dated August 1, 2014 to correct the date of the third revisit that determined substantial compliance from July 17, 2014 to July 16, 2014. In addition, the correction dates of the deficiencies found corrected at the time of the July 16, 2014 revisit have been revised on the attached CMS-2567B form.

On April 8, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 13, 2014. (42 CFR 488.422)

We also notified you that remedies were being recommended for imposition to the Centers for Medicare and Medicaid Services (CMS).

On April 11, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of $6,300.00 per day for the nine (9) days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00

- Federal Civil Money Penalty of $250.00 per day beginning March 18, 2014

- Discretionary Denial of Payment for New Admissions effective April 29, 2014

Also, the CMS Region V Office notified you in their letter of April 11, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

The letter of April 11, 2014 also advised you that, should you fail to attain substantial compliance by August 18, 2014, CMS would impose the remedy of termination from the Medicare and Medicaid programs.

This was based on the deficiencies cited by this Department for an extended survey completed on March 18, 2014. At the time of our March 18, 2014 extended survey your facility was not in substantial compliance with the participation requirements and conditions in your facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On May 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 18, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 28, 2014. Based on our revisit, we determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on March 18, 2014, and conditions in the facility constituted both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety. The most serious deficiencies identified in your facility at the time of the May 13, 2014 revisit were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. At the time of the exit on May 13, 2014 the IJ situation had not been removed and the facility was notified that failure to remove the IJ would result in termination of the facility's Medicare and Medicaid provider numbers by CMS, to be effective June 5, 2014.

On May 21, 2014 a second revisit was conducted to verify removal of the IJ which was identified at F224, F323 and F490 during the revisit conducted on May 13, 2014. As a result of the May 21, 2014 revisit, it was determined that the immediate jeopardy at F224, F323 and F490 was removed on May 21, 2014. We notified your facility on May 21, 2014 that we recommended to CMS that the remedy of 23 day termination of your Medicare and Medicaid provider agreement not be imposed. Although the IJ was removed, substantial non-compliance remained. Thus, all other deficiencies from the May 13, 2014 revisit remained as written on the May 21, 2014 statement of deficiencies (CMS-2567).

As a result of the revisit findings, you were notified on June 2, 2014 that the Category 1 remedy of state monitoring would remain in effect. You were also notified that we recommended to the Region V Office of CMS that the previously imposed remedies would remain in effect and that we recommended that the following new remedy would be imposed:

- Federal Civil Money Penalty for the deficiency cited at F490 at a S/S level of J

On July 10, 2014, the CMS Region V Office notified you of the following actions related to our recommendations and the imposed remedies in their letter of April 11, 2014:

- Federal Civil Money Penalty of $6,300.00 per day for the nine (9) days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00

- Federal Civil Money Penalty of $250.00 per day for the forty-four (44) days beginning March 18, 2014 and continuing through April 30, 2014 for a total of $11,000.00

- Federal Civil Money Penalty of $6,700.00 per day for the twenty (20) days beginning May 1, 2014 and continuing through May 20, 2014 for a total of $134,000.00

- Federal Civil Money Penalty of $600.00 per day beginning May 21, 2014

- State Monitoring effective April 13, 2014, would remain in effect

- Discretionary denial of payment for new admissions, effective April 29, 2014, would remain in effect

- Modification of the date for termination of your Medicare and Medicaid provider agreement, to September 18, 2014

On July 16, 2014, the Minnesota Department of Health completed a third PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the PCRs completed on May 13, 2014 and on May 21, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 6, 2014. Based on our visit, we determined that your facility has corrected the deficiencies issued pursuant to our PCRs, completed on May 13, 2014 and on May 21, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective July 16, 2014. The Region V Office of CMS will notify you of their determination regarding the previously imposed remedies from their letters of April 11, 2014 and July 10, 2014.

As we notified you in our letter of April 8, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

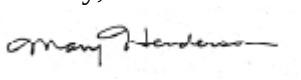
Correction of the Life Safety Code deficiencies at the time of the March 18, 2014 extended survey was verified May 1, 2014.

A revised copy of the Post Certification Revisit Form (CMS-2567B) from the health revisit completed on July 16, 2014 is being submitted to you electronically.

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

Feel free to contact me if you have questions about this correspondence.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4115 Fax: (651) 215-9697
Email: mary.henderson@state.mn.us

Enclosure

cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing	7/16/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0221** Reg. # **483.13(a)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0223** Reg. # **483.13(b), 483.13(c)(1)(i)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0224** Reg. # **483.13(c)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) - (4)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0275** Reg. # **483.20(b)(2)(iii)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **07/16/2014**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0319** Reg. # **483.25(f)(1)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **07/16/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	08/15/2014	30951	07/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing	7/16/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0412** Reg. # **483.55(b)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0469** Reg. # **483.70(h)(4)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0490** Reg. # **483.75** LSC	Correction Completed **07/16/2014**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0493** Reg. # **483.75(d)(1)-(2)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0497** Reg. # **483.75(e)(8)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0499** Reg. # **483.75(g)** LSC	Correction Completed **07/16/2014**
ID Prefix **F0500** Reg. # **483.75(h)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0502** Reg. # **483.75(j)(1)** LSC	Correction Completed **07/16/2014**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **07/16/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	08/15/2014	30951	07/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing	7/16/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/ or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **07/16/2014**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	08/15/2014	30951	07/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/18/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

REVISED LETTER

August 15, 2014

Ms. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

Re: Enclosed Reinspection Results - Project Number S5544023

Dear Ms. Killian-Smith:

This letter revises and should replace our letter dated August 1, 2014 to correct the date of the third revisit that determined correction of the licensing orders from July 17, 2014 to July 16, 2014. In addition, the correction dates of the orders found corrected at the time of the July 16, 2014 revisit have been revised on the attached State Form - Revisit Report.

On July 16, 2014 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 18, 2014 and revisits conducted on May 13, 2014 and on May 21, 2014. At this time of our July 16, 2014 revisit these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Mary Henderson

Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4115 Fax: (651) 215-9697
Email: mary.henderson@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00166	A. Building B. Wing	7/16/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20130** Reg. # **MN Rule 4658.0050 Subp. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **20135** Reg. # **MN Rule 4658.0050 Subp. 2** LSC	Correction Completed **07/16/2014**	ID Prefix **20165** Reg. # **MN Rule 4658.0050 Subp. 3.F** LSC	Correction Completed **07/16/2014**
ID Prefix **20255** Reg. # **MN Rule 4658.0070** LSC	Correction Completed **07/16/2014**	ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **07/16/2014**	ID Prefix **20285** Reg. # **MN Rule 4658.0100 Subp. 2** LSC	Correction Completed **07/16/2014**
ID Prefix **20530** Reg. # **MN Rule 4658.0300 Subp. 4** LSC	Correction Completed **07/16/2014**	ID Prefix **20540** Reg. # **MN Rule 4658.0400 Subp. 1 & 2** LSC	Correction Completed **07/16/2014**	ID Prefix **20545** Reg. # **MN Rule 4658.0400 Subp. 3 A-I** LSC	Correction Completed **07/16/2014**
ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **07/16/2014**	ID Prefix **20570** Reg. # **MN Rule 4658.0405 Subp. 4** LSC	Correction Completed **07/16/2014**	ID Prefix **20625** Reg. # **MN Rule 4658.0450 Subp. 1 A-I** LSC	Correction Completed **07/16/2014**
ID Prefix **20800** Reg. # **MN Rule 4658.0510 Subp. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **20820** Reg. # **MN Rule 4658.0510 Subp. 5** LSC	Correction Completed **07/16/2014**	ID Prefix **20830** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **07/16/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	08/15/2014	30951	07/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00166	A. Building B. Wing	7/16/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **07/16/2014**	ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **21426** Reg. # **MN St. Statute 144A.04 Subd. 4** LSC	Correction Completed **07/16/2014**
ID Prefix **21475** Reg. # **MN Rule 4658.1005 Subp. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **21530** Reg. # **MN Rule 4658.1310 A.B.C** LSC	Correction Completed **07/16/2014**	ID Prefix **21535** Reg. # **MN Rule4658.1315 Subp.1 ABC** LSC	Correction Completed **07/16/2014**
ID Prefix **21610** Reg. # **MN Rule 4658.1340 Subp. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **21665** Reg. # **MN Rule 4658.1400** LSC	Correction Completed **07/16/2014**	ID Prefix **21730** Reg. # **MN Rule 4658.1415 Subp. 11** LSC	Correction Completed **07/16/2014**
ID Prefix **21850** Reg. # **MN St. Statute 144.651 Subd. 1** LSC	Correction Completed **07/16/2014**	ID Prefix **22000** Reg. # **MN St. Statute 626.557 Subd.** LSC	Correction Completed **07/16/2014**		

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MK/mm	08/15/2014	30951	07/16/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/18/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5544

August 15, 2014

Ms. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

Dear Ms. Killian-Smith:

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 July 16, 2014 the above facility is certified for:

87 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 87 skilled nursing facility beds.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRYI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**

2.STATE VENDOR OR MEDICAID NO.
(L2) **456190000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **05/21/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 06/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/26/2014 (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
01/01/1991
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2014
(L33)

DETERMINATION APPROVAL

CCN: 24-5544

This revisit was conducted only to verify removal of the immediate jeopardy (s) at F224, F323 and F490 which were cited during a federal revisit survey exited on 5/13/14. As a result of this revisit, it was determined that the immediate jeopardy (s) at F224, F323 and F490 were removed on 5/21/14. Although the immediate jeopardy (s) was removed, substantial non-compliance remains at F224 at a s/s of G level; substantial non-compliance remains at F323 at a s/s of H; substantial non-compliance remains at F490 at a s/s of F. Only deficiencies that were cited at the immediate jeopardy level were reviewed during this survey. Thus, all other deficiencies from the 5/13/14, Federal revisit survey remain as written on the 5/13/14, statement of deficiencies. Refer to the 2567 and plan of correction and the 2567B for details.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Emailed: June 6, 2014

Ms. Leah Killian-Smith, Administrator
Camden Care Center
512 - 49th Avenue North
Minneapolis, Minnesota 55430

RE: Second Post Certification Revisit (PCR) for Project Number S5544023

Dear Ms. Killian-Smith:

On April 4, 2014, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 13, 2014. (42 CFR 488.422)

On April 11, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Federal Civil Money Penalty of $6,300.00 per day for nine (9) days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00

- Federal Civil Money Penalty of $250.00 per day beinning March 18, 2014

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective April 29, 2014 (42 CFR 488.417 (b))

- Discretionary termination of your facility's provider agreement, effective August 18, 2014 (42 CFR 488.412 and 488.456)

Also, the CMS Region V Office notified you in their letter of April 11, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

This was based on the deficiencies cited by this Department for an extended survey completed on March 18, 2014. The most serious deficiencies were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

On May 13, 2014, the Minnesota Department of Health and on May 1, 2014, the Minnesota Department

of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 18, 2014. Based on the Department of Health revisit, we identified conditions of both substandard quality of care (SQC) and immediate jeopardy (IJ) to resident health or safety, and determined that your facility had not corrected the deficiencies issued pursuant to our extended survey, completed on March 18, 2014. In addition, at the time of the exit on May 13, 2014 the immediate jeopardy situation had not been removed. As a result of the revisit findings, we notified you on June 2, 2014 that the Category 1 remedy of state monitoring would remain in effect.

On May 21, 2014, the Minnesota Department of Health completed a second PCR to verify that the immediate jeopardy situation identified at the time of the May 13, 2014 PCR had been removed. Based on our May 21, 2014 revisit, we have determined that your facility has not obtained substantial compliance with the deficiencies issued pursuant to our PCR, completed on May 13, 2014 but that the immediate jeopardy situation involving F224, F323 and F490 had been removed as of May 21, 2014. The deficiencies not corrected are as follows:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
F0223 -- S/S: D -- 483.13(b), 483.13(c)(1)(i) -- Free From Abuse/involuntary Seclusion
F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: E -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0250 -- S/S: H -- 483.15(g)(1) -- Provision Of Medically Related Social Service
F0275 -- S/S: D -- 483.20(b)(2)(iii) -- Comprehensive Assess At Least Every 12 Months
F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0319 -- S/S: D -- 483.25(f)(1) -- Tx/svc For Mental/psychosocial Difficulties
F0323 -- S/S: H -- 483.25(h) -- Free Of Accident Hazards/supervision/devices
F0329 -- S/S: E -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0412 -- S/S: D -- 483.55(b) -- Routine/emergency Dental Services In Nfs
F0428 -- S/S: E -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals
F0465 -- S/S: E -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ
F0490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
F0493 -- S/S: F -- 483.75(d)(1)-(2) -- Governing Body-Facility Policies/appoint Admn
F0497 -- S/S: C -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0500 -- S/S: D -- 483.75(h) -- Outside Professional Resources-Arrange/agrmnt
F0514 -- S/S: E -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, at the time of this revisit, we identified the following new deficiencies:

F0224 -- S/S: J -- 483.13(c) -- Prohibit Mistreatment/neglect/misappropriatn

F0274 -- S/S: D -- 483.20(b)(2)(ii) -- Comprehensive Assess After Significant Change
F0469 -- S/S: D -- 483.70(h)(4) -- Maintains Effective Pest Control Program
F0492 -- S/S: E -- 483.75(b) -- Comply With Federal/state/local Laws/prof Std
F0499 -- S/S: D -- 483.75(g) -- Employ Qualified Ft/pt/consult Professionals
F0502 -- S/S: D -- 483.75(j)(1) -- Administration

The most serious deficiencies in your facility at the May 21, 2014 revisit were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of April 11, 2014:

- Federal Civil Money Penalty of $6,300.00 per day for nine (9) days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00 remain in effect

- Federal Civil Money Penalty of $250.00 per day beginning March 18, 2014 remain in effect until the facility attains substantial compliance

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective April 29, 2014 remain in effect

- Discretionary termination of your facility's provider agreement, effective August 18, 2014 remain in effect

As CMS notified you in their letter of April 11, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

Furthermore, we are recommending to the CMS Region V office the following additional remedies for imposition:

- Civil money penalty for the deficiency cited at: F224, at a S/S level of J (at the time of the PCR) (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F323, at a S/S level of K (at the time of the PCR) (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F490, at a S/S level of J (at the time of the PCR) (42 CFR 488.430 through 488.444)

Enclosed is a copy of the Statement of Deficiencies (CMS-2567). Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

Remedies - the type of remedies that would remain in effect with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 5 months after the survey date; and

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found**

to have received substandard quality of care.
Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health

P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 18, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

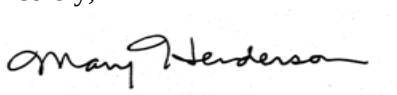
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

Feel free to contact me if you have questions about this letter.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4115 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

June 13, 2014

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
PO Box 64900
St. Paul, MN 55164-0900

Re: Camden Care Center

Dear Ms. Derfus:

Attached please find Camden Care Center's credible allegation of compliance for the survey exit date of May 21, 2014. The plan of correction being submitted is the same plan of correction being submitted for survey exit date of May 13, 2014. You can reach me with any questions or concerns at 612-529-7747 x201 or leah.smith@pathwayhealth.com . Thank you in advance for your consideration.

Respectfully submitted,

Leah Killian-Smith
Interim Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This revisit was conducted only to verify removal of the immediate jeopardy (s) at F224, F323 and F490 which were cited during a federal revisit survey exited on 5/13/14. As a result of this revisit, it was determined that the immediate jeopardy (s) at F224, F323 and F490 were removed on 5/21/14. Although the immediate jeopardy (s) was removed, substantial non-compliance remains at F224 at a s/s of G level; substantial non-compliance remains at F323 at a s/s of H; substantial non-compliance remains at F490 at a s/s of F. Only deficiencies that were cited at the immediate jeopardy level were reviewed during this survey. Thus, all other deficiencies from the 5/13/14, federal revisit survey remain as written on the 5/13/14, statement of deficiencies.	{F 000} MM/MK 06/24/14		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	{F 157}		7/6/14

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

Refer to cover letter for designees signature-mpm | 01/13/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 157}	Continued From page 1	{F 157}		

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the physician and family member(s) was promptly notified for 1 of 1 resident (R13) observed to elope from the building during the survey on 5/6/14.

Findings include:

On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 exited the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 157}	Continued From page 2 the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly observed to be smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to finish smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair using her feet to propel the wheelchair towards 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 3	{F 157}		

rapidly (posted speed limit was 30 miles per hour). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor that R13 had been observed on the city sidewalks. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, assisted her to wheel back to the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, identified diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had a history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples' belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, the assessment indicated R13 was required to have supervised LOAs (Leave of Absences) only, and that R13 had a past history of drug abuse.

A LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and that the resident was unable to leave the facility unsupervised.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 4	{F 157}		

A Camden Care Center Care Conference form dated 10/1/13, included; "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of daily living (ADLs).

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 5 resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, indicated R13 had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "WanderGuard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision." An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 6 The receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident." Although the note indicated a message had been left for the NP, the NP and family member(s) were not called until three days after the incident. On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, did O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. registered nurse (RN)-C stated she was in the room when O-C had reported R13 had eloped. RN-C stated the	{F 157}		

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{F 157}	Continued From page 7 announcement was made and RN-C, licensed practical nurse (LPN)-E, LPN-A and dietary manager (DM) was present for the announcement. RN-C stated she had not reported the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; and would be responsible to notify the family and physician regarding the elopement.	{F 157}		
{F 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) reviewed for restraint, was free of physical restraints while directly supervised by staff during meals. Findings include: On 5/7/14, at 8:28 a.m. R89 was observed to be at a meal in her wheelchair (W/C) with the right break locked. Anti-rollbacks (devices which engage and keep wheelchair from rolling back when a resident stands) were observed to be applied to the back of the W/C. A nursing assistant (NA)-V was observed to be sitting directly to R89's left and assisted R89 to eat.	{F 221}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 8 When asked why the W/C brake was locked, NA-V stated "we lock one brake," and verified the left brake was unlocked. NA-V explained "brakes" needed to be locked "to protect her [R89]." NA-V further explained R89 needed to protect from "falling." NA-V was unclear why the left brake was left unlocked. The right side of the W/C was observed to be flush to the table. During the observation, R89 was observed to stand repeatedly, had worried expression on her face and repeated in an anxious voice, "I gotta go!" On 5/8/14, at approximately 8:30 a.m. R89 was observed to be at the dining room table in the same location. R89 was observed to have both W/C brakes locked; the anti-rollback device remained appropriately applied to the W/C. R89 attempted to stand multiple times, appeared worried when standing, then immediately sat back down. - From 8:30 a.m. until 9:40 a.m. R89 remained at the breakfast meal. NA-V was observed to provide R89 her breakfast, set up the breakfast and sit directly next to R89 and assist her to eat. At no time were W/C brakes unlocked. R89 was observed to stand repeatedly throughout the meal, pushing back slightly with her legs as she stood. The W/C was flush to the top of the table, preventing R89 from leaving the table. The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a W/C and had "N/A [non-applicable]" written by hand in the section. Review of the	{F 221}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 9 clinical record lacked evidence R89 was assessed for restraints. R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint. The Care Area Assessment (CAA) for activities of daily living (ADLs) Function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease.	{F 221}		

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{F 221}	Continued From page 10 The clinical record lacked evidence R89 had been assessed for restraint use, including locked W/C brakes and having the W/C pushed flush to the table. R89's care plan dated as last reviewed on 3/28/14, identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and did not include direction to place R89 against a desk or table. The care plan was updated on 4/30/14, to include, "Anti-roll back brakes installed onto wheelchair to prohibit wheelchair from rolling backwards when resident offloads independently. Least restrictive safety device while in wheelchair." On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E stated R89 "was not restrained" and stated "anti-rollback brakes were placed on the wheelchair." LPN-E stated R89's W/C was "looked at by therapies" and therapies had assessed R89 for the use of the anti-rollbacks on the W/C. LPN-E was unclear whether the locking of R89's W/C brakes had been assessed as a form of restraint. - At 9:28 a.m. LPN-E stated the therapy department had only made a "recommendation" and since R89 was not on the therapy case load, they "didn't document the evaluation." LPN stated direct care staff had been "educated" not to lock R89's brakes or restrain her against a desk or table. LPN-E verified if R89 was directly supervised by a staff person, the W/C brakes should not have been locked.	{F 221}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 11 On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of anti-rollbacks and the use of potential restraints, such as having both brakes locked and the W/C pushed flush to a table. DON repeatedly stated he thought "physical therapy assessed the use of the anti-rollbacks" but was unclear if R89 was assessed for restraints. DON verified therapy assessments should have been documented in R89's clinical record. On 5/12/14, at 12:28 p.m. the physical therapy assistant and rehab manager (PTA), occupational therapist (OT), and physical therapist (PT) were interviewed together in the therapy gym. All denied having assessed R89 for the use of the anti-rollbacks, W/C brake locking, or restraints. PTA stated the anti-rollbacks had been an idea that had been "brought up" in the morning meeting as "a way to keep her [R89] safe without locking the brakes." The OT stated therapy staff had "helped maintenance order the device," and stated since maintenance had not seen the device before, therapy staff had assisted him to "apply it." The PT stated no therapy staff had actually assessed R89 because there was no "physician's order" and because R89 "was not on case load." All therapists verified they would not "assess" a resident without a physician's order and stated they were unclear when they should "get involved." All verified they were employees of Videll Healthcare Limited Liability Company (LLC), but then stated, "The facility doesn't have polices to let us know our responsibilities." On 5/12/14, at 12:23 p.m. R89 was observed to be in her W/C at the lunch meal. NA-V was observed seated directly to the left of R89. NA-V	{F 221}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 12	{F 221}		

was interacting with R89 before the meal. R89 was observed to have the W/C pushed up flush against the table and both W/C brakes were observed to be locked which caused R89 to be restrained. The left anti-rollback arm was observed to be twisted off R89's left W/C tire (rendering the anti-rollback ineffective). The surveyor alerted NA-V to the anti-rollback being ineffective.
- At 12:26 p.m. R89 was observed to be provided her meal. NA-V setup the meal and remained with R89. R89 was observed to remain in the dining room throughout the meal with the brakes locked. NA-V sat next to R89 until approximately 1:20 p.m. NA-V then unlocked both brakes and wheeled R89 away from the table and into the activity room on the South unit.

On 5/13/14, at 9:03 a.m. LPN-E verified R89 should not have been restrained at the table while supervised during the meal.

The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lap buddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking a resident's W/C brakes, seating a resident up against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DON or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 13 shift and released according to physician's orders. The policy did not address the release of restraint devices, such as releasing the restraint every two hours, during supervised activities, or while the resident was supervised at a meal.	{F 221}		
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse from another resident (R36). Findings include: On 5/6/14, at 9:49 a.m., 5/6/14, at 11:32 a.m., 5/6/14, at 2:48 p.m., 5/7/14, at 1:40 p.m., 5/8/14, at 9:29 a.m., 5/8/14, at 2:08 p.m., 5/10/14, at 12:45 a.m. R34 and R36 were both observed on the smoking patio. The annual Minimum Data Set (MDS) dated 4/1/14, for R34 included a Brief Interview of Mental Status (BIMS) score of nine which indicated moderate cognitive impairment and a Patient Health Questionnaire (PHQ-9) score of five which indicated mild depression. The MDS	{F 223}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 14 indicated R34 did not have delusions or hallucinations. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/3/14, lacked a summary regarding R34's cognitive status. A Vulnerable Adult Assessment date 3/18/14, indicated R36 was verbally abusive and condescending towards others. A Vulnerable Adult Assessment dated 4/4/13, indicated R34 had behaviors which made her susceptible to abuse by others. A Social Service Note dated 4/17/14, indicated R34 had reported on 4/15/14, R36 was verbally abusive towards her. The note indicated when R36 was interviewed on 4/16/14, he stated he calls R34 "a parasite every time I see her because that is what she is." The note indicated R36 was told calling other residents names was verbal abuse and verbal abuse was not tolerated. A Progress Notes dated 4/17/14, indicated the contracted licensed social worker (CLSW) met with R34 on 4/16/14, and R34 indicated R36 "calls her every name in the book, he is just mean." A Progress Notes dated 4/17/14, indicated social services met with R36 and R36 stated he was going to "do what he wants" and would continue to call R34 a parasite. R36 was informed calling R34 names was verbal abuse and R36 responded "I don't care." The Admission Record dated 4/28/14, indicated R34 was admitted to the facility on 3/28/13, with	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 15 diagnoses which included dementia and depressive disorder. A copy of an Incident/Accident Report dated 5/5/14, was provided on 5/8/14. The Incident/Accident Report indicated R34 had reported R36 had pushed her into a patio chair and R34 had become stuck when the patio chair fell over. It was noted the incident had occurred on 5/4/14, at night with no exact time. R36 was noted to have denied the incident; the police were called and spoke with R34. On 5/7/14, at 3:10 p.m. a copy of the facility investigation was requested. The Incident/Accident Report lacked any additional investigation into the incident. A Progress Note dated 5/9/14, indicated R34 reported she did not like R36 because "he is an old drunk." The note indicated R34 had agreed to stay away from R36 and that R34 had stated she was used to handling old drunks, and had showed staff an old scar she reported was from when her late husband broke her leg. When interviewed on 5/7/14, at 2:41 p.m. R34 stated R36 called her names "all the time." When asked how being called names made her feel, R34 stated she had filed a police report because R36 had "assaulted her" two nights ago. When asked what she meant by assaulted, R34 stated R36 waited until nobody was around and then pushed her. R34 reported the director of operations helped her file a police report. Review of the medical records for R34 and R36, lacked documentation regarding the incident which was allegedly reported on 5/5/14, and lacked indication of how R34 would be protected from R36.	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 16	{F 223}		

When interviewed on 5/7/14, at 3:10 p.m. the director of operations reported he was aware of the incident which had occurred during the evening of 5/5/14, and confirmed he'd helped R34 call the police. During the interview, the administrator stated he was aware of the incident and that it had been reported to him on 5/6/14. The administrator reported R34 and R36 "spar all the time."

Upon interview on 5/8/14, at 11:36 a.m. the director of nursing (DON) reported he had received the Incident/Accident Report on 5/8/14. The DON stated he was not sure whether the incident was reportable because it had occurred on 5/5/14, and it was a "resident to resident altercation."

The director of operations was interviewed on 5/12/14, at 9:20 a.m. and stated R34 was very upset about the incident from 5/5/14, and had wanted the police called because it was not the first time, and that R34 had felt assaulted and wanted to press charges.

Upon interview on 5/12/14, at 9:24 a.m. the administrator stated the incident on 5/5/14, had been reported to the state agency and that he would provide documentation regarding the report made.

R34 was interviewed on 5/12/14, at 1:31 p.m., R34 stated R36 was abusive to her every day but that she'd heard he had gotten sent to another nursing home. R34 stated she felt what R36 was doing to her was both verbal and physical abuse.

When interviewed on 5/12/14, at 1:52 p.m. the administrator and consultant administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 223}	Continued From page 17	{F 223}		

reported R34 and R36 have had an ongoing fight going on. The administrator stated R34 and R36 allege physical things and then change their stories. The consultant administrator stated that although the police had been called regarding the incident on 5/5/14, R36 had denied it happened and R34 had no visible injuries noted. The administrator stated when allegations of abuse are made, an incident report was to be filled out and a supervisor consulted to determine whether a report was needed. The administrator said the residents would be separated, an assessment would be made, the incident would be reported to the Common Entry Point (CEP) if appropriate, would be presented at their stand-up meeting the next day, and an investigation would be started. The administrator stated incidents were reported to the administrator, DON or CLSW but verified, "that system has not always been working." The administrator stated the incident form 5/5/14, had not been reported to the State Agency (SA) or to the CEP and acknowledged things needed to be reported right away and then investigated.

Minneapolis Police Department officer (MPD)-E was interviewed on 5/12/14, at 3:38 p.m. and confirmed the police department had come to the facility regarding the incident between R34 and R36 on 5/5/14. MPD-E stated the facility was aware the residents called each other names and stated it was a facility problem.

The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated May 2012, indicated staff must not permit "anyone" to engage in verbal or physical abuse. The policy indicated the facility would implement policies and procedures to ensure that residents are not subjected to abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 223}	Continued From page 18 by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. The definition of verbal abuse was described in the policy as, "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." The policy indicated the facility would protect residents from harm during the investigation and would "report allegations to the state survey and certification agency and any other state agencies pursuant to state regulations."	{F 223}		
{F 224} SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to neglect of supervision for residents was identified during the revisit survey on 5/12/14. The immediate jeopardy began on 5/10/14, and was removed on 5/21/14. However, noncompliance remained at the lower severity level of G, isolated actual harm that is not immediate jeopardy (IJ). Based on observation, interview and document review, the facility neglected to provide adequate	{F 224}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 19	{F 224}		

supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. The IJ was not removed by exit of the 5/13/14 survey.

Findings include:

The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety.

On 5/9/14, the facility had been informed of serious and immediate safety of the residents related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present.

R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. According to documented progress notes, R37 had been found with ETOH/vodka on 2/21/14, 2/22/14, 2/27/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 20 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14 and 5/10/14. The record also indicated R37 had required hospitalizations related to the use of alcohol and or drugs on 2/22/14, 4/23/14, and 5/10/14. During observations of R37 the following was observed: -On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility. - On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was "crazy". - On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and speak to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left rear pant pocket. - On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two. - On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused. - On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 21	{F 224}		

good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. Nursing assistant (NA)-L approached R37 and stated she was with him today. NA-L verified she was assigned to provide the 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken out of the facility to an ambulance.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, R37 removed the WanderGuard (departure alert system) and refused a new one to be placed.
- On 5/3/14, R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 22	{F 224}		

appearance. R37 was noted to have continually gone outside, stated he had called a limousine and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a notation had been made indicating it was a late entry for 5/5/14, at 6:00 p.m., the note indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 23	{F 224}		

appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on one to one (1:1) [to be within arm's length at all times] observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from leave of absence (LOA) accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's Orders and Nurse Practitioners (NP) Orders were reviewed and the following was noted:
- On 1/8/14, included a diagnosis of ETOH abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 24 - On 2/28/14, directed to discharge R37 to another facility (that allowed drinking). - On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's ETOH, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14,	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 25 ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain, and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision but was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending Alcoholics Anonymous (AA) or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 26	{F 224}		

R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the WanderGuard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH use, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 27	{F 224}		

noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated the resident had received a first offense of the facility's smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 had obtained the ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money for ETOH, and stated he has heard about exchanges but could not remember who he'd heard about it from.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. The HUC said R37 had told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14, or 5/6/14, she had observed R37 in the parking lot, and had been told there was nothing they could do about it by the facility administrator. She said she'd requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested that the safety monitor put R37 on every 15 minute checks but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 28	{F 224}		

knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of ETOH withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 had refused to go to the bank with R37 and that friend-A had signed R37 out. The DON said the consultant administrator had been going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 29 stated during a room search a quart bottle of ETOH and three plastic containers with the labels removed, which nursing indicated were methadone containers, had been found in R37's room. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on LOA and that R37 had returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and stated the DON had not told him about the order for no LOA and friend-A's relationship with R1. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 having left on LOA, she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and that she'd told friend-A that R37 could not go there. CLSW-A said friend-A had reassured her he had been sober for ten years and would never take R37 to a liquor store. The CLSW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and had informed her that friend-A was R1's drug dealer. CLSW-A stated it would have been nice to know the information before she had	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 30	{F 224}		

allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing did not find the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

R129 was identified by the facility to have a history of drug seeking and ETOH dependency. Although the facility had determined R129 required a 1:1 staff member since at least 3/18/14, according to a Vulnerable Adult (VA) assessment, the appropriate supervision was not implemented and/or effective.

According to review of the progress notes in R129's record, on 5/3/14, R129 had reported to the facility that she had obtained and consumed cocaine. The documentation indicated R129 had a staff assigned as a 1:1 at the time of the incident.
An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 31	{F 224}		

light." The note indicated the nurse asked R129 what she had taken and indicated R129 then "confessed" to having taken cocaine. The report documentation indicated R129 had been sent to the emergency room (ER) and included, "She said, 'I knowingly took cocaine'.. Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1...remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others."

A North Memorial Medical Center (NMMC) Emergency Department (ER/ED) note dated 5/3/14, identified R129 had reported she'd taken cocaine at the nursing home. The ER note indicated R129 had taken the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED." The Clinician History of Present Illness section of the form identified R129 had reported to hospital staff she had snorted cocaine "5 hours ago."
On 5/11/14, at 4:00 a.m. the progress notes indicated R129 had obtained and consumed a life threatening amount of ETOH, causing her to require hospitalization in an intensive care unit (ICU) with subsequent intubation (mechanical ventilator assisted breathing) as a result of a blood ETOH level of 0.323. (According to Minnesota Statute 169A.20, 0.08 is considered impaired for driving). A 1:1 staff was supposed to have been in place at the time of the incident.

The resident's record included a note documented by the facility's HUC on 5/11/14, at 10:09 a.m. which indicated NMMC had called the facility "requesting" R129's medication administration records (MARs). The note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 32	{F 224}		

indicated the registered nurse (RN) from the hospital had notified the HUC that R129 had been admitted to the ICU, and had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of 0.323."

The record also included a note documented by the director of nursing (DON) on 5/11/14, at 10:55 a.m. The DON's note recapitulated R129 had been sent to the hospital, identified the time of transport as "around 4 a.m." on the night shift, and identified R129 had been sent in "for intoxication." The DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the nursing assistant (NA) staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but that she had not noticed any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident [R129] is visiting." In addition, the DON's documentation indicated R14 had denied giving or knowing how R129 had obtained the ETOH, and documented R14 had "mentioned that resident had alcohol overnight."

An additional progress note, dated 5/11/14, at 2:49 p.m. had been written by the DON indicating NMMC had been contacted to request updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 33 the hospital for snorting cocaine." Additional record review revealed an admission MDS dated 2/1/14, that indicated R129 had a BIMS score of 15, indicating R129 was cognitively intact. The MDS identified R129 was independent with all ADLs. The MDS identified R129 rejected cares and wandered one to three days during the assessment period. R129's comprehensive assessment analysis (CAA) for mood state dated 2/7/14, identified R129 as having intact cognition, with poor decision making and as having diagnoses of "substance induced psychotic disorder, opiate dependence, and ETOH dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug ETOH use" and depression. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAA lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment. A Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had behaviors including a history of rummaging through others' belongings and "drug use." The assessment indicated R129 had been placed on 1:1 due to rummaging in other resident rooms. R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 34 history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and required a "1:1" which was spelled out in large bold print. On 5/12/14, at 10:26 a.m. DON was interviewed about R129 having obtained ETOH and/or drugs while on a 1:1. The DON verified the 1:1 should have been within arm's length of R129 at all times. The DON denied having any knowledge of how R129 had obtained ETOH. On 5/13/14, at 2:21 p.m. the administrator stated during interview that the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and ETOH use.	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 35 On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 36 The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed: "If staff have reasonable suspicion that a resident has used, has in their possession, or has distributed to other residents in the facility ETOH, street drugs, or other pharmacological substances not prescribed by treating physician the facility staff, under the direction of administration, shall: · Search the residents room and remove such substances · Notify the physician and obtain an order for blood and urine drug testing · Notify the family and/or responsible party of the event If the tests return positive the resident with the positive results will be immediately discharged for placing the resident population at risk for abuse. If ETOH, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified." The facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 37 policy also included "Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision." Appendix A of the policy included examples of neglect including: "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision) which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety." According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14. On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance." A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 38	{F 224}		

experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 39 outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 224}	Continued From page 40	{F 224}		

was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door.

On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby.

On 5/13/14, at 1:00 p.m. the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 41	{F 224}		

administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door.

The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed. The ombudsman stated she wanted to be sure the state agency surveyors were aware that resident's of the facility were purchasing ETOH and drugs. The ombudsman reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 42 chemical dependency problems had been drinking, room checks were being completed and staff were finding ETOH bottles. In addition the ombudsman reported R37 had been found intoxicated several times and she was involved in discussing abuse prevention planning and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. The ombudsman stated the police had been notified and had been to the facility "quite often". She also stated she was aware R129 was on a 1:1 and had somehow obtained and consumed an "illegal drug [cocaine]" in the facility. On 5/7/14, at 10:05 a.m. the administrator verified during interview that the ombudsman had been called 5/6/14, to speak with the facility regarding R37 having given his credit card to R117 to purchase ETOH because R37 had been "drunk for days." The IJ that began on 5/10/14, was removed on 5/21/14, when the facility had implemented an IJ removal plan that included: The development and/or revision of policies related to obtaining a drug and alcohol free facility and policies related to prevention of elopements. The facility initiated assessments for reisdents who had been identified at risk for drug/alcohol issues and elopements; The facility also developed a system for investigation of ongoing incidents; Staff were educated to their responsibilities for how to supervise, care for and protect residents; Direct care staff and licensed nursing staff were	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 224}	Continued From page 43 interviewed and were able to explain their responsibilities for identification of residents who were elopement risk. Administration convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate concerns. However, non-compliance remained at the lower scope and severity (s/s) of a G (isolated harm but not an immediate jeopardy) because two residents had required medical treatment and hospitalization after the facility had been informed of the failures of their systems, however there were no new hospitalizations identified for residents due to illicit drug and/or alcohol use at the time of the revisit on 5/21/14. In addition, although the facility had initiated assessments and policy implementation, they had not completed all assessments for all residents related to elopements at the time of the re-visit on 5/21/14.	{F 224}		
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	{F 225}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 225}	Continued From page 44 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Findings include: R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 45 that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated. R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on	{F 225}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 46 the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 47	{F 225}		

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 225}	Continued From page 48 facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 49 a.m. and 11:52 a.m. R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated. R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not	{F 225}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 225}	Continued From page 50	{F 225}		

indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk."

The clinical record lacked evidence R13's

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 51	{F 225}		

elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 52	{F 225}		

being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified.

On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified.

On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 225}	Continued From page 53 unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."	{F 225}		
{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	{F 226}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 54 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their Prohibiliton of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Propery policies for immediate reporting and thorough investigation were implemented for 8 of 9 residents (R37, R66, R70, R14, R41, R13, R129, R116) reviewed with allegations of such; the facility also failed to screen new employees for reference checks, back ground studies and license/certification verification for 6 of 6 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q, NA-W). Findings include: The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 226}	Continued From page 55	{F 226}		

by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency (SA) and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."

R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 56 members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 57	{F 226}		

and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 58 was unclear why it had not been reported to him until then. A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk." The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. On 5/9/14, at 1:43 p.m. LPN-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the form did not identify when the administrator or SA was notified. On 5/12/14, at 10:26 a.m. director of nursing (DON) stated he was not in the facility at the time of R13's elopement and had not been informed until 5/8/14. The DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with a WanderGuard were at risk for elopement and leaving the facility without supervision was a	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 59 safety concern. The DON also verified the incident had not been thoroughly investigated. R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated. R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 60	{F 226}		

problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 61	{F 226}		

being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified.

On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified.

R116 had eloped and the facility did not report to the administrator or SA in a timely manner.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 62 writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 63 Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m. On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 64	{F 226}		

above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

EMPLOYEE SCREENING:
On 5/12/14, at 10:00 a.m. the employee files were reviewed and the following was observed:

Licensure verification:
Licensed practical nurse (LPN)-A's employee file folder lacked verification of the LPN's license. The administrator verified at 12:45 p.m. there had been no proof of nursing licensure obtained for LPN-A from the Minnesota Board of Nursing.

Registered nurse (RN)-C's employee personnel file indicated RN-c had been hired on 4/8/14, and that a back ground study request had been submitted on 4/8/14, however there were no results yet. In addition, no licensure verification completed, only a copy of a license with expiration of 10/4/13.

Background study:
RN-D's file indicated RN-D had been hired 4/16/14, and that a background Study Request had been submitted on 4/14/14. However, the background study incorrectly indicated NA-U's background study information.

Nursing assistant (NA)-U's file was reviewed and was found to include a statement that NA-U had a Minnesota Department of Human Services Background Study (MN DHS BS) form dated 5/25/14, which indicated NA-U "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 65 administrator verified that NA-U could not provide care but had been providing care unsupervised, from 4/23/14, through 5/12/14. NA-U had RN-D's BS in NA-U's employee file. Also, RN-D's BS was in NA-U's employee folder. RN-D's BS indicated that RN-D could not perform cares unsupervised. However, during the survey the administrator obtained the blue BS form which indicated RN-D could perform cares unsupervised. NA-Q was hired on 3/6/14. The facility received a yellow MN DHS BS on 3/10/14, which indicated NA-Q "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The white BS computer genreated copy request indicated the form was submitted on 3/6/14, and passed as of 3/10/14, however the employee file lacked the information as the facility provided the information during survey. The facility did not have system in place to ensure BS were being monitored for the employees ability to work unsupervised. Reference checks: RN-C was hired on 4/8/14, and no reference checks had been completed. RN-D was hired 4/16/14, and no reference checks, could be located in the employee file. LPN-A's file lacked a hire date and no reference checks were completed as the facility policy had directed staff to complete. NA-W hired 4/23/14, had no reference check	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 66 completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge of doing license verifications and background checks for new employees. The administrator further stated the HR person had been terminated two weeks ago and no one else had been designated to follow-up on background checks that had been flagged. The administrator acknowledged the facility had not ensured tracking for new employees' license verification and background checks. On 5/13/14, at 8:10 a.m. NA-U verified during interview that she was a NA and had started orientation on 4/23/14. When asked if she worked under supervision, NA-U stated she had received "a couple of days training" and had started working on her own on 4/28/14. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, but stated she had been working full time on her own since 4/16/14.	{F 226}		
{F 250} SS=H	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 observation, interview and document	{F 250}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 67 review, the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) for alleged substance abuse, and for 2 of 11 residents (R13, R103) who allegedly eloped from the facility. Findings include: Alleged substance abuse: On 5/8/14, at 8:02 a.m. a list of residents allegedly bringing drugs and alcohol (ETOH) into the facility, as well as a list of residents known to use drugs or alcohol in the facility was requested. A list provided by the administrator at 11:00 a.m. included R129, R86, R41, R37, R14, R56, R117, R62 and R9 as alleged substance users. R129 was not provided consistent medically related social services to address ongoing drug seeking behaviors and sustained harm. Although R129 was assigned a one to one (1:1) as of 3/14, the clinical record lacked evidence of social service assessment and interventions. On 5/3/14, R129 reported to facility staff, that she had obtained and consumed cocaine while under 1:1 supervision. On 5/11/14, at 4:00 a.m. R129 had obtained and consumed ETOH while supervised 1:1 by facility staff. This resulted in harm when R129 required hospitalization in an intensive care unit (ICU) where she was intubated (mechanical ventilator assisted breathing) for a blood ETOH level of 0.323.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 68	{F 250}		

R129's admission Minimum Data Set (MDS) dated 2/1/14, revealed a Brief Interview of Mental Status (BIMS--a tool to determine cognitive status) score of 15, indicating the resident was cognitively intact. In addition, it was noted R129 was independent with all activities of daily living (ADLs), rejected cares, and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R129 displayed poor judgment, and had impaired cognition and poor decision making skills. The CAA identified diagnoses including "substance induced psychotic disorder, opiate dependence, and alcohol dependence," as well as hepatitis C, "Hx [history] of drug alcohol use" and depression. Although the history of drug and ETOH dependence was identified, the CAAs lacked documentation of interventions to promote sobriety, such as but not limited to offering chemical dependency (CD) treatment.

The Vulnerable Adult Assessment (VAA) dated 3/18/14, identified R129 had a history of ETOH abuse and "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse related to substance use and required supervision with leaves of absence (LOAs) from the facility. It was noted R129 had a history of rummaging through others belongings and "drug use," and 1:1 staffing was initiated due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, directed staff to "monitor for ETOH use or over sedation."

A Pain Evaluation and Management Plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 69	{F 250}		

5/1/14, identified R129 had daily chronic pain, and a history of pain and seeking drugs. "Resident is on a restricted recipient program [where only one pharmacy may fill narcotic prescriptions to deter drug seeking behavior] due to drug seeking...MD [medical doctor] is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." R129 was described as "very sweaty, weak and tired...she looked very sleepy," and pupils were "large and nonreactive to light." When the nurse asked the resident what she'd taken, she "confessed" to taking cocaine. The report noted, "She said, 'I knowingly took cocaine'...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The resident's history of drug use and receipt of drugs from others was noted, as well as the fact that the resident had current 1:1 staffing. Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14.

An Emergency Department Chart [from the hospital ER] dated 5/3/14, identified R129 reported to have taken cocaine while residing at the facility to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "'5 hours ago.'" Although R129 was identified as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 70	{F 250}		

requiring the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use, only pain. The laboratory (lab) reports indicated various pertinent lab values were checked, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of Dilaudid (narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the designated State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug had been obtained while the resident had 1:1 staff supervision.

A unlabeled typed page insert in the front of R129's paper chart dated 4/15/14, read "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program...All scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their on call MD."

On 5/7/14, at 10:24 a.m. the a return call was made to the ombudsman who had requested contact. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she visited the facility on 5/6/14, and spoke with various residents as well as management staff regarding drug, alcohol and discharge planning concerns. The ombudsman, facility staff, and residents were "suspicious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 71	{F 250}		

residents may be giving money or credit cards to another [resident] to go out and purchase things [cigarettes, alcohol and drugs] for them." The ombudsman stated the police had been notified and responded "quite often." Allegedly residents who were chemically dependent were drinking in their rooms and facility staff were conducting room checks each shift and "finding empty alcohol [vodka] bottles" in resident rooms, and residents had been found "intoxicated." The ombudsman specifically reported R129 had 1:1 staffing, yet had "somehow" obtained and consumed an illegal drug (cocaine). Although the facility had employed "three temporary social workers, social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified the resident was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated 4/11/14, directed staff to provide "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru [sic] their personal belongings."

Review of the undated Group 7 nursing assistant (NA) assignment sheet (for quick reference guide providing care-related direction) indicated R129 was independent with ADLs and "1:1" was noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 72 in larger bold print. Pertinent Nursing Progress Notes read as follows: 1) On 3/14/14, at 6:18 p.m. R129 "had an appointment yesterday and was immediately transferred to the hospital...while on the way home [unclear on prior destination] stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams (mg) (a narcotic and Tylenol pain medication)...failed to alert staff and stated that there were no new orders." The hospital, on call MD and triage nurse were updated on R129's "history of narcotic use." 2) On 3/16/14, at 6:34 a.m. R129 was "caught going through another resident's belonging...opening her purse." The note indicated R129 admitted going in the room but denied taking "any money." 3) On 3/17/14, at 3:34 p.m. "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the record lacked documentation when the 1:1 staffing was initiated. At 10:17 p.m. "called on call [physician]," reported two incontinent episodes, "lower extremities [sic] hurts" and edema (abnormal build up of fluid in the tissues). Was encouraged to "sit and rest the leg" but refused and reported the pain was "unbearable." R129 wanted to be evaluated at the hospital, and "called 911 herself." Although a previous note indicated R129 required 1:1 staffing, it was noted R129 planned to "take care of her own transportation to ER...left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. 4) On 3/18/14, at 3:56 a.m. R129 returned from the ER at 3:30 a.m. with a "New order. No new concern at this time." At 2:31 a.m. R129 reported	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 73	{F 250}		

to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
5) On 3/20/14, at 10:08 a.m. the physician R129 identified as her new primary care physician (PCP) was contacted to inform the provider R129 lived in a health care facility, and orders needed to be coordinated with the facility. The PCP was provided an update regarding R129 changing her PCP, trips to the ER and drug seeking behavior. The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "Went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (hypnotic used to promote sleep). "Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. Patient will be monitored for increased sedation." Although the previous note indicated the transportation company was directed not to make any stops during transport, R129 had been brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription had been written and a report the script was lost had been reported by R129. The physician denied taking R129 on as a patient, however, and referred the facility to R129's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 74	{F 250}		

current PCP.
6) On 3/28/14, at 11:52 a.m. R129 met with social services and "Also spoke with resident regarding her drug seeking. [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
7) On 4/4/14, at 7:11 p.m. R129 met with psychologist, as well as the DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's...informed her she was on 1:1's because of her frequent drug seeking...admits that she has urges to seek medications to manager her pain...denies addiction." Inpatient treatment was discussed such as drug and emotional counseling, which R129 rejected. The note indicated the psychologist agreed with the need for treatment, "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
8) On 4/7/14, at 10:47 a.m. R129 remained, but requested she be removed from 1:1 supervision, which was noted as required "for going into other resident rooms."
9) On 5/4/14 12:03 a.m. R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [R1's room number]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to the ER for evaluation. "The nurse requested for toxicology screen and a copy should be send [sic] to the nursing home per the administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 75	{F 250}		

order." Although the note indicated R129 obtained cocaine from another resident and identified R129's involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified,and toxicology screening was obtained. Although R129 had an assigned 1:1, the record lacked evidence as to how the resident obtained and ingested the drugs, the incident was not immediately reported to the administrator and SA, nor was it investigated. In addition, the record lacked evidence R129 had received a CD evaluation or were immediate changes made in the monitoring and supervision provided for the resident's safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice...remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.

10) On 5/4/13, at 12:12 p.m. an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they were only accepting on-call emergencies. Staff would notify doctor the morning of 5/5/14. The resident returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, she immediately requested pain medication upon return to the facility (the note was not closed or signed by the writer).

On 5/5/14, during the initial tour of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 76	{F 250}		

NA-K was observed to be sitting in a chair directly outside R129's room. The door was open and R129 was dressed and was lying in bed with her eyes closed. NA-K reported she was assigned as a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

The following day at 8:30 a.m. NA-M (1:1 staff) followed R129 down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length and looking in the opposite direction from R129 and talked with another staff person in the smoking area. R129 stood with other residents and smoked out of direct sight of NA-M. At 8:33 a.m. R129 sat on a bench with another resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same staff person. NA-M was not near enough to R129 to intervene should there have been a concern. At 8:37 a.m. staff spoke to each other and then NA-M turned his back on all smokers (including R129) and spoke to a male who was in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the staff directly. NA-M was not within arm's length or direct eye sight of R129. At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind her into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 77	{F 250}		

hallway. At 9:34 a.m. R129 pushed R62 in her wheelchair out of the facility and onto the smoking patio. R62 held out a cigarette for R129 ask she pushed the chair, and R129 concealed the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. At 9:35 a.m. a staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents who were unsupervised. At 9:37 a.m. R117 came out of the facility, lit a cigarette at the front entrance, jumped up onto the cinder landscape block planter with ease, and walked across the top of the planters with a skipping gait. Neither the smoking monitor nor another female staff in the area intervened. R117 was observed to speak briefly with the female smoking monitor, approached R36, pulled out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter. NA-M was not within arms reach nor eyesight of R129, and was not supervising the resident. NA-M remained with the other female staff, with his back to R129. At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 78	{F 250}		

of the facility. R129 pushed the wheelchair down the hallway with NA-M walking beside R129. At 10:19 a.m. R120 walked out to the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retrieved a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make eye contact with R129 and was not in arms reach as he spoke with the smoking monitor. At 10:25 a.m. NA-M and R129 went inside with NA-M walking within arms reach of the resident.

On 5/8/14, at 11:22 a.m. R129 was observed lying in bed, NA-E was making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, which she had reported to facility staff. When asked when this occurred, R129 stated it was "on Saturday" (5/3/14)." When asked where she snorted the the cocaine, R129 replied, "not in the facility...down the block." When asked if she received the cocaine from another resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember the person's name, description, or gender. R129 said she snorted "about $20 worth." When asked what happened then R129 stated, "They sent me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 79	{F 250}		

to the hospital...They accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day by the 1:1 assigned to her that day. R129 stated the 1:1's name (NA-G) who was to be with her at all times. She said the reason for the 1:1 was because she was accused of "rummaging" in other residents rooms. R129 reported she had a 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 said she was "a recovering addict," but denied social services had been provided by facility staff, including assistance to obtain CD treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the ER, but was given two shots of Dilaudid. R129 explained she "thought" that was going to happen, yet admitted she was "surprised" to have received the narcotic pain medication. Although R129 was relaxed during the interview, she was hesitant to answer some questions and did not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified the responsibility of the 1:1 staff was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated was unaware of alcohol or drugs were being exchanged on "my shift," but stated was aware of situation "weeks ago" when she came to work and noticed R14 was not in his room. NA stated she asked where he was and a NA "who was [R129's] 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 80	{F 250}		

sent to the hospital for "eating something." Stated had not witnessed any exchanges and stated if she had she would have reported it to the nurse.

On 5/8/14, at 11:40 a.m. NA-S reported seeing alcohol bottles in residents' rooms and smelled alcohol on a resident and reported it to a nurse, but was unclear when it had occurred. NA-S "heard rumor" of a resident dealing drugs in the facility, and recalled seeing a resident with marijuana in January or February, and "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she overheard residents talk about it. NA-S believed R117 was a drug dealer, as the resident left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was from an "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. housekeeper (H)-A when asked, reported she had seen "empty pint bottles" of vodka in the trash by the front doors. The last time had been, "a few months ago," and she had reported any bottles she found. " H-A was unsure which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew how the bottles had been obtained, she was unsure, but thought they may have been brought in by family members.

On 5/8/14, at 12:03 p.m. LPN-H stated she had confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, as well, but it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 81 unclear how it was being provided. LPN-H verified R129 was on 1:1 which meant within arms reach. LPN-H was unaware R129 had obtained cocaine in the facility. On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. The HUC stated there was "always hearsay between residents...their selling [drugs and alcohol] to each other...it's always stories," including hearsay stories regarding heroin and cocaine. The HUC had put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program, and R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." R129 "refuses to tell" about the prescriptions, and the HUC went to the social worker to report these concerns. R129 denied having pills, "but I know she did get them...every week" R129 was finding a new doctor, and not providing the correct paperwork, or altering paperwork. The HUC was aware residents consumed alcohol in the facility, and some became intoxicated, however, it was unclear how they had obtained it. "I feel like we're supposed to do something, 'cuz no one will take charge." The HUC was aware R129 obtained cocaine and was sent to the ER, but was unsure if a toxicology screen had been done, although she had asked for them in the past. The HUC said she and other staff believed R129's (making quotation gestures) "son" was R129's dealer, and described him as a man she referred to as her son, who was at the facility at the time the resident snorted the cocaine. Further review of the nursing progress notes also revealed indicated the following:	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 82 1) On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (narcotic pain medication) refills and determined 110 Percocet tablets had been delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information. 2) On 5/11/14, at 10:09 a.m. a note written by the HUC indicated North Memorial Medical Center (NMMC) called "requesting" R129's Medication Administration Records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 had been able to obtain and ingest a life threatening amount of alcohol. Although the administrator was updated, the clinical record lacked evidence the SA was also immediately notified of the incident. The record lacked documentation at the time of the incident, as well as pertinent assessment information such as vital signs and symptom descriptions. In addition, the record lacked evidence of an immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time. 2) On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." R129 had "become weak" and needed to be lowered to the floor." Two LPNs were contacted and the NA staff assigned to the 1:1 was called. The NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 83 exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting...." R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained the alcohol. 3) On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine." 4) On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait." R129 was identified at risk for falling, was verbally aggressive to staff and stated, "'I'm drunk.'" The room was checked and no evidence of alcohol was found. R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m. On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening that was "reducing her hours to once a week." Both verified they had not specifically worked with R129 regarding CD treatment and verified was last offered to R129 on 4/4/14 and had not revisited CD treatment options after R129	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 84 reported cocaine use on 5/3/14. Neither was aware R129 had been hospitalized for alcohol toxicity and said they "should have been notified." CLSW-A and B had not worked the previous few days, as facility had not paid the contracted company's bill. CLSW-B expressed concern for the residents, and said R129 should have been reassessed after she had obtained and used cocaine, and both SWs felt R129 had been harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." R86 was committed as mentally ill and chemically dependent per Hennepin County Commitment papers dated 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. R86 was placed at harm as R86 was hospitalized due to alleged substance abuse. On 3/16/13, R86 was admitted to the facility per the Admission Record. Diagnoses include hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 85	{F 250}		

drunkenness.
A care conference dated 1/2/13 [sic -2014], lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.
A progress note dated 2/22/14, at 11:00 p.m. "Pt was found smoking 'pot' in his room. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."
A progress note dated 2/23/14, at 10:33 a.m., "Resident left with family member in a VAN for unknown destination at this time, hoping to return today. We will follow up with resident safe returned."
A progress note dated 2/23/14, at 10:23 p.m., "Resident returned from visiting with a family. The nurse checked resident. No injury observed."
A progress note dated 2/24/14, at 4:38 a.m., "Resident had been very confused and having difficulty to settled [sic] down in bed. judgment [sic] has been non-intact [sic] and appeared restless with a lot of tremor. He attested to this writer that when he goes LOA he smokes marijuana but never drink alcohol at all. He state [sic] "If I drink I will die". His platelet has been dangerously lower [sic] thus posing him at a risk for bleeding. Update on call doctor about resident change in condition, who then mandate this writer to send resident to the emergency room for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. " The resident was admitted to the hospital.
A progress note dated on 2/24/14, at 3:32 p.m., " Writer called PCP and updated on his current use of marijuana, as well as updating that he is in the

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 86 hospital." A progress note on 2/27/14, at 3:59 p.m."Nurse from U OF M,updated writer about resident current status, stating that, resident is alert and oriented x 3, appear to be quiet stable, but a little restless" and that R86 will "arrive at 1445 at facility, will pass this info to p.m. nurse." A progress note dated 3/4/14, at 6:11 a.m., "While executing initial nursing rounds this shift, this writer smell [sic] and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staffs [sic] that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinue. He had flexeral [sic- Flexeril (cyclobenzaprine) is a muscle relaxant used to treat skeletal muscle conditions] with some benefit noted. He want [sic] another sleeping pills [sic] at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg [milligrams] of Trazodone [an antidepressant], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment." A progress note dated 3/15/14, at 09:48 a.m., "[R86] having behaviors which are not in line his norms. Behaviors like going into other resident's room and sitting on their bed, coming in the hallway half naked. Patient at time have uncontrolled coughing as well." A progress note dated 3/15/14, at 10:22 a.m., "Resident left the facility this morning around 10:20 am for the Fairview ER [emergency room]. He was escorted by two paramedics and admitted to the hospital." A progress note dated 3/17/14; at 8:21 p.m. R86	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 87 came back from hospital at 3:45 p.m.., "Resident is alert and oriented. A progress note dated 5/10/14 at 10:04 p.m. R86 did not sign out when leaving facility. Writer called resident. Resident states he will be back by 11 p.m.." A progress note on 5/11/14, at 6:30 p.m., "Writer not able to assess and talk to resident in relation to his h/o [sic history of] chemical dependency due to resident being LOA at this time. Writer will approach at a later time." A progress note dated 5/19/14, at 1:37 a.m. indicated: at about 11:00 p.m. " Res noted with increased confusion, coughing constantly, and emesis X 2 [two times]. Cough meds admin per HSO [house standing orders] with no relief. Refused VS [vital signs]. Call placed to on-call MD at 12:10 a.m. Returned call from [MD ' s name] with an order to send resident to UMFH for eval [evaluation]. MPD [Minneapolis Police Department] non-emergency called at 12: 30 a.m. to request for transportation. " A progress note dated 5/21/14, at 5:05 p.m., "Resident readmitted to facility from Fairview Medical Center. LOA safety assessment completed. Resident assessed to be appropriate to leave the facility unsupervised without medications and supervised with medications except narcotics due to history of chemical abuse. MD faxed for LOA orders and clarification of all other admitting orders. Resident is able to make needs known and removed himself from unsafe situations. Able to verbalize steps to take should a situation arise while out in the community. Able to verbalize LOA policy. Risk of drug/alcohol assessment/re-assessment completed. Resident is at risk for drug/alcohol abuse. Has a dx of depression and ETOH abuse. Was recently discharged from the hospital. Has had no room or other significant changes in	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 88	{F 250}		

routine since return to the facility. Medication side effects remain on MAR. Offered and resident refused social service visits, spiritual counseling, in house psych, outside psych, and AA/NA. Bio-psychosocial assessment of drug and alcohol use in the facility completed. Resident denies any drug/alcohol use and reports using only his prescribed medications. Declined all resources offered. Repeatedly said throughout interview, 'If I drink it will kill me.' Smoking assessment completed, resident denies any tobacco use. Risk of elopement/wandering assessment completed. Resident is not at risk for elopement/wandering. Has no history of elopement/wandering. Is alert and oriented x 3. Able to make needs known. Uses call light appropriately. Katherine Leslie, responsible party, called and updated on assessments and residents readmission to facility at 1635. Care plan updated to reflect assessments."

A vulnerable adult assessment dated 3/18/14, noted "past and recent chemical abuse. Fluctuating cognitive deficits related to liver damage, chemical use. Needs supervised LOA due to fluctuating cognition and chemical use."

A smoking assessment dated 3/18/14, indicated "reports of smoking marijuana outside, and recent drug use reported by resident."

A LOA safety assessment dated 3/18/14, indicated "mental illness, fluctuating cognition related to liver disease. Needs supervised LOA due to fluctuating cognition and chemical use. (Lacked mention of committed to the facility related to substance abuse and mental illness."

An annual MDS dated 3/22/14, had a "BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares."

On 4/13/14, a care conference indicated: "long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 89 term placement waiting for liver transplant. Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past." The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. Per CLSW-B, "tried to build report with him. He had been given 30 day notice for Marijuana in his room, but it was not a proper notice and he had not been given another." R86 planned to stay in the facility until he received a liver transplant. CLSW-A stated, "I thought people would not be eligible for a liver transplant if they were actively doing drugs." R86's The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. R86 was committed to prevent exposure to alcohol and chemical substances of abuse. The facility lacked coordination of care between departments and lacked review of facilities own progress notes, which verified substance abuse, and failed to provide an environment free of chemical/alcoholic	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 90	{F 250}		

substances, or to transfer R86 to a secured environment where appropriate care could be provided.

R41:
The facility failed to provide supervision to prevent ingestion of alcoholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m., 5/9 at 3:00 p.m., 5/10 at 2:30 p.m., 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m. On 5/11/14, at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 91	{F 250}		

behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 92	{F 250}		

narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 93	{F 250}		

because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as alcoholics anonymous (AA) or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.

The medical record lacked evidence that social service intervention had been put into place since his last MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression was identified at 7 out 15. The Care Area Assessments indicated he would be seeing the house psychologist and R41 had not been seen by the house psychologist. The medical record also lacks any staff intervention for providing information for his drinking such as like AA and referral to any place for help. Therefore, he was still drinking for depression and left the facility unsupervised. R41 remains at harm.

The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. #. Participate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 94	{F 250}		

in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required.
R37's Progress Notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism.

Observations of R37 revealed the following:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the HUC and in a loud voice stated he was crazy.
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 95	{F 250}		

bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 was intoxicated, when he was friendly and chatting.

The Nutritional Status CAAs dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 96 - On 5/3/14, indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas. - On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait. - On 5/5/14, at 10:25 p.m. indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, which indicated it was a late entry for 5/5/14, at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 97 pressure due to alcohol withdrawal and demanded medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated. - On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time. - On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 98 The Physician's Orders and NP Orders were reviewed and the following was noted: - On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility. - On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol. - On 2/28/14, directed to discharge R37 to another facility (that allowed drinking). - On 3/5/14, directed "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 mg orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 99 elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 100 no other unsupervised LOA. - A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37's alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA. The quarterly MDS dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 101 A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been "drunk for days."	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 102	{F 250}		

On 5/8/14, at 11:51 a.m. LPN-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN-B stated she did not know where R37 got alcohol from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:19 p.m. the consultant administrator was approached after several staff reported they had not been informed of the immediate jeopardy (IJ) that was called on 5/9/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 103	{F 250}		

at 2:02 p.m. The consultant administrator stated she wanted the administrator to indicate why staff was not informed of the IJ and asked "are we in trouble?" The administrator approached and stated, yesterday when the IJ was called, by the time we were done with a meeting with our boss, the nurse managers had gone for the day. The administrator stated he thought they would come up with a plan and would have an all staff meeting 5/10/14, to inform staff of the IJ. The administrator further stated a meeting was scheduled at 1:45 p.m. and verified staff had not been informed of the IJ.

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. RN-B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and friend-A signed R37 out. The consultant administrator was going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 104 decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from. When interviewed on 5/12/14, at 1:35 p.m. CLSW-A stated during a room search a quart bottle of alcohol had been found in R37's room and three plastic containers with the labels removed which nursing indicated were methadone containers. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A and had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and the DON had not told him about the order for no LOA and friend-A's relationship with R1. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and R37 could not go there. Friend-A reassured her he had been sober for ten years and would never take R37 to a liquor store. The SW-A stated after R37 left, nursing (did not	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 105	{F 250}		

remember who) told her R37 had orders for no LOA and friend-A was R1's drug dealer. She stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping alcohol under the edge of his mattress and she could not understand why nursing did not find the alcohol when they made the bed. R37 remained at harm as he did not receive the requested services to assist him with the self-reported drug/ETOH abuse.

R14 was not provided medically-related social services to address known illegal drug use in the facility as recently as 5/3/14.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knee amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others one to three days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA was all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. The CAAs did not identify any history of drug use.

R14's Vulnerable Adult care plan dated as revised on 4/26/14, defied R14 had a "History of chemical abuse, including marijuana and heroin. The care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 106	{F 250}		

plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility.

A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a NA reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician was notified and R14 was sent to the ER for evaluation.

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified R14 had the lab for "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, but not limited to: immediate notification of the administrator and SA, thorough investigation of the incident to determine potential source(s) R14 may obtained the illegal drug from, notification of law enforcement, follow up assessment of R14's safety, evaluation of R14's access to leave the facility, such as to smoke; documentation of how they would prevent potential future instances of

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 107 R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically-related social services. On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "epileptic." R14 denied awareness of illegal drug and alcohol activity in the facility. When asked what R14 would do if she observed illegal drug or alcohol activity in the facility, R14 stated he would "tell the resident not to do it," but would not notify staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, verified had not read the plan of correction and did not know what the plan was. DON verified he was not aware of changes made and reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. Stated he read the survey results from 2013 and stated he was not given an accurate picture of the facility problems. Verified there was no system for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both	{F 250}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 108 CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R56 had conflicting advanced directives dated 4/21/14 and 4/26/14, in her record. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband. A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of intravenous (IV)/intramuscularly (IM) antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56. The annual MDS dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact). Review of the facility care plan dated 4/23/14,	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 109	{F 250}		

indicated R56 was DNR/do not intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice.

Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE."

A Physician's Order dated 4/18/14, directed ok for hospice to evaluate and treat and ok for in-house psych to see.

A nurse practitioner progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition.

A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST.

A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56 about her POLST. R56 reported to CLSW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. CLSW-B indicated she placed the correct POLST information in the advanced directives section of the medical record.

A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares.

On 5/13/14, at 8:41 a.m. a review of the Physician's Orders signed 4/9/14 continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 110 direct "Full Code." On 5/7/14, at 9:31 a.m. RN-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. LPN-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. CLSW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care. On 5/7/14, at 12:14 p.m. the HUC verified the facility did not have a hospice care plan for R56.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 111 On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. NA-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14 with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14 and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. CLSW-B stated she had followed up with hospice and the intent is for R56 to be DNR and CLSW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the Physician's Orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 112 each resident." A hospice policy was requested and was not provided. R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents. R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression. The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility. R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 113	{F 250}		

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called."

The progress notes were reviewed and noted:
- On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator."
- On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility."
- On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to

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{F 250}	Continued From page 114 fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware." - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours." - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident."	{F 250}		

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{F 250}	Continued From page 115 - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding." - On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning." - On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives,	{F 250}		

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{F 250}	Continued From page 116 multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks." - On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen." - On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated. - On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer	{F 250}		

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{F 250}	Continued From page 117 and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "	{F 250}		

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{F 250}	Continued From page 118 - On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a DM did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket. - On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to	{F 250}		

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{F 250}	Continued From page 119	{F 250}		

charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).
- On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on."
- On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility."
- On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
- On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
- On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on

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{F 250}	Continued From page 120	{F 250}		

residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic."
- On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office."
- On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital."
- On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police

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{F 250}	Continued From page 121 have been called to back up EMS, since he is not cooperating." - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and CHF condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident	{F 250}		

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{F 250}	Continued From page 122	{F 250}		

appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" resident stated "yes." Police and EMT then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and

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{F 250}	Continued From page 123 was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time." - On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified." - On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information." - On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 124 MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present." - On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road. - On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called." On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed. When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 125	{F 250}		

facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

R62 had documented drug use on the facility grounds without any social service interventions developed to address substance abuse.

R62 was admitted on 8/31/13, with diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 126 address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the most recent Social Services Quarterly review dated 2/25/14, indicated no changes to the LOA Safety, Vulnerable Adult and Smoking Assessment. Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes. Review of R62's Progress Notes revealed the following: -On 1/24/14, at 5:03 p.m. indicated "a resident approached writer alerting us that another resident is sitting out front smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 127 denied having any." - On 1/24/14, at 5:17 p.m. indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor." During an interview on 5/13/14, at 10:18 a.m. the DM stated, "I did what the 1/24/14, progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were un-aware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14, identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month." CLSW-B stated she has been at the facility since 3/19/14, a day after the Vulnerable Adult Assessment had been completed. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 verified she was smoking 'weed' and told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume that administrator would take care of it because she was there." RN-B verified the care plan was not	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 128 updated and that she "didn't think" R62 was offered chemical dependency assistance. No social service interventions had been developed for R62 for assistance for services associated with substance abuse even though it had been identified and verified by the facility. R9 had been identified as "Known pot smoker" but was not provided medically-related social services to address known illegal drug use at the facility. On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke. -At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area. At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 129 -At 10:19 a.m. R9 returned back to the building. R9's significant MDS dated 3/24/14, identified R9's diagnoses included Schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease (COPD). The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with ADL's. The nutritional status CAA dated 3/25/14, had identified R9 had history of tobacco abuse. R9's Vulnerable Adult care plan revised 10/20/11, identified R9 was a vulnerable adult related to cognitive limitations and physical limitations. The care plan goal indicated R9 would "remain safe within Camden Care Center at all times." The care plan identified R9 required supervision for LOA's from the facility. The care plan lacked to indicate R9 was a "Known pot smoker" A Vulnerable Adult assessment dated 3/18/14, indicated R9 had history of aggression to others, had mental illness/poor judgment, had no history of chemical abuse and "Cannot leave the facility unsupervised." The assessment did not indicate R9 was a "Known pot smoker." When asked on 5/13/14, at 8:36 a.m. regarding smoking "Pot" R9 stated "It's a deem lie that am using any pot" and kept repeating same statement to the surveyor. Social Service Notes were reviewed which revealed: -Social Service Note dated 4/23/14, indicated R9 had gone to social worker (SW) requesting to get her tobacco materials that had been taken from her roommate side back and had indicated they were hers. SW's reported to R9 the materials	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 130 taken from the room were not on her side of the room and was informed her family was encouraged to come and get the plastic bag of smoking things as well as the cigarette roller "since her roommate would no longer be able to do this for her." Note indicated social service would follow as deemed necessary. -Social service Note dated 4/30/14, per request of director of maintenance both social workers accompanied him to R9's room. Neither R9 nor her roommate was in the room. "Per regulations, the bottle of "Shout" was removed from the room." R9 was outside the room and the director of maintenance had reported to R9 the bottle of "Shout" was taken. R9 was upset and turned her w/c away from staff and the bottle of "Shout" along with R9's raw tobacco & other materials (for the tobacco to be rolled) were placed in the Administrators office so it was more convenient for the family to pick up when they visit. Note indicated social service would follow as deemed necessary. When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 131	{F 250}		

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up.

Elopements:
R13 eloped from the facility on 5/6/14, after staff allowed the resident to transport to and from the designated smoking area without staff. R13 was not provided with medically-related social services to address her elopement risk and smoking.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 132	{F 250}		

smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly 30+ miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 133	{F 250}		

immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, R13 was identified to require supervised LOAs only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a wanderguard [sic-departure alert system] to alert staff if she attempts to leave the building. She also has a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 134	{F 250}		

history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs.

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard [sic] in place." An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 135	{F 250}		

intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 136 desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and dietary manager (DM) were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or State agency (SA) would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 137	{F 250}		

administrator or SA. RN-C was unclear if this occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement. RN-C provided a copy of a corresponding nursing progress note dated 5/8/14

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

R103 was admitted to the facility on 7/29/13, per the Admission Record with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

A progress note on 1/5/14, at 5:30 a.m. "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 138	{F 250}		

An MDS quarterly assessment dated 1/31/14, indicated R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

Physician's Orders dated 4/16/14, indicated R103 may have a LOA unsupervised with medications.

A progress Note dated 4/20/14, at 9:48 p.m. read, "Pt went on LOA." The chart lacked documentation of return to the facility. The medical record was reviewed on 5/11/14, and lacked documentation of LOA or discharge. The facility could not locate the Patient Sign In/Sign Out log sheet for that date.

On 5/10/14, at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA.

On 5/11/14, at 10:00 a.m. facility staff were asked whether the resident had been discharged, was on LOA, or had returned to the facility. The HUC checked to see and resident was in room. He had signed out on the Resident Sign Out sheet on 5/10/14, and R103 had signed in on the Resident Sign Out sheet on 5//11/14, at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility.

On 5/11/14, at 10:10 a.m. RN-A was interviewed and was unaware R103 had left the building for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 139 ten and a half hours. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had any documented notes for R103, but knew he had been working with a relocation worker. They verified R103 had not received any social service interventions for planning for discharge. The Videll Healthcare Limited Liability Company (LLC) Elopement policy dated as effective 5/2012, identified, "Videll Healthcare LLC facilities shall provide a safe environment for resident who are assessed at risk for elopement." The policy defined elopement as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure directed if exit seeking behavior was identified to immediately implement interventions to "manage exit seeking behaviors" such as applying "personal security devices such as WanderGuard..." The procedure to directed staff to complete a "thorough" investigation of the event, document a factual account of the occurrence in the medical record and to update/complete an elopement risk evaluation. Although the policy included pertinent direction for searching if a resident eloped, the policy did not address risks such as smoking and access to the designated smoking area.	{F 250}		
{F 274} SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	{F 274}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 274}	Continued From page 140 resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 residents (R56, R116) who had sustained a decline in functional status; and for 1 of 3 residents (R103) who had experienced a significant improvement in activities of daily living (ADLs). Findings include: R56's record was reviewed. A SCSA minimum data set (MDS) assessment was initiated with an assessment reference date (ARD) of 4/26/14, and when reviewed on 5/7/14, at 9:00 a.m. the MDS was noted as in progress with an expected completion date of 5/12/14, twenty-two days after the change in status had been identified. When interviewed on 5/7/14, at 10:40 a.m. registered nurse (RN)-C stated the SCSA MDS was scheduled to be completed on 5/12/14, and the care plan would be completed seven days later on 5/19/14.	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 274}	Continued From page 141 When interviewed on 5/13/14, at 9:53 a.m. RN-C stated she had never done MDSs before and had only received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS policy was requested and was not received. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The admission MDS dated 1/26/14, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which showed no cognitive deficit, and a Patient Health Questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. According to the admission MDS, R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. On 4/15/14, at 10:49 p.m. a nursing Progress Note indicated, "Pt is declining. He is very weak and needs a lot of assistance." The quarterly MDS dated 4/24/14, depicted R116 as needing assist of one person for bed mobility, ambulation in and out of room, dressing toilet use and hygiene. R116 had also deteriorated and required supervision for eating and transfers.	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 274}	Continued From page 142 On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that "a significant change MDS should have been done when it had been determined his condition declined in two areas of functional status." Although the resident had declined in bed mobility, transfers, toileting, dressing, ambulation and personal hygiene, no significant change MDS had been conducted. The quarterly MDS (ready to export, but not exported) did show the extensive assist that R116 now required but interim MDS coordinator verified "it should have been a significant change MDS." R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident. The progress note dated 1/5/14, at 5:30 a.m. indicated R103 was oriented X 3, able to communicate needs and wants. In addition, the notes indicated R103 was independent with movement and bed mobility, and currently utilized a Foley catheter. An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter was in use. R103 was assessed as independent in all functional activities of daily living. Although R103 had improved in more than two	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 274}	Continued From page 143 functional areas, no significant change MDS had been completed as a result of the improved status. According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident 's condition is not expected to return to baseline within two weeks."	{F 274}		
{F 275} SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 3 residents (R36) who required an annual comprehensive assessment. Findings include: The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12. On 5/13/14, at 9:52 a.m. the electronic record (Point Click Care) was reviewed and revealed R36 had an admission Minimum Data Set (MDS)	{F 275}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 275}	Continued From page 144 completed on 5/29/13. The Quarterly MDS's were completed on 8/29/13, 11/21/13, and 2/18/14. A fourth quarterly MDS had been initiated with an assessment reference date of 5/14/14. An annual comprehensive MDS was not initiated as required. When interviewed on 5/13/14, at 9:53 a.m. registered nurse (RN)-C verified she had initiated a quarterly MDS instead of the required annual MDS and confirmed that an annual MDS should have been implemented. RN-C stated she had never done MDSs before and received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS scheduling and completion policy was requested and was not received.	{F 275}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	{F 280}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 145 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter use for 1 of 3 residents (R36); for 1 of 1 resident (R116) who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who had substance abuse issues. Findings include: Review of R36 ' s quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 did not have a Foley catheter in use. Review of the care plan for R36 dated 3/18/14, identified a focus topic; " alteration in elimination". The care plan further indicated R36 had a temporary indwelling Foley catheter in place due to diuretic use. Interventions listed; change R36 catheter as needed per Physician ' s Orders and to irrigate the catheter as needed. When interviewing R36 on 5/7/14, at 7:41 a.m. he stated he did not have a catheter and used the toilet independently. During interview on 5/7/14, at 1:45 p.m. with registered nurse (RN)-A, she confirmed R36 did not have an indwelling Foley catheter.	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 146 During interview on 5/13/14, at 11:41 a.m. with RN-B, she indicated R36 previously had an indwelling Foley catheter but no longer used one. RN-B confirmed the care plan should have been updated to reflect R36's current status. A care plan policy was requested and was not provided. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. R116 was receiving hospice care since 1/21/14, the resident was independent in self-cares, transfers, and mobility. The admission MDS dated 1/26/14, identified a brief interview for mental status (BIMS) score of 15/15, which showed no cognitive deficit, and a patient health questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. The MDS further indicated R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. Review of the quarterly MDS dated 4/24/14, indicated R116 as requiring 1assistance with bed mobility, ambulation in and out of room, dressing, toileting and hygiene. The MDS further indicated R116 required supervision for eating and	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 147 transfers. Review of the progress notes for R116 on 4/15/14, at 10:49 p.m. indicated R116 condition was declining and requiring more assistance with ADL's. Review of R116 ' s care plan with a revision date of 5/2/14, indicated, "Cognition intact and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis." The care plan had not been revised to depict the changes in ADLs. On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that R116 care plan was not current to reflect R116 decline in health status that required assistance with ADL's updated with the needed assistance with ADLs. R62 was admitted to the facility on 8/31/13, with diagnoses that included; memory loss, dementia and cerebrovascular accident (CVA) per the Admission Record. Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, verified that she had smoked marijuana, denied having more marijuana and verbalized understanding regarding discharge if she continued this behavior. Review of the most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the residents health status Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 as having "past/recent substance abuse" and a history of risky behaviors	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 148 and being in an abusive relationship. R62 required supervised LOA (leave of absence) except for appointments with scheduled transport. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, R62 denied she was smoking marijuana Review of R62's care plan with a revision date of 4/26/14, identified R62 having a history of being in an abusive relationship, and as having impaired cognitive function/dementia. Interventions included "approach resident in a calm manner, assess and report any change in mood/behavior and provide the resident with resources as needed. R62 has been assessed and may not leave the facility without supervision." The care plan had never been revised to include R62's known alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment dated 3/18/14, and documented in the nursing progress notes on 1/24/14. During an interview with the facility contracted licensed social worker (CLSW)-A and CLSW-B confirmed the plan of care had not been revised to reflect R62's substance abuse.	{F 280}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	{F 282}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 149 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed and target behaviors were monitored for the use of Zyprexa (olanzapine-an antipsychotic medication) for 1 of 1 resident (R89), and failed to ensure smoking interventions were followed in accordance with the care plan for 4 of 4 residents who smoked (R36, R1, R9, R22), and failed to ensure the care plan was followed for 1 of 3 residents (R9) who required dental services. Findings include: R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 as having a physician order for Zyprexa (an antidepressant) related to "potential injury to self or others, dementia, agitation and pick [sic] disease." The care plan directed the staff to administer the medication as ordered, monitor/document for side effects and effectiveness of the medication. The care plan further directed the staff to "discuss with MD [physician], family regarding ongoing use of the medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of target behaviors such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 150 Review of the clinical record indicated R89 was not monitored for target behaviors. Review of the Consultant Pharmacist Recommendations dated 4/17/14, identified olanzapine (Zyprexa) 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist (CP) review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. Observations of R36 on 5/6/14, at 11:32 a.m. the resident was observed retrieving a cigarette from the inside of his coat and lit it with a lighter from his right pocket. The smoking monitor personal was directed away from the resident and approximately 20 feet away. Observations of R36 on 5/7/14, at 7:07 a.m. the resident was observed smoking a cigarette without a smoking apron on. The smoking monitor personal was approximately ten feet away from the resident. Observations of R36 on 5/7/14, at 7:41 a.m. the resident was observed to have multiple burn holes in his gloves.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 151 Observation of R36 on 5/7/14, at 8:18 a.m. the resident obtained a cigarette from inside his coat and a lighter from his right pocket and lit the cigarette. R36 did not have a smoking apron on. The smoking monitor personal did not offer R36 a smoking apron. Observations of R36 on 5/7/14, at 9:21 a.m. the resident was observed smoking without a smoking apron on and the smoking monitor personal was approximately 20 feet from R36 and was focused on the street and not the resident. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed in his room with a pack of eight cigarettes in his shirt. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed smoking without a smoking apron. The smoking monitor personal was approximately 15 feet from R36. Observations of R36 on 5/7/14, at 3:15 p.m. the resident was observed smoking without a smoking apron and the smoking monitor personal was not within arm's reach. Observations of R36 on 5/8/14, at 9:29 a.m. the resident was observed smoking a cigarette; the smoking monitor personal offered a smoking apron to R36 but the resident refused. The staff did not encourage the resident to wear. Observations of R36 on 5/8/14, at 2:08 p.m. the resident was observed smoking without a smoking apron on. The smoking monitor personal was approximately 15 feet away and was looking in the opposite direction.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 152 Observations of R36 on 5/9/14, at 7:15 a.m. the resident was approached by facility staff to wear a smoking apron. R36 stated he wouldn't wear one after what happened yesterday. R36 stated when staff put a "bib" on R34, R34 took it off and threw it on the ground. R36 stated if she (R34) did not have to wear one, he did not either. R36 wheeled to the smoking patio and smoked a cigarette without an apron on. Observations of R36 on 5/12/14, at 11:38 a.m. the resident wheeled by the smoking monitor personal and lit a cigarette and smoked without an apron on. The smoking monitor personal did not offer R36 a smoking apron. Review of R36 ' s care plan dated 6/14/13, identified R36 as having impaired cognitive function/dementia, alteration in decision making, and/or impaired thought processes. The care plan further indicated R36 required supervision when smoking, and that the resident was to smoke only in designated areas utilizing adaptive equipment apron for safety. An undated list of facility smokers indicated R36 was a supervised smoker and indicated staff keeps smoking material with directions to wear a smoking apron and stay within arm's reach. When interviewed on 5/7/14, at 7:33 a.m. nursing assistant (NA)-B stated she offers to lock the cigarettes in the facility locked box for residents who are unsafe to keep them on their person. NA-B stated if a resident refuses to follow the smoking rules, such as refusing to turn in their smoking materials, refusing to wear aprons, or smoking in non-smoking areas, she makes a	{F 282}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 153 note in the smoking monitor log. R1 was observed on 5/5/14, and consecutive days 5/6/14, 5/7/14 and 5/8/14, smoking without wearing an apron, keeping her smoking material's on her and not smoking in the facility designated areas. When interviewed on 5/8/14, at 10:03 a.m. NA-E stated R1 had a pack of cigarettes and a lighter when she got off the transportation van. NA-E stated "She is very stubborn". When interviewed on 5/8/14, at 11:32 a.m. R1 indicated she had left to the appointment with five cigarettes and her lighter because it was going to be a long time without smoking and when she returned to the facility she had handed the cigarettes back to the smoking monitor. Review of R1's smoking evaluation dated 3/17/14, identified R1 as having a history of unsafe smoking practices when heavily medicated and or tired and falls asleep while smoking. R1 cannot safely utilize lighter/matches and cannot safely handle lit smoking materials and was a supervised smoker. The smoking care plan dated 3/12/14, identified R1 was a smoker. The goals were "Will follow all guidelines regarding smoking at Camden Care Center and will remain safe while smoking." The care plan directed R1 will smoke only in designated smoking areas, was a supervised smoker and had refused Cigarettes and lighter to be kept at nursing station for safety. When interviewed on 5/9/14, at 1:59 p.m. the director of nursing (DON) stated R1 had been educated about leaving her smoking materials in	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 154	{F 282}		

the cart and had been asked to take the cigarettes one at a time. The DON confirmed the plan of care had not been followed.

On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to a covered ash tray. During observation NA-B noticed R9 smoking and covered her with a smoking apron at that time.

Observation at 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.

On 5/6/14, at 2:45 p.m. when interviewing R9, surveyor observed a cigarette box in each of her socks. When R9 was asked why she was storing the cigarettes in her socks she stated "You can leave now, go now".

The smoking care plan dated 10/20/11, identified R9 as a smoker. Goal "R9 will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker.

When interviewed on 5/6/14, at 3:06 p.m. the DON verified R9 was a supervised smoker which meant she should relinquish her cigarette and lighter. DON stated R9 should not have had any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 155 tobacco products on her person, but did not have to wear an apron. . When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified R9 did not have cigarettes in the facility locked box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box. Observation on 5/6/14 at 8:05 a.m., staff was observed assisting R22 to the smoking area, applied a smoking apron and placed a blanket around his shoulders. Staff remained near but not within an arms-length as R22 held a handful of Kleenex while smoking. Observation on 5/7/14, at 9:27 a.m. R22 was observed outside in the designated smoking area sitting in his w/c next to the building pillar. R22 was holding a cigarette on the right hand and the other hand holding a the self-extinguishing ash tray. R22 was not wearing a smoking apron and had a blanket across his lap. R22 dropped his cigarette on to his shirt/blanket, was able to pick it up himself. The smoke monitor personal was not at arms-length and did not observe this happen. NA-B was standing approximately six feet away from the resident. At 9:31 a.m. R22 continued to smoke with no smoking apron, he dropped his cigarette for the second time on to his lap and was able to pick it up himself. NA-B was observed standing by the smoking cart approximately 5 feet away from the resident and was not at arms-length to quickly assist the resident. Review of R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "(R22)	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 156	{F 282}		

will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was wear smoking apron while smoking. Staff to intervene is resident displays unsafe smoking behaviors or refuses safety interventions, and R22 was a supervised smoker.

Review of R22's Smoking Evaluation dated 4/22/14, indicated R22 had a history of smoking in inappropriate places, burn holes in his clothing , was a supervised smoker and smoking materials were secured by staff.

When interviewed on 5/7/14, at 9:33 a.m. NA-B stated she had not witnessed R22 drop his cigarette at 9:27 a.m. and again at 9:31 a.m. even though she was standing near the smoking cart and designated to monitor resident during smoking.

When interviewed on 5/9/14, at 1:59 p.m. the DON confirmed the plan of care had not been implemented related to R22 smoking privileges and safety.

Review of the annual Minimum Data Set (MDS) dated 10/11/13, did not identify R9 dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene.

R9's care plan reviewed 4/9/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 157 Dental for their dental needs." R9 had diagnoses which included Schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and 12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful." On 5/6/14, at 2:45 p.m. R9 was observed to have missing teeth during an interview in her room. On 5/7/14, at 3:28 p.m. LPN-A was interviewed and stated "I went thru the progress notes and I don't see anything that addresses the dental exam. " During an interview on 5/7/14, at 3:30 p.m. household unit coordinator (HUC) stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this."	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 158	{F 309}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Findings include:

R56's annual Minimum Data Set (MDS) dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact).

A physician's order dated 4/18/14, gave approval for hospice to evaluate and treat and for in-house psychiatry services to be provided.

A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband.

Review of the facility care plan dated 4/23/14, indicated R56 was DNR/Do Not Intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice.

A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of IV/IM antibiotic treatment and IV fluid administration. The POLST dated 4/26/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 159 was signed by R56. A nurse practitioner (NP) progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Note dated 5/12/14, indicated contracted licensed social worker (CLSW)-B spoke with R56 about her POLST. R56 reported to SW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. SW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares. On 5/13/14, at 8:41 a.m. a review of the physician's orders signed 4/9/14, continued to direct "Full Code."	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 160 On 5/7/14, at 9:31 a.m. registered nurse (RN)-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. licensed practical nurse (LPN)-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, at 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. SW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care. On 5/7/14, at 12:14 p.m. the health unit coordinator (HUC) verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 309}	Continued From page 161 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. nursing assistant (NA)-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14, with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14, and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. SW-B stated she had followed up with hospice and the intent is for R56 to be DNR and SW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the physician's orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. On 5/13/14, at 1:50 p.m. RN-B provided a copy of the POLST signed by the hospice physician and stated the NP was aware of the code status	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 309}	Continued From page 162 because she had given orders for hospice. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided.	{F 309}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers at the time of admission to the facility. Findings include: R123's Hospital Nursing Progress Note dated 4/11/14, indicated R123 had three pressure ulcers which were connected to continuous wound vacuum (vac) suction and the dressings were intact. The pressure ulcers locations and stages were not identified.	{F 314}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 314}	Continued From page 163 R123 was admitted to the facility on 4/18/14, and deceased on 4/21/14. R123's diagnoses included: spastic paralysis due to multiple sclerosis (MS), pressure ulcers, physical deconditioning, generalized weakness, abnormal pain, diabetes, cerebral palsy, and weakness of both legs obtained from the Discharge Orders and Plan dated 4/18/14. Admission Nursing Assessment dated 4/18/14, indicated a full skin assessment had been completed and a right hip pressure ulcer area with measurements 6.5 centimeters (cm) length (L) x 3 cm width (W) x 2.2 cm depth (D) and 2.5 cm tunnel at 6 o'clock position, right buttock with measurements 4.6 cm (L) x 2.0 cm (W) X 0.0 cm (D) cm and right heel area measured 1.2 cm (L) x 1.0 cm (W) x 2.0 cm (D) had all been identified. The form did not indicate if the areas were pressure related nor were the areas staged. Progress Notes dated 4/18/14, indicated a full skin assessment had been completed with measurements as noted on the Admission Nursing Assessment dated 4/18/14. On the right hip area a wet to dry dressing had been removed and wound bed consisted of moist yellow, pink, red tissue with moderate amount of yellow, red odorless drainage were observed and the surrounding wound tissue had no redness, warmth, or tenderness noted and wound vac dressing had been applied. On the right buttock foam dressing had been removed from with wound bed consisting of dry pink and red tissue, no drainage, no redness, warmth, or tenderness noted to the tissue surrounding the wound and non-adherent dressing applied. On right heel foam dressing had been removed ulcer observed with wound bed consisting of moist red and	{F 314}		

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{F 314}	Continued From page 164	{F 314}		

yellow tissue with scabbing, large amount of odorless drainage noted, no redness or warmth noted to the tissue surrounding the wound and non-adherent dressing was applied. The Progress Note did not also indicate if the areas neither were pressure related nor were the areas staged.

A Physician's Order dated 4/18/14, directed staff to "Apply non-adherent dressings to right ischial tuberosity wound and right heel until needed supplies are received."

The facility Initial/Temporary Care Plan dated 4/18/14, identified R123 had pressure areas marked and indicated with wound vac. However, the medical record lacked evidence of any other interventions being put into place to prevent and/or minimize potential further skin breakdown such as turning and repositioning, wound care, and pressure relieving mattress.

During document review it was revealed a Braden Scale-For Predicting Pressure Sore Risk dated 4/21/14, indicated R123 had a score of 11 which indicated R123 was at high risk and the Comprehensive Evaluation of Skin Risk Factors dated 4/21/14, identified the risk factors but lacked immediate interventions to minimize further potential skin breakdown.

R123's admission Minimum Data Set (MDS) dated 4/21/14, indicated R123 required limited to extensive assist of one to two with activities of daily living (ADL's) including bed mobility and transfers; had impairment on one side on the lower extremity with limited range of motion (ROM) and had one Stage 1 (a Stage I pressure ulcer is an observable pressure related alteration

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{F 314}	Continued From page 165 of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching) and two Stage 2 pressure ulcers (a Stage 2 is partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS noted R123 was not on a turning and repositioning schedule and did not have wound care treatments that were completed in the last seven days. When interviewed on 5/12/14, at 9:58 a.m. registered nurse (RN)-C MDS coordinator verified the temporary care plan had been developed but there without interventions to minimize further potential skin breakdown. RN-C further indicated "I believe there should have been more interventions listed than just the wound vac as resident had already pressure ulcers." On 5/13/14, director of nursing was unavailable for interview. The facility policy entitled Skin Integrity Management, dated 5/12, directed director of nursing services (DNS) or designee and the interdisciplinary team (IDT) were responsible to ensure the development and implementation of a comprehensive plan of care including prevention and wound treatments as indicated. The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin issues, maintain function and improve quality of life.	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 319} SS=D	Continued From page 166 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate treatment/services were offered for 1 of 1 newly admitted resident (R41) who had expressed difficulty with adjustment related to chemical dependency. Findings include: R41 was admitted to the facility on 2/4/14, according to the Admission Record from another long term care facility. The Admission Record indicated R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was	{F 319}		7/6/14

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{F 319}	Continued From page 167 dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist. A LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff. A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were	{F 319}		

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{F 319}	Continued From page 168 scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 had become intoxicated while off the facility property on a LOA. Upon his return to the facility, R41 had driven his electric w/c off the curb of the driveway to the facility. R41 had been found lying on the pavement on his right side and his speech was slurred, but R41 remained alert and oriented. The notes indicated, "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, documentation in the record indicated R41 had been readmitted to the facility from the hospital at 1:43 p.m. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. progress note documentation indicated facility staff had met with the resident to discuss the incident that occurred on 5/1/14, the facility had obtained an order for a supervised LOA. According to the progress note,	{F 319}		

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{F 319}	Continued From page 169 R41 had stated he was drinking because he was depressed. The only new intervention was that the facility placed a WanderGuard on R41's wheelchair (w/c). Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk as the facility staff continued to silence the alarm at the front desk and let him out of the facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention to help with adjustment at the facility had been offered, even though staff were aware the resident had depression and had acknowledged he continued to drink related to depression. No referrals had been made to meet the resident's needs such as referral to alcoholics anonymous (AA), or referral to any other counseling services to help or support R41. The medical record lacked evidence that interventions had been developed or initiated since R41's MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression, scoring a 7 out 15 on the depression scale. The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. 3. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required.	{F 319}		
{F 323}	483.25(h) FREE OF ACCIDENT	{F 323}		7/6/14

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{F 323} SS=H	Continued From page 170 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to neglect of supervision for residents was identified during the revisit survey on 5/9/14. The immediate jeopardy began on 5/1/14, and was removed on 5/21/14. However, noncompliance remained at the lower severity level of H, isolated actual harm that that is not immediate jeopardy (IJ). Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in an Immediate Jeopardy (IJ) for these four residents. A second IJ component was identified for 2 of 3 vulnerable residents at risk for elopement (R13, R116), due to the facility's failure to ensure adequate supervision and protection to prevent elopement from the facility. In addition to the resident(s) identified in the IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113) and failed to ensure 3 of 3 residents (R1, R36, R22) who smoked cigarettes did so in a safe manner as determined by their plans of care.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 171	{F 323}		

The IJ began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of the additional IJ concerns related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by exit of the 5/13/14 survey.

Findings include:

The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety.

Alleged substance abuse:
R37's progress notes indicated the resident had required hospitalizations 2/22/14, 4/23/14 and 5/10/14, related to ETOH/drug use. The Admission Record dated 1/14/14, indicated R37 had been admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and a history of alcoholism. Progress note documentation indicated R37 had been found with ETOH/vodka while in the facility on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14.

Observations of R37 revealed the following:
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. This surveyor was unable to see whether R1 took anything from the

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 172 wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket. - On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident's wheelchair down the West hallway and was observed outside R9's room. There was no staff with R37 when during the observation. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and the HUC asked him where his partner was. Nursing assistant (NA)-L approached at that time and told the HUC she was the 1:1 for R37 today. - On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. Additional review of R37's record revealed these Progress Notes: - On 11/26/13, the notes indicated chemical dependency (CD) treatment/Alcoholics Anonymous (AA) was discussed. R37 had stated he'd participated in AA services in the past and he'd had success including three years of sobriety before a recent relapse. The note indicated nursing had reported two episodes of ETOH intoxication while in the nursing home since the last visit and R37 had acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no ETOH use with nursing to monitor. The NP indicated there were "clear dependency concerns."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 173 - On 1/8/14, the notes indicated the resident had a history of ETOH abuse which had also occurred since living at the facility. - On 2/21/14, the notes indicated R37 had been drinking vodka and that an empty bottle had been found. The notes also indicated R37 had been observed to be distributing money to staff and residents. When R37 had noticed he had no money to buy vodka, he had gone to the automatic teller machine (ATM) machine to get money. The notes indicated staff were concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. a note had been documented which indicated R37 was handing out his money to "anyone who would listen" and staff had taken $116.00 dollars from him to lock up. - On 2/22/14, at 10:14 p.m. the notes indicated R37 had called 911 to send himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift had taken a bottle of vodka from him. The notes indicated R37 had asked the p.m. shift to return the vodka or pay him $25.00. - On 2/27/14, at 1:13 p.m. the notes indicated R37 wanted to leave on a leave of absence (LOA), was advised he could not go on an unsupervised LOA, but had left the facility. - On 2/27/14, at 10:07 p.m. indicated R37 was "drunk" and had a blood pressure of 147/105. - On 3/2/14, indicated R37 was "drunk" and was noted to have a blood pressure of 176/98 and a pulse of 99. - On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital. - On 4/13/14, the notes indicated R37"seemed intoxicated" and one full bottle of vodka and one quarter full bottle were removed from the room.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 174 - On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37's room. At 12:04 p.m. staff checked R37's room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink ETOH at the facility. R37 was offered a transfer to a facility that allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of ETOH. R37 stated he would like to get help to have ETOH removed from his body. Staff called 911 and police escorted R37 to detox. - On 4/24/14, at 9:30 a.m. the notes indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of ETOH. At 12:01 p.m. on that day, the notes indicated R37 approached staff and "again was clearly intoxicated." The notes indicated the contracted licensed social worker (CLSW)-A and a police officer had entered R37's room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assaultive in any way. A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 had been observed earlier walking into and out of R117's room and "seemed to be like an exchange of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for ETOH consumption. Further the note indicated, "A few hours later" R37 was shouting and appeared "intoxicated" and a 75% emptied bottle of vodka was found in R37's room.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 175 - On 4/25/14, at 9:58 a.m. notes indicated R37 was "clearly inebriated", had slurred speech and could barely wake up. R37 refused to provide the source where he continued to get ETOH. - On 4/25/14, at 3:24 p.m. notes indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and still smelled like he had ETOH on his breath. - On 5/2/14, notes indicated R37 had removed a wander guard and refused a new one to be placed. - On 5/3/14, notes indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. the notes indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of ETOH and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and had said he was going to Las Vegas. - On 5/5/14, at 4:56 p.m. the notes indicated R37 had slurred speech, smelled of ETOH and had a staggering gait. - On 5/5/14, at 10:25 p.m. the notes indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, a note, which indicated it was a late entry for 5/5/14 at 6:00 p.m., indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 had stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 176 he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. the progress notes indicated R37 had been placed on 1:1 observation related to incidences of getting intoxicated. - On 5/9/14, notes indicated R37 "was clearly intoxicated" and that an empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 177 hour span of time. - On 5/10/14, notes indicated R37 had been observed giving his credit card to R117 on 5/9/14. A second note indicated R37 had returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, the progress notes indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for Methadone. The Physician (MD) and Nurse Practitioner (NP) orders indicated they were aware of R37's alcohol use. Notes included: - On 1/8/14, included a diagnosis of ETOH abuse and a note the resident continued to have problems while living in the facility. - On 2/5/14, indicated R37 had recently been found with a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH. - On 2/28/14, an order directed staff to discharge R37 to another facility (that allowed drinking). - On 3/5/14, an order directed; "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, notes indicated R37 had been hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement. the notes indicated R37 had been treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 178 - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's use of alcohol, to encourage R37 not to use, and that even if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, an order directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, an order directed "no LOA-supervised or other". In addition, the NP included an order for a WanderGuard, and to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and ETOH counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric	{F 323}		

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{F 323}	Continued From page 179 assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs. - The Depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 180 - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had a history of significant ETOH use when out on unsupervised LOA. The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions. Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of ETOH intoxication and ETOH withdrawal noted 9/23/13, and substance abuse noted 2/23/14. A Care Conference Summary dated 4/1/14, indicated a discharge plan of "discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37 had a history of drinking and bringing ETOH in the building or going on unsupervised LOA and R37 had stayed in the building with no ETOH use since 3/3/14. A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait	{F 323}		

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{F 323}	Continued From page 181	{F 323}		

and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing ETOH and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding ETOH bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase ETOH and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 182	{F 323}		

detox. LPN- B stated she did not know where R37 got ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or ETOH and stated he has heard about exchanges but could not remember who he had heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for Delirium tremens (DTs-significant withdrawal symptoms). During interview on 5/12/14, at 8:59 a.m., registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 183 The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy (stated name) a friend of R1" went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware of who R1's friend was. The DON stated the 1:1 had refused to go to the bank with R37 and that the friend of R1 had signed R37 out. The DON stated the consultant administrator was going to go with R37 and R1's friend to the bank until it was decided the facility was not comfortable with her (the consultant administrator) going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA, but stated the administrator, consultant administrator and the social worker had decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from. When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH had been found in R37's room and 3 plastic containers with the labels removed which nursing indicated were methadone containers. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on a LOA, and stated R37 had returned with a card from Walgreens so they knew he hadn't followed his agreement to only go to the bank. The administrator stated the friend of R1 would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOA and that he had believed CLSW-A and had not checked the chart himself.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 184 The administrator stated he was also not aware of R1's relationship with the friend and that the DON had not told him about the order for no LOA or the relationship between R1 and the friend. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she had been informed by nursing (she could not remember who) that R37 could leave the facility with supervision. CLSW-A reported she'd made it clear to the person taking R37 out, R1's friend, that R37 could only go to the bank and nowhere else. She stated she'd told R1's friend that R37 would try and talk him into going to the liquor store but that R37 could not go there. CLSW-A said R1's friend had reassured her he had been sober for ten years and would never take R37 to a liquor store. CLSW-A stated it was not until after R37 had left, that nursing (did not remember who) told her R37 had orders for "no LOA" and that R1's friend was a drug dealer. CLSW-A said it would have been nice to have known that information before she'd allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she'd trusted nursing to know the correct information. She also stated she was aware R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing hadn't been finding the ETOH when they made the bed. When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs or aware that R1's friend was her drug dealer prior to having allowed R37 to leave with R1's friend on an LOA.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 185 R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times). R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed ETOH on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation (mechanical ventilator assisted breathing) for a blood ETOH level of .323. The admission MDS dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's CAA for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with ADLs. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering CD treatment. The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 186	{F 323}		

susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, identified to "monitor for ETOH use or oversedation."

The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 187 sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the DON on 5/5/14. An Emergency Department Chart [a form from the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or ETOH use. R129 was given two doses of Dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1. A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res goes to the Hospital for any	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 188 reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD." On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, ETOH and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 189 procedures in place." R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print. Nursing Progress Notes: - On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 mg [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 190 - On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money." - On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. - On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty. - On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 191	{F 323}		

stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP.

- On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
- On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her

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{F 323}	Continued From page 192 [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest." - On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms." - On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 193 drugs was identified, reported to the administrator immediately, reported to the SA or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring. - On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer]. On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 194 On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length from R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M. - At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern. - At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129. - At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway. - At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 195 cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. - At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised. - At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129. - At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 323}	Continued From page 196 beside (to the left) of R129. - At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. - At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor. - At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk. On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 323}	Continued From page 197 received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and ETOH treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 198 not make eye contact. On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times. On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of ETOH or drugs being exchanged on "my shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse. On 5/8/14, at 11:40 a.m. NA-S stated they had seen ETOH bottles in residents rooms and smelled ETOH on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January 2104 or February 2014. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 199 On 5/8/14, at 11:55 a.m. a housekeeper (H)-A was asked if they were aware of any residents drinking ETOH in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any ETOH bottles found in the facility "and has." H-A was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the ETOH bottles came from, H-A stated she was unclear, but thought they may have been provided by family. On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated ETOH from R37. LPN-H verified ETOH was provided to R37 and suspected to other residents of the facility, but was unclear how the ETOH was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility. On 5/8/14, at 12:10 p.m. the HUC stated she was aware of resident drug and ETOH use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 200	{F 323}		

social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming ETOH in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the ETOH was coming from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and ETOH use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts

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{F 323}	Continued From page 201 provided. The note indicated R129 was informed of the information. - On 5/11/14, at 10:09 a.m. a note written by the HUC indicated NMMC called the facility "requesting" R129's medication administration records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough ETOH to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the ETOH and/or if the assigned 1:1 was interviewed at the time. - On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two LPNs were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of ETOH. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving	{F 323}		

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{F 323}	Continued From page 202 R129 ETOH, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her ETOH. - On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine." - On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of ETOH was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m. On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed." - Was asked regarding R129 obtaining ETOH or drugs while on a 1:1, DON verified the	{F 323}		

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{F 323}	Continued From page 203	{F 323}		

information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and ETOH while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained ETOH, but verified R129 was harmed by the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for CD treatment and verified was last noted to be offered to R129 on 4/4/14. Both verified they should have revisited CD

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{F 323}	Continued From page 204	{F 323}		

treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for ETOH toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. CLSW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much ETOH in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R41:
The facility failed to provide supervision to prevent ingestion of alocholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m. , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on

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{F 323}	Continued From page 205 the smoking patio. All observations were unsupervised. R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily function problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detected depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist. An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff. A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 206 2/10/14, indicated independent with smoking and smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 9-1-1 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 207 status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c. Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as AA or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 208	{F 323}		

R117:
R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents.

R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression.

The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility.

R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.

The care plan revised 4/27/14, indicated R117 did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 209 exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called." The progress notes were reviewed and noted: - On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator." - On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility." - On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 210 to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware." - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours." - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident." - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 211	{F 323}		

about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding."
- On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning."
- On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was

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{F 323}	Continued From page 212 filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks." - On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen." - On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated. - On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 213 discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. " - On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 214	{F 323}		

the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.

- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.

- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 215	{F 323}		

verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).
- On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on."
- On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility."
- On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
- On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
- On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 216 medical appointments. Awaiting return call from clinic." - On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office." - On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital." - On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 217 - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and congestive heart failure (CHF) condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 218	{F 323}		

substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" Resident stated "yes." Police and emergecnt medical technician (EMT) then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 219 was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time." - On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified." - On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information." - On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 220 MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present." - On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road. - On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called." On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed. When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 221	{F 323}		

facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

ELOPEMENT:
On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 222 on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 223	{F 323}		

wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly The speed limit was 30 miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 224 abuse. LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised. A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection." The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs. A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 225 The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision. An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 226 received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident. On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then. The SA form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk." On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 227	{F 323}		

area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At not time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building.

On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and DM were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or SA would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if that occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 228	{F 323}		

report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a WanderGuard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 229 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14. On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance." A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor." Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 230 one to one rotation to prevent him from falling." A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 231	{F 323}		

a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 232 at 11:30 a.m. On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 233	{F 323}		

located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).
R9 was not supervised during smoking, was keeping smoking materials and was an alleged "Pot smoker."

On 5/6/14, at 7:40 a.m. R9 was observed smoking cigarettes out front on the designated smoking patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area, she retrieved cigarettes and a lighter from her right sock and placed them on the table next to a covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. During observation, NA-B went over to the smoking cart to get a smoking apron, applied the apron on R9, and sat directly across from R9.
-At 9:05 a.m. NA-B continued to watch R9 as she smoked.
-At 9:08 a.m. R9 was observed wheeling herself into the building. No burn holes noted on the front of her shirt or clothing.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 234 applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke. -At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area. At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked. -At 10:19 a.m. R9 returned back to the building. On 5/6/14, at 2:45 p.m. when interviewing R9 surveyor observed a cigarette box in each white sock on each inner leg. When R9 was asked why she was storing the cigarettes in the socks she stated "You can leave now, go now". Surveyor left the room as requested. When interviewed on 5/6/14, at 3:06 p.m., the DON stated he was not sure if R9 was supposed to be supervised during smoking, and indicated he had been given a list of smokers who required supervision just that day. Upon review of the list, the DON stated R9 was a supervised smoker which meant she should relinquish her cigarettes and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. Following the interview, the DON was observed to approach R9 at the smoking area and speak to her, and to return to tell the surveyor R9 had refused to give him the cigarettes she had in her socks. When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified after looking through the locked cigarette box on the cart R9 did not have cigarettes in box. NA-I stated he had been	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 235	{F 323}		

working at the facility for a month and R9 had never had cigarettes in the locked box.

When interviewed on 5/6/14, at 3:20 p.m. the administrator, DON and LPN-A (the resident care manager for R9) all stated if a resident was a supervised smoker they were supposed to relinquish all smoking materials but many refused. They said they couldn't force them to do it as the residents were part of the supervised program. LPN-A further stated "They have been told that they have to do this and we had a meeting with all smokers last week. They were given a copy of the smoking policy by social services and were supposed to sign it, but some refused. We have told them the rules and when they are or aren't allowed to keep them [their cigarettes], but they don't care. [R9] should be in there, but she won't give them to us."

When interviewed on 5/6/14, at 3:25 p.m. the DON stated, "We have a smoking policy updated and it does include that they should relinquish, are still supervised, the smoking monitor makes sure they are safe with their usage, that is why they are out there and we are still keeping them safe, we have tried to get her lighter and cigarettes on repeated effort but have not been able to do so."

When interviewed on 5/6/14, at 3:43 p.m. LPN-A stated "Problem is if I took her cigarette and lighter, she would just get the cigarettes from somewhere else probably gives someone money to go buy a pack of cigarettes. We tried this morning to take them from her and she stated "I'm not giving them to you because you will sell them to another resident". LPN-A stated the policy had been explained and R9 had asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 236	{F 323}		

what would happen if they did not abide and LPN-A had stated they were consequences. LPN-A further stated the NA who was monitoring the smoking had a book on the cart and documented when a resident refused or when they are not safe. When asked by surveyor if the smoking monitor had reported off to her LPN-A stated she was not sure maybe the social worker had been reported to.

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found on the roommate's side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family had been very upset about staff removing the roller from the room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not received the list of all the residents who had been thought to have substance abuse issues.

When R9 was interviewed on 5/13/14, at 8:36 a.m., and asked whether she smoked "pot', R9 stated "It's a lie that I am using any pot" and kept repeating same statement to the surveyor.

R9's MDS dated 3/24/14, identified R9's diagnoses included schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease. The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 237	{F 323}		

transfers, dressing, hygiene, and R9 was did not use any mobility devices yet R9 used a w/c during the course of the survey around and off the unit for mobility. The nutritional status Care Area Assessment dated 3/25/14,, had identified R9 had history of tobacco abuse.

The smoking care plan dated 10/20/11, identified R9 was a smoker. Goal "[R9] will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker.

Smoking Evaluation dated 10/7/13, indicated R9 was independent with smoking and smoking materials. After concern was brought to the facility attention on 5/6/14, another Smoking Safety Assessment was completed which indicated R9 was to remain as a supervised smoker, facility was to store tobacco products but may choose to wear apron or not.

Progress Note dated 4/30/14, indicated the director of facility operations and two social workers had been to R9's room and a bottle of "Shout", raw tobacco and other materials (for the tobacco to be rolled) had been removed from the room and placed in the Administrator's office for the family to pick up when they visited.

The undated and untitled list of Unsupervised and Supervised Smokers, revealed R9 was identified as a supervised smoker,did not need to wear a smoking apron, but was supposed to be within an arms distance from the smoking monitor.
R14 was observed to ingest an unknown substance, was sent to the hospital and tested

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 238 positive for THC (the active substance in marijuana) on 5/3/14, R14 was not evaluated for substance abuse, assessed for safety or provided supervision to prevent potential future access to illegal drugs. R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knew amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others 1-3 days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA were all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. CAAs did not identify any history of drug use. R14's Vulnerable Adult care plan dated as revised on 4/26/14, indicated R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility. A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a nursing assistant (NA) had reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14,	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 239	{F 323}		

noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician had been notified and R14 had been sent to the ER for evaluation.

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified the laboratory report had been obtained for R14 due to "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, investigation of the incident to determine potential source(s) R14 may have obtained the illegal drug from, notification of law enforcement, any follow up assessment of R14's safety, an evaluation of R14's access to leave the facility, such as to smoke; documentation of how to prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically related social services.

On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "eplileptic." R14 denied awareness of illegal drug and ETOH activity in the facility. When asked what R14 would do if she observed illegal drug or ETOH activity in the facility, R14 stated he would "tell the resident not to do it," but would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 240 notifiy staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, and verified there was no current system in place for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R62 was identified by the facility to have past/recent substance abuse. R62 had diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the quarterly MDS, dated 2/25/14, indicated R62 had moderate cognitive impairment. Review of facility progress note dated 1/24/14, at	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 241 17:03, indicated "a resident approached writer alerting us that another resident (res) is sitting outfront smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any". Review of facility progress note dated 1/24/14, at 17:17, indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor". Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address ETOH and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 242 progress notes. Review of a facility provided list of residents with questionable or known ETOH and drug use dated 5/8/14, at 8:02 a.m. identified R62 for drugs. During an interview on 5/13/14, at 10:18 a.m., the DM stated "I did what the 1/24/14 progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were unaware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14 identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month". SW-B stated she has been at the facility since 3/19/14. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 had verified she'd been smoking 'weed' but had told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume the administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 had ever been offered any chemical dependency assistance. R86 had been committed as mentally ill and chemically dependent on 10/31/12, which was amended on 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 243	{F 323}		

participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker.

According to the Admission Record dated 3/16/13, R86 had been admitted to the facility with diagnoses including: hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness.

A care conference dated 1/2/13[sic] (2014), lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.

A progress note dated 2/24/14, at 4:38 a.m. " Resident had been very confused and having difficulty to settled down in bed. judgement [sic] has been non intact and appearing restless with a lot of tremor. He did attested [sic] to this writer that when he goes LOA he smokes marijuana but never drink ETOH at all. He state "If I drink I will die. " His platelet has been dangerously lower thus posing him at a risk for bleeding. Update DR smiley about resident change in condition, which then mandate this writer to send resident to the emergency for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. "

A progress note dated 2/24/14, indicated at 11:00 p.m. "Pt was found smoking 'pot' in his room. His roommate was in the room at that time. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 244	{F 323}		

nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."

A progress note dated 3/4/14, at 6:11 a.m. noted, " While executing an initial nursing rounds this shift, this writer smell and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staff that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinued. He had flexeral [sic]with some benefit noted. He want [sic] another sleeping pills at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg of Trazodone [sic], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment. "

An annual MDS dated 3/22/14, had a BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares. A vulnerable adult assessment dated 3/18/14, noted past and recent chemical abuse. R86 had fluctuating cognitive deficits related to liver damage, chemical use and needed supervised LOA due to fluctuating cognition and chemical use.

A smoking assessment dated 3/18/14, indicated reports of smoking marijuana outside, and recent drug use reported by resident.

A LOA safety assessment dated 3/18/14 indicated mental illness, fluctuating cognition related to liver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 245 disease. R86 needed supervised LOA due to fluctuating cognition and chemical use (no mention of committed to the facility related to substance abuse and mental illness. On 4/13/14, a care conference indicated: long term placement waiting for liver transplant. " Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past. " The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. R86 was committed to prevent exposure to ETOH and chemical substances of abuse. The facility lacked coordination of care between departments, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided. R113 was a known alleged narcotic seller by the facility staff. On 5/12/14, at 12:36 a.m. R113 was observed ambulating across the nursing station with his walker as he conversed to both residents and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 246 staff as he ambulated to his room down the hallway. On 5/12/14, at 1:53 p.m. R113 was observed sitting on his bed back facing the door and was observed rolling cigarettes using a cigarette roller. R113 asked if it was okay to continue to roll the cigarettes as surveyor talked to him. -At 1:54 p.m. R113 stated he knew exactly who started the rumor about the narcotics. R113 indicated he is currently trying to resolve his marriage and his wife who would not allow him to come out to her house for visits if she found out he had ETOH and drugs issues. R113 stated he remembered the incident when the therapy staff had intervened when he had been approached by another resident for cigarettes and he remembered being talked to by the administrator and social worker about the policy. R113 further stated he also took his medications in front of the nurses as he knew this was going to be a concern/issue and also indicated he knew of ETOH being used at the facility by other residents but because he was a recovered alcoholic he kept his nose out of all trouble to get back with his wife. When interviewed on 5/12/14, at 1:57 p.m. RN-A stated he always watched R113 take all his medications and made sure he swallowed them then took the medication cup out of the room. When interviewed on 5/12/14, at 2:18 p.m. both CLSW-A and CLSW-B stated they were not aware of R113 using any illicit drugs at the facility. CLSW-A stated she remembered talking to R113 for less than ten seconds when he had asked if he would continue to roll the cigarettes and had told him not to until he was told otherwise.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 247 R113's significant MDS dated 2/14/14, indicated R113's diagnoses included acute ETOH hepatitis, ETOH withdrawal, ETOH dependence and insomnia. The ADL Functional/ Rehabilitation Potential CAA dated 2/14/14, indicated R113 had history of ETOH abuse. The mood/Behavior care plan dated 4/28/14, identified R113 had history of ETOH abuse, had history of depression and had recent amputation of toes due to frost bite. Resident List Report dated 5/8/2014, provided by the administrator indicated R113 was selling narcotics. Smoking Evaluation dated 3/17/14, indicated R113 had no history of unsafe smoking practices and was independent with smoking and smoking materials. Vulnerable Adult Assessment dated 3/17/14, indicated R113 had history of chemical abuse but no recent history. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. Progress Notes review revealed the following: -Progress note dated 4/24/14, indicated R113 was in therapy when another resident approached him and asked to buy rolled	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 248	{F 323}		

cigarettes from him. Therapist stopped transaction to check facility policy. R113 and therapist approached social services to ask about policy and were directed to the administrator but the administrator was unavailable and a note was left for administrator to please visit with R113 regarding policy. R113 was instructed not to sell any rolled cigarettes until cleared by administrator.
-Social Services Progress Note dated 5/2/14, indicated R113 had declined to attend the smokers meeting to be updated on the facility policy and procedure regarding smoking. The administrator and social worker had met with R113 and was given a copy of the facility policy and discussed the rules regarding smoking. R113 was also educated on rolling cigarettes for other residents and informed until further notice he could not be not allow to give, sell, trade, or buy cigarettes with other residents which R113 acknowledged.

R1 was not smoking at the designated area, was not wearing an apron, had known alleged drug involvement at the facility and was keeping her smoking materials.
On 5/5/14, at 1:50 p.m. during the initial tour R1 was observed to be assisted to light a cigarette while outside on the smoking patio. At 1:52 p.m. staff provided R1 with a smoking apron and attempted to apply but R1 was observed to shake head no. At 1:54 p.m. R1 still had no smoking apron applied but continue to smoke in the front designated smoking area and staff was within arms-length reach of R1.

On 5/7/14, at 7:34 a.m. R1 was observed with a lit cigarette right outside the front door with no smoking apron on. NA-E got into the front seat of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 249 the transport van and R1 was observed throwing her cigarette over her shoulder prior to getting into the van. On 5/7/14, at 8:47 a.m. R1 was asked to look at her clothing for burn holes, since she was observed smoking	{F 323}		
{F 329} SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 329}		7/6/14

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{F 329}	Continued From page 250 review, the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R91, R36, R37, R89, R1, R113, R29). Findings include: R91 had physician orders for PRN Tylenol, Ibuprofen and Oxycodone (pain medications) without identified parameters for when to use which medication. Review of the Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13 with a diagnosis of osteoporosis. The significant change in status Minimum Data Set (MDS) dated 4/1/14, indicated R91 had frequent pain rated at a six. Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain and lacked parameters for use. Review of the Medication Administration Record (MAR) dated 4/1/2014-4/30/2014, revealed R91 did not receive any PRN Tylenol and Ibuprofen and received multiple doses of PRN Oxycodone. R36 had physician orders for PRN Tylenol and Oxycodone without identified parameters for when to use which medication. The Admission Record dated 4/28/14, indicated	{F 329}		

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{F 329}	Continued From page 251 R36 was admitted to the facility on 5/26/12 with diagnoses of femur fracture and alcoholic cirrhosis of the liver. The quarterly MDS dated 2/18/14, indicated R36 had occasional pain rated at a four. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (tid) as needed and Oxycodone 10 mg tid both for pain and lacked parameters for use. Review of the MAR dated 4/1/2014-4/30/2014, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. When interviewed on 5/7/14, at 1:51 p.m. registered nurse (RN)-A reported he would usually do a pain assessment for PRN pain medications and for a pain level below three he would not give Oxycodone. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. On 5/9/14, at 8:46 a.m. licensed practical nurse (LPN)-B was interviewed and stated when there is multiple PRN pain medications ordered, she would assess pain level and start with the lowest pain medication unless the resident's pain was "really bad" or something else worked for the resident. Upon interview on 5/12/14, at 9:40 a.m. RN-B stated she would start with Tylenol first and see if it works, then would document if it was ineffective	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 252 and then try Oxycodone unless there was a specific physician order. The facility Pain Management policy revised May 2013, lacked direction regarding parameters for PRN pain medication. R37 had physician orders for Seroquel (an antipsychotic medication) without adequate indications for use, without side effect and symptom monitoring and lacked evidence of a gradual dose reduction (GDR) or documentation of a clinical contraindication. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/7/13, indicated R37 was receiving antidepressant and antipsychotic medications; however, lacked a comprehensive assessment summary regarding the medications in use. A Psychotropic Medications care plan revised on 3/16/14, included Seroquel was used for psychoses and directed to monitor for side effects and consult with pharmacy and physician to consider dosage reduction when clinically appropriate. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. Review of the Physician's Order Sheet dated	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 329}	Continued From page 253	{F 329}		

5/1/14, lacked a diagnosis for the medication. The Information and Consent for Psychotropic Medications dated 9/19/13 and 2/26/14, indicated the diagnosis to support use were "agitation/sleep."

A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur.

Physician and nurse practitioner notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist (CP) stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident.

Upon interview on 5/12/14, at 3:57 p.m. the nurse practitioner (NP) stated R37 received Seroquel for psychosis, verbal outbursts and generalized anxiety which were mainly problematic when R37 was drinking. The NP stated she believed a different medication was used when R37 was in the hospital prior to admit and was unsuccessful because of liver disease. The NP stated she had not reviewed R37's medications because he had been in the hospital frequently and she tries to do dose reductions quarterly.

When interviewed on 5/13/14, at 8:46 a.m. LPN-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 254 stated the indication for use for Seroquel was not listed and she would have to check with the physician. LPN-A stated she was not sure what target behaviors were being monitored for Seroquel. LPN-A stated orthostatic blood pressures were recorded in the electronic record. After review of the Weights and Vitals Summary, LPN-A verified there were no orthostatic blood pressures recorded for R37 since December 2013. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received. The facility Psychoactive Medication Management policy revised May 2013, directed the DNS [director of nursing services] or designee was responsible to ensure timely medical consultation when a psychoactive medication requires a medical review. R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic medication). In addition, R89 was not monitored for potential side effect of orthostatic hypotension (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position). R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions,	{F 329}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 255 and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 329}	Continued From page 256	{F 329}		

document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg.

The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis.

A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 257 Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg [milligrams] daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident."	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 329}	Continued From page 258 Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective." The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more." The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia. On 5/5/14, at approximately 1:40 p.m. R89 was observed to be laying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Observations of R89 on 5/7/14, at 8:28 a.m.; 5/8/14, at 8:30 a.m.; and 5/12/14, at 12:23 p.m. Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the LPN-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 259 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of antirollbacks and restraints. DON verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 260	{F 329}		

"Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the consultant pharmacist was called and a message left. The consultant pharmacist did not return the call.

R1 was not monitored for potential side effects related to use of Trazodone and Venlafaxine (an anti-depressants) and Zolpidem (a hypnotic).

Findings include:

R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day.

The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan

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{F 329}	Continued From page 261 dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 Milligrams (mg) by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. RN-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as	{F 329}		

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{F 329}	Continued From page 262 we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. The Psychoactive Medication Management policy dated as reviewed 5/2013, indicated the care plan	{F 329}		

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{F 329}	Continued From page 263 would identify side effects of the use of any psychoactive medications but lacked monitoring of side effects of anti-depressants and sleep study/logs for resident who were taking medication to aide sleep. R113 lacked parameters for as needed pain medication Oxycodone. R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. Physician's Order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. Pain Assessment dated 4/25/14, indicated R113 had pain daily and was predictable and the pain	{F 329}		

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{F 329}	Continued From page 264 did not prevent resident from doing or results in mood or behavior. The assessment indicated the pain was worse and/or breakthrough pain with therapy and dressing change. Summary indicated the pain was from the amputation sites to his both feet toes and was aggravated by therapy and wound care but was relieved by treating with PRN medications prior to treatment and resident reported current pain regime was effective. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider. When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." DON was not unavailable to interview on 5/13/14, regarding pain medication parameters. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided. R29 had physician orders for PRN morphine (pain medication) with no parameters for use, in addition no pain monitoring was completed.	{F 329}		

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{F 329}	Continued From page 265 Review of the Admission Record dated 4/28/14, indicated R29 was admitted on 1/15/14, with diagnoses that included chronic pain, diabetic polyneuropathy (nerve damage) and adult failure to thrive. The quarterly MDS dated 4/17/14, indicated R29 had frequent pain rated at a pain level of six. The CAA dated 1/28/14, indicated R29 "has chronic back pain, she gets Neurontin, OxyContin and oxycodone PRN, it has been effective at time". The CAA did not indicate diseases or conditions that may cause the pain, characteristics or frequency of the pain, but indicated it adversely affects mood. During observation on 5/12/14, at 9:10 a.m. R29 was observed to be very thin, awake in a darkened room, in bed and when surveyor asked to enter room, resident stated "no". During observation on 5/12/14, at 2:01 p.m. R29 was in darkened room, in bed sleeping. During observation on 5/13/14, at 850 a.m. R29 was observed lying in bed, dressed in a hospital gown in a darkened room. R29 stated "I am not doing well today, the pain is constant, the meds help for a while, then it starts again". R29 stated she does go to a pain clinic. Review of the physician's order sheet dated 5/9/14 included an order for morphine 30 mg four times daily as needed. Review of the MAR dated 4/1/14 to 5/31/14, revealed R29 received multiple doses of PRN morphine. Review of the pain evaluation and management plan dated 4/17/14, indicated R29 had occasional	{F 329}		

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{F 329}	Continued From page 266 pain in back and feet, current pain regimen was effective and nursing would continue to monitor and update MD/NP as needed. R29's care plan with revision date of 4/12/2014, identified R29 was on pain medication therapy due to foot surgery and chronic back pain. Interventions included: pain assessment per facility policy, administer medication as ordered and to frequently review for pain medication efficacy. During an interview on 5/12/14 at 3:29 a.m., LPN-E stated that for R29, "some days are good, some days are bad, she is on quite a bit of meds for pain" and that on 5/9/14 R29's primary physician increased some meds, "that may be why she is sleepy". LPN-E stated R29 was not on her caseload, but she would have put short term implementations of pain monitoring in place when there is a change in meds. LPN-E verified that it looks like every three to four hours the morphine is given and that the order should be more specific "like every 4 or 6 hours [hrs]". LPN-E verified there was no pain monitoring being completed, "it must have fallen thru the cracks when we went from paper to the computer". During an interview on 5/13/14, at 10:58 a.m. LPN-G stated he had not given any morphine yet today and would ask the resident if she has any pain. LPN-G further stated he would expect the order to be more specific such as "every 4 or 6 hrs" in addition to PRN, but would ask the nurse manager for more clarification. Review of Medication Administration General Guidelines, section 7.1, page 3 of the facility Nursing Care Center Pharmacy Policy &	{F 329}		

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{F 329}	Continued From page 267 Procedure Manual date 2007, indicated that medications are administered in accordance with written orders of the prescriber. If a dose seems excessive....or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. The DON was not available to interview on 5/13/14, regarding pain medication parameters and monitoring. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.	{F 329}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	{F 353}		7/6/14

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{F 353}	Continued From page 268 section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate staff to meet the individual needs for safety, supervision and care for 13 of 44 residents reviewed during the revisit (R22, R129, R1, R41, R37, R13, R86, R116, R36, R117, R9, R14, R62). In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect each of the 67 residents who resided at the facility. Findings include: The facility has started using agency staff, licensed nursing and nursing assistants (NA) from Soul Care LLC 1521 Como Ave Southeast Minneapolis, 55414. On 5/6/14, orientation was requested for any agency staff that has worked since the last survey. A review of the orientation files verified that the facility did not ensure staff had background checks, and had received the required tuberculin skin testing (TST). A review of the facility schedules dated from 4/5/14 through 5/17/14, indicated the facility staffing plan called for on the day shift: two licensed nurses with 13 nursing assistant (NA's); on the evening shift: two licensed nurses with 13 NA's and on the night shift: two licensed nurses with 6 NA's.	{F 353}		

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{F 353}	Continued From page 269 Open nursing and NA shifts in the two week block of time from 5/4/14 through 5/17/14, included nine nursing day shifts and 53 NA's open day shifts, 17 open evening shifts, and 30 open night shifts. Two additional staff was being used for 1:1's for R1 who was alleged by the facility to both ingest and provide illicit substances to residents within the facility and R129 after she had obtained and ingested cocaine within the facility and required hospitalization. An undated facility typed document titled 1:1 Observation Staff Responsibilities indicated: only one staff person performs the 1:1 observation with only one resident during the assigned time, and follows the resident wherever he/she goes and maintains a distance no further than arm's length at tall times. When the resident is in the room, staff will be either sitting outside or inside his/her room and make sure that they maintain residents visual at all times. Notify nurse/supervisor with any suspicious activity observed on resident. Will accompany resident if he desires to go out and smoke and make sure that appropriate clothing is worn, and oxygen is removed 5 minutes before going out to smoke. Nursing was to oversee the 1:1 observations and respond to concerns reported. One additional staff per shift was used as a smoke monitor. The Smoking Monitor Responsibilities (undated document) directed the monitor to ensure the smoking areas are monitored at all times, carry a list of smokers, and the smoking assessment results at all times. The monitors were to use the list to determine which residents require close supervision or other	{F 353}		

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{F 353}	Continued From page 270 interventions and ensure the interventions are in place. "Supervised smokers must be within direct line of sight at all times. Those requiring assistance with smoking materials must be within reach of the smoking monitor.... Direct all smokers to the designated smoking areas only... No smoking will be allowed in front of the building. Notify supervisor immediately if: a resident not on the list is smoking. A resident refused indicated interventions, such as wearing a smoking apron or staying within the designated smoking area." On 5/7/14, at 9:27 a.m. and again at 9:31 a.m. R22 (a resident identified by the facility as a supervised smoker required to wear a smoking apron) was observed by surveyors to drop a lit cigarette onto his shirt, both times the resident was able to pick it back up. When interviewed at 9:32 a.m. the smoke monitor NA-B stated she had not observed R22 dropping the cigarette at 9:27 a.m. or 9:31 a.m. and verified that she had been more than an arm ' s length away from the smoker. R22's clothing was checked and no burn holes were noted in his shirt, or in the blanket that had been covering his lap. NA-B stated that R22 was supposed to be a supervised smoker with a smoking apron, but the resident had refused to wear the smoking apron. NA-B verified she had given R22 a cigarette to smoke, even though she knew he was assessed to require a smoking apron. NA-B stated when R22 or any resident refused to wear the smoking apron, or follow the rules; they would record it in the smoke monitor notes. The smoke monitor notes were reviewed and revealed that notes started on 3/15/14, and were present for March 16th through 21st, 24th through 27th, 28th was blank, 29th and 30th, and the 31st was blank. On April 28th and 30th and	{F 353}		

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{F 353}	Continued From page 271 May 2nd-3rd, and 4th were left blank. On all of the days listed residents had refused to wear smoking aprons, and/or relinquish the smoking materials. The administrator stated he thought the other logs had been collected, but stated he had not reviewed them for compliance with the smoking policy. Residents within the facility were able to obtain, ingest and allegedly sell alcohol and drug substances within the facility while the smoking monitor, safety monitor and 1:1 staff were in place for R129 and R1. Immediate Jeopardy (IJ) was identified at F323 for lack of supervision to prevent alcohol and drug use that lead to hospitalization for (R41, R129, and R37) and elopement by R13, a resident with a WanderGuard (an alert system that lets the facility know a resident has left the building) who was let outside to smoke and went from there to the public sidewalk, the facility had to be notified by surveyors of the elopement) Refer to F323 on 5/9/14. After the IJ was identified on 5/9/14, two Residents (R129 and R37) who both had one to one (1:1) staff (defined by the facility administrator as being within arm's length of the resident to prevent incidents from occurring) were able to obtain and ingest alcohol and drug substances on 5/10/14. On 5/10/14 at 1:07 p.m. R37 was taken to North Memorial Medical Center for intoxication. R37 was animated and chatting with the medics as he was taken, and the health unit coordinator (HUC) stated that is how you know he is intoxicated, he was friendly and chatting, when not intoxicated he was usually very quiet. It was reported from the	{F 353}		

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{F 353}	Continued From page 272 hospital that the resident had alcohol and methadone (a drug he had not been prescribed) in his system. The administrator stated the 1:1 staff assigned to R37 should have been able to prevent him from obtaining and consuming alcohol and methadone. On 5/11/14, at 10:55 a.m. the administrator notified surveyors he had not been notified that R129 was sent to emergency room, at 4:00 a.m., after she had reported to a staff member that she was intoxicated. A blood alcohol level was determined to be .323 (more than three times the legal limit) and R129 was in the intensive care unit, intubated and assisted to breath by a mechanical ventilator. The administrator stated the 1:1 staff assigned to R129 should have been able to prevent her from obtaining and consuming alcohol. After investigation it was noted by contracted licensed social work (CLSW)-A that R1 accelerated away from her 1:1 staff at a high rate of speed in her electric w/c and was able to make an exchange with R117 (a former resident), R1 and R129 were noted to make an exchange later in R129's room, both had 1:1 staff who did not report the exchange, and failed to protect the residents on 1:1 observation. A special Staffing - One to One Assignment policy dated May 2012 and revised May 2013 included: one to one staffing assignments are in place based on an assessed need until appropriate permanent alternative arrangements can be made reasons may include, but are not limited to: treat of suicide by a resident, altered mentation that may dislodge treatment lines or devices, escalating exit seeking behavior, altered cognition in an agitated state that is not easily redirected., or not respected the boundaries of	{F 353}		

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{F 353}	Continued From page 273 other residents. The procedure stated "to keep the one to one within arm's reach at all times. (if not suicidal may have visual privacy for toileting). Alternatives to one to one assignment are investigated as timely as possible. (alternative care setting, medical evaluation), family or responsible party are notified to see if they are available to provide this heightened level of supervision. Documentation of the one to one assignment is made in the clinical record; appropriate care plan/review/revision is made during the one to one assignment. IDT [interdisciplinary team] will meet to determine the appropriateness of removing a one to one and under what circumstances it may be reinitiated." The one to one staff, and safety monitor were not effective in preventing residents from obtaining and consuming drugs and alcohol within the facility, the facility lacked an analysis of that staffing failure and lacked additional interventions to safe guard residents. Refer to F224: the facility failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, the facility failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents (R13). These facility failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. This had the potential to affect all 67 residents in the facility.	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 353}	Continued From page 274 F323: the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in Immediate Jeopardy (IJ) on 5/9/14, at 2:03 p.m. Also a second IJ was identified for 2 of 3 residents (R37, R129) on 5/12/14, at 2:51 p.m. In addition, the facility failed to ensure residents with WanderGuard were supervised when leaving the facility for 2 of 3 residents (R13, R116) observed to elope from the facility. R13 was observed on 5/6/14, to leave the facility with a WanderGuard attached. This resulted in IJ on 5/9/14, at 2:03 p.m. R116 was observed to leave the facility on 5/11/14, at 9:30 a.m. This resulted in IJ on 5/12/14, at 2:51 p.m. In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113). Also, the facility failed to ensure residents were smoking safely according to the plan of care for 3 of 3 residents (R1, R36, R22).	{F 353}		
{F 412} SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	{F 412}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 412}	Continued From page 275 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed without dentures during the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m. When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s) (edentulous); maintained oral care independently and R36 had reported he had dentures at home not at the facility.	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 412}	Continued From page 276	{F 412}		

Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him.

Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums.

The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..."

The Camden Care Center Quarterly Care Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet.

R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns.

The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or dentures and is able to chew adequately without his teeth and noted weight as stable.

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 277 Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested. When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care. When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms. When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him. When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..." On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a while ago and would like new ones if his old ones	{F 412}		

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{F 412}	Continued From page 278 could not be found. On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones. The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided. The facility plan of correction indicated by 4/28/14, social service and nursing would coordinate getting R36 fitted with dentures and these activities would be clearly documented in the clinical record to include any and all communication with the guardian. Review of R36's record on 5/7/14, at 1:50 p.m. lacked evidence of a dental visit. When interviewed on 5/7/14, at 2:10 p.m. the health unit coordinator (HUC) stated reported she had spoken to R36 and he stated his dentures were in a storage locker and he did not want new ones and stated the information was in the progress notes. The HUC was again interviewed on 5/8/14, at 8:17 a.m. and she stated she was unable to locate any documentation regarding her conversation with R36 regarding his dentures and she verified she had not offered R36 a routine dental exam. At 2:32 p.m. the HUC reported R36 had agreed to a dental visit and would be scheduled for one. When interviewed on 5/13/14, at 2:29 p.m. licensed practical nurse (LPN)-E stated the facility did not have a dental policy and the corporate consultant stated it was on a case by case basis. The facility Medical Services policy dated May	{F 412}		

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{F 412}	Continued From page 279 2012, indicated the social services director or designee was responsible to arrange dental services to meet the needs of the residents. R9 had a dental exam on 2/27/14, which indicated that more dental treatment was needed, however had not received dental follow up as recommended. The annual MDS dated 10/11/13, did not identify R9 had any dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene. Review of R9's care plan dated 4/10/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." The careplan indicated R9 had diagnoses that included schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC (limited liability company) Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and #12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful. Res was cooperative, though has difficult time holding her mouth still, and her tongue is very active."	{F 412}		

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{F 412}	Continued From page 280 During an interview on 5/6/14, at 2:45 p.m. R9 stated "I can chew. I saw a dentist here. I'm missing some teeth but he said they have to fall out before I can get dentures." During an interview on 5/7/14, at 3:28 p.m. LPN-A stated "I went through the progress notes and I don't see anything that addresses the dental exam." During an interview on 5/7/14, at 3:30 p.m. HUC stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this." Review of the facility Medical Services policy with revision date of May 2013, indicated the facility will ensure each resident has access to dental/vision/hearing/podiatric services to meet their individualized needs, resident needs are identified at the time of admission and additionally through the RAI [resident assessment indicator] process and daily assessment/monitoring of resident condition and change in condition also alerts staff to the need for medical services.	{F 412}		
{F 428} SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	{F 428}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 428}	Continued From page 281	{F 428}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the consultant pharmacist failed to identify lack of medication parameters for as needed (PRN) pain medications for 2 of 7 residents (R91, R36), failed to identify a lack of adequate indication for use, resident specific target behaviors and monitoring for antipsychotic medication for 2 of 7 residents (R37, R89) and failed to identify a lack of side effect monitoring and sleep monitoring for antidepressant medications for 1 of 7 residents (R1) reviewed for unnecessary medications.

Findings include:

R91's Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13, with a diagnosis of osteoporosis.

Review of the Medication Regimen Reviews (MRR) for R91 from 10/17/13 through 5/7/14, lacked evidence the missing parameters for PRN pain medications were identified.

Review of the Medication Administration Record (MAR) dated 4/1/14 through 4/30/14, revealed R91 did not receive any PRN Tylenol (a mild amalgesic) and Ibuprofen (an anti-inflammatory medication) and received multiple doses of PRN Oxycodone (a narcotic).

Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 428}	Continued From page 282 every six hours PRN all for pain. R91 had orders for multiple PRN pain medications which lacked parameters for use. R36's Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12, with diagnoses of femur fracture and alcoholic cirrhosis of the liver. Review of the MRR for R36 from 4/22/13 through 5/6/14, lacked evidence the missing parameters for PRN pain medications were identified. Review of the MAR dated 4/1/14 through 4/30/14, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (TID) as needed and Oxycodone 10 mg TID, both for pain, and lacked parameters for use. R36 had orders for multiple PRN pain medications which lacked parameters for use. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. Review of the MRR for R37 on 11/14/13, indicated R37 was taking Seroquel for psychosis, however lacked direction for target behavior monitoring. Review of the MRRs from 9/25/13-4/18/14, revealed the CP failed to identify the need for a gradual dose reduction or	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 428}	Continued From page 283 documentation of the clinical contraindication. Physician and Nurse Practitioner (NP) Notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. R37 received Seroquel (an antipsychotic medication) daily without adequate indication for use, monitoring or an attempt at a gradual dose reduction. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist (CP) stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. When interviewed on 5/7/14, at 3:09 p.m. the CP stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received.	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 284 The consultant pharmacist did not identify the lack of monitoring for resident specific target behaviors and the lack of orthostatic hypotension side effect monitoring for R89's use of Zyprexa (an antipsychotic medication). R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 285 dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily,	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 428}	Continued From page 286	{F 428}		

"Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.

A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 428}	Continued From page 287	{F 428}		

continues to receive Zyprexa 7.5 mg daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective."

The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more."

The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia.

On 5/5/14, at approximately 1:40 p.m. R89 was observed to be lying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door.

Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target

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{F 428}	Continued From page 288 behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document	{F 428}		

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{F 428}	Continued From page 289 target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. The consultant pharmacist did not identify monitoring of R1's side effects for Trazodone and Venlafaxine (Effexor-both anti-depressants) and sleep monitoring was lacking. R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that	{F 428}		

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{F 428}	Continued From page 290 you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the Monthly Medication Regimen (MMR) from 3/18/14 forward, revealed the consultant pharmacist had reviewed R1's medications, both were undated and unsigned. The MMR's failed to identify side effects monitoring, and sleep monitoring were lacking, as indicated in the plan of correction dated 4/28/14. Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank	{F 428}		

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{F 428}	Continued From page 291 Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. registered nurse (RN)-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on	{F 428}		

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{F 428}	Continued From page 292 implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. R113 CP failed to identify lack of parameters for as needed pain medication. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15mg) by mouth every four PRN, Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider.	{F 428}		

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{F 428}	Continued From page 293 When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. The PharMerica Medication Regimen Review completed by the CP monthly dated 4/18/14, and two other times after which were signed but undated did not identify R113's physician orders lacked the parameters. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. On 5/7/14, at 1:56 p.m. CP stated he would expect parameters written by the physician to clarify when to give which medication.	{F 428}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		7/6/14

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{F 431}	Continued From page 294 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5 medication and treatment carts had the internal	{F 431}		

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{F 431}	Continued From page 295 drawers kept clean; the facility failed to ensure medications were dated when opening; eye medications, suppositories, topical medications were observed to be stored together for 11 of 67 residents (R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88). In addition, the white refrigerator in the medication room (used to store refrigerated medications) was observed to have a heavy buildup of frost in the freezer compartment. These practices had the potential to affect all 67 residents residing in the facility. In addition, the facility failed to lock a medication cart which held biologicals and medications (anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication). This had the potential to affect 4 of 7 residents (R73, R37, R83, R115) who were near the medication cart. The four residents were able to access to the cart according to staff. Findings include: WEST MEDICATION CART On 5/7/14, at 7:52 a.m. first (top) drawer was observed to have the following: R13 had an open Advair Diskus inhaler (used for breathing) without an open date. R13's Minimum Data Set (MDS) dated 3/25/14, noted R134 had breathing problems and was cognitively intact. According to the package insert by GalxoKlineSmith dated 2008, staff were to "Take ADVAIR DISKUS out of the box and foil pouch. Write the 'Pouch opened' and 'Use by' dates on the label on top of the DISKUS. The 'Use by' date is 1 month from date of opening the pouch."	{F 431}		

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{F 431}	Continued From page 296 R92 had an opened and expired bottle of Travatan Z 0.004% (reduce the elevated pressure inside your eye) eye drops for R92. The label indicated to "Order After 3/27/14." A sticker affixed to the bottle indicated the medication was opened on 3/3/14. The bottle was observed to be stored loosely with oral medications. A second bottle of the same eye drop with date opened of 4/19 (no year) written on the label, had no open date documented on the Date Opened sticker. A third bottle of the same eye drop was also observed to be stored loosely (no zip lock bag) in and with oral medications for various other residents and had no open date. All three Travatan Z bottles for R92 were opened and had remaining doses in each bottle. R92's MDS dated 1/15/14, indicated R92 had adequate vision and no vision problems. According to the package insert by Alcon Laboratories (SA) (Pty) Ltd, Revised 11/02, directed staff, "STORAGE INSTRUCTIONS: Store below 25°C., DO NOT USE MORE THAN 30 DAYS AFTER OPENING. KEEP OUT OF REACH OF CHILDREN." R9's Insulin Aspart pen (Novolog- used to control blood sugar) had no open date and had a sticker on the pen which indicated "EXP [expires]: 04/11/14." A second pen of the same medication for R9 lacked the protective cover for the end of the pen (where the needle affixes) and lacked an open date. Both pens were stored in and with eye drops for other residents. R9's MDS dated 3/24/14, indicated R9 was cognitively intact and had diabetes. According to the package insert by Novo Nordisk	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 431}	Continued From page 297 INC, dated 2002 through 2008, staff were to store as follows: " Recommended Storage: Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated. Unpunctured vials can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused vials in the carton so they will stay clean and protected from light. R54 had a bottle latanoprost 0.005% (used to reduce the intraocular pressure) eye drops was observed to be stored loosely with other oral medications. R54's MDS dated 1/15/14, indicated R54 had adequate vision and no vision problems. - A 3 milliliter (ml) vial of 2.5 mg albuterol was observed to be stored loosely in the top drawer. The vial had no label to identify which resident the Albuterol was ordered for. - The first drawer was observed to have a light brown and crumb like consistency buildup of debris in the upper right corner of the drawer. A heavy buildup of sand colored debris was observed in the upper left corner of the first draw. The debris was observed to be with and under the stored inhalers. - The second drawer had a heavy buildup of brownish colored debris in the corners and bottom of the drawer. The debris appeared to be from pulverized/crushed medication tablets. On 5/7/14, at 8:15 a.m. the licensed practical nurse (LPN)-C verified the findings. SOUTH TREATMENT CART	{F 431}		

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{F 431}	Continued From page 298 On 5/7/14, at 8:39 a.m. the registered nurse (RN)-B verified he worked out of the cart and opened the cart. The following was observed: R29's Levemir insulin flexpen (used to control blood sugar) had no open date on the sticker. R29 's MDS dated 1/29/14, indicated R29 was cognitively intact and was a diabetic. According to the package insert by Novo Nordisk INC, dated 2005 through 20012, staff were to store as follows: "Recommended Storage: 3 mL LEVEMIR FlexPen: Not in-use (unopened) Room Temperature (below 30°C) for 42 days. In-use (opened) was to be stored for 42 days at room temperature." R25's Lantus insulin had an open date of 4/4 (no year) and expiration date of 5/3 (no year). The insulin was open, partially used and expired. R25's MDS dated 4/8/14, indicated R25 was a diabetic and was moderately cognitively impaired. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " R66's Lantus Solostar insulin had no open date.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 431}	Continued From page 299 R66's MDS dated 3/25/14, indicated R66 was cognitively intact. The MDS did not indicate R66 was a diabetic. However, the MDS did indicate R66 received insulin injections in the past seven days. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " RN-B verified the findings at the time of the observation and stated the medications should have open dates. RN-B verified the expired medication was used "today." The second drawer of the south treatment cart was observed to have a buildup of potential pulverized medication debris in the corners of the drawer. The third drawer was observed to contain a plastic bin containing various tubes of topical medications for different residents. Some tubes were observed to be stored in zip lock bags with labels. All topical medication tubes in the bin had been used. Topical medications in the bin not in zip lock bags were observed to be in contact with each other. The topical medications not stored separately included a tube of unlabeled Dimethicone Skin no label (barrier ointment). R22's tube of Capsaicin 0.25% Cream (used to	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 300 control pain from arthritis) directed staff to apply the medication to the left hip and right rib. R22's MDS dated 1/9/14, indicated no musculoskeletal problems, no indications of pain, and also revealed R22 was moderately cognitively impaired. R95's Hydrocortisone 1% Cream (used to treat skin inflammation and itching) identified to apply the medication to R95's stomach and back; R95's MDS dated 2/28/14, indicated no rashes were present and revealed R95 was cognitively intact. - An unlabeled tube of Aquaphor healing ointment (barrier ointment) was approximately 90% used. R86 had a tube of Fluocinononide 0.05% solution (used to treat the itching, redness, dryness, crusting, scaling scalp) which directed to apply the medication to scalp; R86's tube of Desonide 0.05% (used to treat the redness, swelling, itching, and discomfort of various skin conditions) directed to apply the medication to axilla, groin and abdomen folds; a bottle of Deep Sea Premium Nasal Moisturizing Spray (moisturizes the nasal passages). The bottle of nasal spray was observed to be in contact with other topical medications in the bin. RN-B stated the spray, "Should be in other cart." R86's MDS dated 3/23/14, indicated no skin problems and was cognitively intact. R86's Treatment Administration Record (TARs) dated May 2014 indciated the R86 received topical cream to the face, skin folds, groin, and axilla once or twice a day for psoriasis bulgaris.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 301 R29's Nystatin - Triamcinolone Cream (used for yeast infections) directed to apply the medication to R29's labia. R29's MDS dated 1/29/14, indicated R29 was cognitively intact, received creams and ointment to other areas other than feet, and noted R29 was a diabetic. R29's Physician's Order sheet undated indicated Nystatin was to be applied to the labia three times daily for itching. - The drawer was observed to have a heavy buildup of crumbs, pulverized pill fragments and paper, foil and plastic pieces debris in all drawers. The corners and sides of the drawers had the highest build up. RN-B verified the findings at the time of the observation and confirmed the topical medications should be stored separate from nasal medications. RN-B verified the tubes of topical medications for different residents, should not be stored together. SOUTH MEDICATION CART At 9:06 a.m. the South Medication Cart second drawer was observed to have one white and one yellow medication tablet loose in the bottom of left section of the drawer, and one yellow tablet, one white tablet, one pink tablet and one beige tablet loose on the bottom of the right section of the drawer. A buildup of foil debris was observed in all corners. - The third drawer had one bright yellow tablet and a buildup of pulverized pills and foil debris in all corners. - Fourth drawer was observed to have a opened and partially used box of Bisac-Evac 10 mg Bisacodyl suppositories used for constipation) stored with nebulizer medications (breathing	{F 431}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 302 medications). - The first small left side drawer was observed to have one unlabeled vial of Albuterol neb solution (breathing medication) stored loosely in the drawer. - The third left side drawer was observed to have a sticky red colored substance spilled on the bottom of the drawer. The substance appeared to be smeared on the bottom of the drawer, was wet to the touch and easily removed with a finger. RN-B verified the above findings and was unclear on when the medication carts were cleaned. MEDICATION ROOM At 9:21 a.m. the white medication refrigerator was observed to have a heavy buildup of frost approximately two to three inches thick which completely encased an ice pack in the frost of the freezer. NORTH MEDICATION CART At 9:24 a.m. the following was observed: R88's Novolog insulin (used to control blood sugar) was observed to have an open dated of 3/22 (no year) and an expiration date of 4/20 (no year). R88's MDS dated 2/7/14, indicated the resident had expired. - The second drawer was observed to have a white half tablet, a red gel cap loose in the bottom of the drawer; foil, paper and pulverized medication debris was observed to have built up in edges and corners of the drawer. - The third drawer was observed to have built up foil, paper and pulverized medication debris in the corners, a red, sticky, circular shaped spill on the bottom of the drawer. LPN-F verified the findings at the time of the	{F 431}		

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{F 431}	Continued From page 303 observation. LPN-F was unclear on medication cart cleaning and stated she, does "not have time to get her medication pass done" due to it being "too heavy." LPN-F explained she had too many other responsibilities such as taking blood sugars, administering insulin verified she did not clean the medication cart. Although LPN-F stated she worked for the agency, LPN-F stated she usually worked on the North Medication cart and had worked in the facility for several weeks. EAST MEDICATION CART At 9:39 a.m. the second drawer was observed to have two white half tablets loose in the bottom of the drawer. On 5/7/14, at 11:45 a.m. LPN-E verified she was in charge of the North Unit and stated the medication carts were "a mess" and stated she believed all the carts were newer and cleaned by "the pharmacy" last week. LPN-E was unclear on the cleaning schedule of the medication carts. LPN-E stated before there was trained medication aide (TMA) responsible for the cart and a nurse responsible for the treatment cart. Explained there were "fifteen different hands" in each cart and they were not being kept clean. -At 12:00 p.m. LPN-E observed the medication carts with surveyor and verified the findings. LPN-E stated it was a new medication cart. LPN-C was present at the time of the observation and stated the medication cart was "not new." LPN-E verified eye drops, Advair Diskus inhalers, and insulin required open dates. On 5/7/14, at 1:26 p.m. LPN-A verified she was in charge of the West and East units. LPN-A stated she had not completed any cleaning audits for the medication carts and did not know if audits were	{F 431}		

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{F 431}	Continued From page 304	{F 431}		

completed. LPN-A stated she did not know the audit or cleaning schedules for the carts. LPN-A was unclear what the facility system was to ensure the medication carts were kept clean. LPN-A further stated she was unclear who was responsible for cleaning the medication carts and was unclear on the policy for medication cart cleaning.

On 5/8/14, at 4:21 p.m. the consulting administrator stated the facility did not have a policy or a procedure for medication cart cleaning and verified the carts should have been cleaned. The consulting administrator stated the facility was "not allowed to write policies," but could write a "procedure."

A PharMerica 3.7 Medications and Medication Labels policy dated 9/2010, directed multi-dose vials "shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)" The policy further identified all medications should have a pharmacy affixed label.

The PharMerica 4.1 Storage of Medication policy dated 9/2010, directed to store eye, internally administered, oral inhalation, nasal, oral and topical medications separately.

Medications carts were left unlock and un-supervised.
South Hallway Medication cart
On 5/5/14, at 1:39 p.m. observed the key lock to the nursing medication cart to be fully extended in the unlocked position on the South unit. Two residents were observed to wheel by the cart and no staff was in the hallway. RN-B, was observed

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 431}	Continued From page 305 to follow the surveyor from the nursing station onto the South unit and approach the medication cart and open the top drawer. East Hallway Medication Cart On 5/8/14, at 3:50 p.m. surveyor observed the unlocked medication cart across the nursing station in the East Hall Way. -At 3:53 p.m. observed the administrator walk past the unlocked cart. -At 3:55 p.m. observed the director of nursing walk past the cart then walk right past the cart back to the nursing station. -At 3:54 p.m. nursing assistant (NA)-F came stood approximately 6 feet beside the surveyor on the counter typing then walked away. -At 3:56 p.m. observed resident with a cane walk past the cart to his room. -At 3:57 p.m. observed NA-G standing on the opposite side of the hallway approximately 2 foot steps from the cart still unlocked. -At 3:58 p.m. director of nursing (DON) walked past the cart again and went down the hallway. -At 3:59 p.m. observed receptionist (O)-D walked past the medication cart approximately 1 step from the cart still unlocked. -At 4:00 p.m. DON walked past the medication cart still unlocked back to the nursing station. Went into the nursing station stood at the inside of the counter looking down the hallway where the unlocked cart was stationed. -At 4:01 p.m. observed NA-I walked past the medication cart to the South hallway. -At 4:02 p.m. O-D again went past the unlocked cart approximately one foot step went to the human resource office and came right out and returned to the front desk. -At 4:04 p.m. observed NA-I walked past the cart again and turned right and walked past the cart to	{F 431}		

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{F 431}	Continued From page 306 the South Hallway. When interviewed on 5/8/14, at 4:06 p.m. LPN-D if the medication cart was supposed to left open stated, "No." LPN-D walked over to unlocked medication cart and locked it. When interviewed on 5/9/14, at 10:05 a.m. LPN-E stated, "All the medication carts are not supposed to left open." When interviewed on 5/9/14, at 1:32 p.m. RN-B stated the medication cart should be locked when staff was not around and when nurses walked away from the carts. RN-B further stated the nurse that had left the cart unlocked had acknowledged she had left the cart unlocked on 5/8/14. The facility Storage of Medication dated 9/10, directed "In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.	{F 431}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	{F 465}		7/6/14

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{F 465}	Continued From page 307 by: Based on observation, interview and document review, the facility failed to ensure resident room carpets for 3 of 3 residents (R22, R56, R33) and an E-Z stand (a mechanical stand used for transfers) were kept in good repair, clean and in a sanitary manner. Findings include: A tour of the facility was conducted on 5/9/14, at 8:59 a.m. through 10:05 a.m. with the director of facility operations (DFO) and the following concerns were identified: Carpets: On 5/9/14, R22's portion of the room was observed. The carpet had large dark brown stain/spots from the bed to the dresser. DFO verified the carpet was not clean and stated, "I think it is filthy and trashed." R22's annual Minimum Data Set (MDS) dated 4/10/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs. R22 used both the walker and wheelchair (w/c) for mobility in his room. On 5/7/14, at 7:59 a.m. R22's carpet was observed to have dark brown spots/stain on the carpet around the bed area and to the entrance of the room. On 5/9/14, at 9:34 a.m. DFO verified R22's carpet was not clean stated "Again this is one of the rooms that I would like to have a deep cleaning and was hoping the cleaning of the carpet would have been done after pest control was here yesterday."	{F 465}		

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{F 465}	Continued From page 308	{F 465}		

R56 was bedfast in the room. When R56's room was observed on 5/9/14, at 8:59 a.m. the carpet had several dark, black ground-in spots and stained red around the bed.

R56's annual MDS dated 2/25/14, indicated R56 required extensive to total assistance with activities of daily living (ADLs) including transfers, was bed bound, used a w/c for mobility and had intact cognition.

On 5/9/14, at 9:30 a.m. DFO verified the carpet in R56's room was not clean and stated, "It needs to be deep cleaned."

R33
On 5/6/14, at 9:00 a.m. surveyor noticed a strong malodorous urine smell coming out of R33's room and the carpet observed to have dark brown large stain/spots from the bed to the radiator and on the area between the foot of bed and dresser (walk area). During observation a housekeeping staff was observed standing outside R33's room but was cleaning the next room.

On 5/9/14, at 9:38 a.m. DFO verified the smell stated, "It's very strong and this is another room that needs to have the carpet cleaned or replaced." DFO stated, "We were supposed to get the air freshener's from Ameri-Pride today but they were supposed to be delivered on Friday." DFO further stated the carpet cleaning company had been to the facility recently and cleaned the common areas. The DFO knew the contract was expired and directed questions to the administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 465}	Continued From page 309 R33's quarterly MDS 2/20/14, indicated intact cognition, required limited assistance with ADLs, had impairment to both lower extremities and used a walker and w/c for mobility. R33's also received a diuretic. Mechanical lift: E-Z stand handle did not have a cleanable surface. On 5/9/14, at 9:05 a.m. the E-Z stand was observed stored on the alcove on the West Hall and the left bar was observed to have vinyl peeling off exposing the foam underneath. The cracked vinyl was covered with gray duct tape and at the end the tape was exposing the sticky side of the tape making it not a cleanable surface. When interviewed on 5/9/14, at 9:07 a.m. DFO verified stated, "I was told by the vice president to put the duct tape over for now and I have a bid for cushions and guard and am waiting." When interviewed on 5/9/14, at 8:38 a.m. the administrator stated there is a carpet cleaning plan with a contractor who would be coming in to clean a couple rooms at a time. Administrator further stated, "We are going to order replacement parts for the E-Z stand, we had been told that the duct tape was sufficient." Review of the w/c cleaning schedule for Maintenance dated May 2014 indicated R36's w/c had not been cleaned. The Wheelchairs To Pull For Night Washing sheets dated 5/1/14, through 5/9/14, also indicated R36's w/c had not been cleaned.	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 465}	Continued From page 310 The facility Maintenance Request Log Policy and Procedure revised April/2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs ..." The policy lacked information on how often residents carpets would be cleaned.	{F 465}		
{F 469} SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a pest control program effective in the control of ants in 1 of 1 resident room (R56). Findings include: During observation on 5/7/14, at 7:42 a.m. 12 winged insects were noted on R56's bed and on the wall at the head of the bed. During observation on 5/7/14, at 7:59 a.m. R56's room was noted to have open food items, The carpeting next to the bed was heavily soiled with brown and red material, and a foul odor was noted in the room. On 5/7/14, at 8:41 a.m. an ant mound and three ants were noted in the corner of R56's room by the window. Multiple ants were noted crawling on	{F 469}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 469}	Continued From page 311 and inside the heater under the window. When interviewed on 5/7/14, at 7:50 a.m. the director of facility operations stated the facility used Xtreme Pest Solutions for pest control. He stated staff identify any concerns with pests by documenting in the maintenance log kept behind the nursing station. When interviewed on 5/7/14, at 8:05 a.m. housekeeper-B verified there were bugs in R56's room and stated he had not seen them the prior Thursday when he'd cleaned the room. Housekeeper-B stated R56, "Has lots of sweets in her room and that may be why." On 5/7/14, at 8:09 a.m. the director of facility operations was asked to come to R56's room and stated, "We have to get her out of the room right away!" and call the pest company. He stated he was not sure what the bugs were but thought they were ants or wasps. The pest control contractor was interviewed on 5/7/14, at 12:52 p.m. and stated the bugs were a form of pavement ants and he had treated the room and the surrounding areas. He reported the ants were drawn into the room for food and the facility would need to maintain treatment to the affected areas. Review of the Service Report dated 2/13/14, included treatment for mice and rats. Review of the Service Report dated 4/3/14, included treatment for multiple targeted pests including ants. The Service Report dated 5/7/14, at 12:30 p.m. included treatment for multiple targeted	{F 469}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 469}	Continued From page 312 pests including ants and indicated four rooms on the south hall were treated as well as the exterior of the south wing. A policy regarding pest control was requested and the director of facility operations stated the facility did not have a policy.	{F 469}		
{F 490} SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to administrative failures was identified during the revisit survey on 5/12/14. The immediate jeopardy began on 5/10/14 and was removed on 5/21/14. However, non-compliance remained at the lower severity level of F (wide spread with no actual harm). Based on observation, interview and document review, the administrator failed to provide adequate supervision and oversight for residents who had known drug and alcohol (ETOH) use for 2 of 11 residents (R37, R129). In addition, the administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues being identified at F490. In addition to the IJ issues, the facility was not administered in a manner to maintain compliance	{F 490}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 490}	Continued From page 313 with other regulations specific to meet the needs of residents for 15 of 40 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; 3 of 5 employees (E1, E2, E3) reviewed whose annual evaluations were not completed; 1 of 5 nursing assistants (NA-Z) did not meet the required inservice hours; 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) did not have current license verification. These administrative failures had the potential to affect all residents of the facility. The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety. The IJ began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by exit of the 5/13/14 survey. Findings include: On 5/9/14, the facility had been informed of serious and immediate safety and supervision issues related to a lack of adequate supervision for residents, specifically related to resident's with known drug and alcohol use issues, and elopements. The facility had been informed these issues constituted an immediate jeopardy situation. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect	{F 490}		

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{F 490}	Continued From page 314	{F 490}		

residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and/or alcohol intoxication. In addition, on 5/11/14, a vulnerable resident was able to elope from the facility on three separate occasions without staff present even though the facility had implemented a WanderGuard device.

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an IJ situation for R37, R129 and R116.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to

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{F 490}	Continued From page 315 screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, develop and implement interventions for medically-related social services, for residents known to provide and/or use illegal drugs and ETOH in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to ETOH abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, and supervise staff. An IJ was identified on 5/9/14, for lack of supervision related to drug and ETOH use for R37, R129, R41, R117, and for the lack of supervision for residents who were at risk for elopements, R13. On 5/9/14 the administrator, On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).	{F 490}		

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{F 490}	Continued From page 316 Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential	{F 490}		

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{F 490}	Continued From page 317 to affect all 67 residents in the facility. A letter was provided to surveyors on 5/19/14 by an employee who wished to remain anonymous. The letter indicated that as of that date, the President and CEO of Videll Healthcare was informing employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had also been posted at the employee time clock. The IJ that began on 5/10/14, was removed on 5/21/14, when the facility had implemented an IJ removal plan which included the development and/or revision of policies related to obtaining a drug and alcohol free facility and policies related to prevention of elopements. The facility initiated assessments for reisdents who had been identified at risk for drug/alcohol issues and elopements; The facility also developed a system for investigation of ongoing incidents; Staff were educated to their responsibilities for how to supervise, care for and protect residents; Direct care staff and licensed nursing staff were interviewed and were able to explain their responsibilities for identification of residents who were elopement risk. Administration convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate	{F 490}		

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{F 490}	Continued From page 318 concerns. However, non-compliance remained at the lower scope and severity (s/s) of an F (no actual harm with potential for more than minimal harm that is not immediate jeopardy) because of the number of deficient practices that remained uncorrected at the time of the revisit 5/21/14.	{F 490}		
{F 492} SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance to ensure freedome from tuberculosis (TB) before they were assigned to work. This had the potential to affect all 67 residents residing in the facility. Findings include: The facility did not comply with the Minnesota Statute 144A.72 REGISTRATION REQUIREMENTS; PENALTIES. Subdivision 1.Minimum criteria. The commissioner shall require that, as a condition of registration: (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel	{F 492}		7/6/14

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{F 492}	Continued From page 319 employed in health care facilities. A review of the supplemental staff files revealed the following: NA-T had a negative tuberculin skin test (TST) administered on 8/26/11. There was no record to show a second TST was done. Licensed practical nurse (LPN)-C had a chest x-ray result dated 10/17/07. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-F's TB screening test result dated 4/10/14, read "Negative. M. tuberculosis infection not likely, but cannot be excluded in cases of immunosupression." There was no screening for symptoms of active TB and there was no examination done by a medical doctor after the TB screening test. LPN-I had a first TST administered on 3/29/11. There was no evidence of a second TST having been done. LPN-J had a negative CXR results done on 12/7/09. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-K CXR results done on 1/19/09, was read as "Unremarkable exam." There was no screening for symptoms of active tuberculosis and there was no examination done by a medical doctor. On 5/13/14, at 9:33 a.m. during a telephone interview, O-I from Soul Care staffing agency	{F 492}		

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{F 492}	Continued From page 320 verified the above-named supplemental staff are employed by Soul Care and that the same staff had been reporting for work at the facility. He further verified all of the findings pertaining to TB screening dates and procedures for the employees named. On 5/13/24, 10:27 a.m. LPN-A, nurse manager, stated the staffing agency would provide to the facility the TB screening records of staff coming to work. LPN-A stated that it was human resources (HR's) responsibility to keep track of the records and to keep the files for the facility. On 5/13/14, at 10:55 a.m., the consultant administrator verified the list of supplemental staff provided to surveyors was current, and the staff had been working at the facility. The consultant administrator stated that supplemental staff was not treated any differently from regular facility staff with regard to TB screening. She stated Soul Care provided the TB screening records of supplemental staff, and if staff were found positive for the TST results, they should have been required to undergo assessments for current TB symptoms, should have had CXR and physician's visit indicating employees were clear from tuberculosis. The consultant administrator stated HR was responsible to keep track of pool staff records and to report to the director of nursing and the administrator if issues were identified. The Clinical and Operations Manual dated 5/2012, directed the facility to administer a 2-step PPD (purified protein derivative used to do a TST) to all employees and that documented copies were to be kept in the employees' file records.	{F 492}		

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{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility for 15 of 44 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; facility failed to ensure 3 of 5 employees (E1, E2, E3) reviewed during the initial survey for annual evaluations were completed; In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed; the facility failed to ensure 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) had current license verification. In addition, the facility's governing body failed ensure vendors were paid in a timely manner. This had the potential to affect all 67 residents in the facility. Findings Include:	{F 493}		7/6/14

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 493}	Continued From page 322 Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse. Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant	{F 493}		

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{F 493}	Continued From page 323 (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).	{F 493}		

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{F 493}	Continued From page 324 Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13. Refer to F412: the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Refer to F490: the administrator failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked	{F 493}		

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{F 493}	Continued From page 325 in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F500: the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because they had not paid the bill to the agency. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 493}	Continued From page 326 Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice on Monday, May 5th, Tuesday, May 6th, and Wednesday, May 7th. The facility had social workers scheduled, but due to not paying their bill, the social workers were not provided." For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from	{F 493}		

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{F 493}	Continued From page 327 individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 493}		
{F 497} SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing	{F 497}		7/6/14

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{F 497}	Continued From page 328 education for 1 of 5 NAs (NA-Z) reviewed. This had the ability to impact all 67 residents in the facility as the facility was a one story facility and the staff could work on all of the units. Findings include: Evaluations: On 5/12/14, at 10:00 a.m. employee performance evaluations for E1, E2 and E3 were requested of the administrator. He said he would get them; however, no evaluations were provided. On 5/13/14, at 12:41 p.m. performance evaluations for E1 through E3, from previous March 2014 survey and evaluations for all employees due for annual performance review in March 2014 and April 2014 was requested of the administrator. He said he would get the information. On 5/13/14, at 3:30 p.m. unable to interview the director of nursing (DON) as the DON had resigned. On 5/13/14, at 3:35 p.m. although the evaluations had been requested, no employee performance evaluations had been provided by facility as of that time. At the time of exit on 5/13/14, at 4:30 p.m. the evaluations still had not been provided. In-service: NA-Z was hired on 4/10/11. The employee file was reviewed for continuing education and noted NA-Z had only 3.5 hours of the 12.0 required hours from 1/1/13 through 5/12/14.	{F 497}		
{F 499} SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	{F 499}		7/6/14

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{F 499}	Continued From page 329 The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification of licensure for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C). These had the potential to affect all 67 residents residing in the facility. Findings include: Licensure verification: LPN-A's employee file folder lacked verification of the LPN license. The administrator verified on 5/12/14, at 12:45 p.m. there was no proof of nursing licensure obtained from the Minnesota Board of Nursing for LPN-A. RN-C was hired on 4/8/14, indicated no licensure verification (copy of license dated 10/4/13) had been completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge for doing license verifications for new employees. The administrator further stated the HR person was terminated two weeks ago. The administrator added the facility did not ensure tracking for new employees' license verification.	{F 499}		

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{F 499}	Continued From page 330 On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, then she started full time work on her own since 4/16/14. The facility's Clinical Manual, Operational Manual dated 5/2012, directed the facility to obtain verification of nursing licensure from the State licensing board upon employment and to keep a completed "License Verification Form" in the employee's personnel file.	{F 499}		
{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have contracted social services	{F 500}		7/6/14

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{F 500}	Continued From page 331 available on 5/5/14, 5/6/14, and 5/7/14, because the facility had an outstanding debt to the agency. Findings include: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. At 2:30 p.m. the administrator stated the contracted social work agency was Circle of Life Aging Services. The owner of Circle of Life, Aging Services (contracted social service), interviewed On 5/12/14, 1:18 p.m.c stated, "The reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." Refer to F250: the facility failed to aggressively	{F 500}		

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{F 500}	Continued From page 332 identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) who needed social services interventions for alleged substance abuse and did not receive the services; and for 2 of 11 residents (R13, R103) who were alleged to have eloped and did not receive the medically needed social services.	{F 500}		
{F 502} SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Findings include: A Progress Notes dated 5/6/14, noted as a late entry for 5/5/14, indicated R37 was found outside of the facility and reported to staff he had gotten heroin and cocaine from another resident and had been injecting the drugs. R37 was noted to have several scattered purple bruises on his forearms.	{F 502}		7/6/14

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{F 502}	Continued From page 333 A Physician's Orders dated 5/6/14, directed urine toxicology screen. A Progress Notes dated 5/6/14, indicated the nurse went to R37's room to obtain a urine specimen for toxicology screen. R37 refused to provide a urine sample to the nurse. The note indicated a urine sample cup and supplies were left in R37's room with instructions to obtain a sample when R37 had the urge to void even though a urine specimen for toxicology needed to be witnessed by staff. Review of the medical record lacked evidence of any further attempts made to obtain the urine toxicology screen or lab results. When interviewed on 5/12/14, at 11:53 a.m. the health unit coordinator stated there was not a urine toxicology screen completed as ordered and the only lab work completed for R37 in May 2014 was done in the hospital. A facility policy regarding lab work was requested and not provided.	{F 502}		
{F 514} SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	{F 514}		7/6/14

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{F 514}	Continued From page 334 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete medical records, the charts lacked nursing notes, laboratory results, behavior monitoring. and assessment and plans for initial physician assessments for 20 of 40 residents (R103, R116, R86, R71, R9, R34, R51, R129, R13, R117, R41, R62, R37, R56, R36, R123, R1, R113, R29, R91). This had the potential to affect all 67 residents. Findings include: R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures of arm, leg, rib and pelvis related to a motor vehicle accident. Last progress note on 1/5/14, at 5:30 a.m., "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility, and currently uses Foley catheter." An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter. R103 was now	{F 514}		

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{F 514}	Continued From page 335 assessed as independent in all functional activities of daily living. The chart lacked documentation of when the Foley catheter was removed. The chart lacked a significant change MDS for improvement in more than two areas of functional status. The care plan dated 8/9/13, and revised 3/29/14, and 4/26/14, indicated, "English as a second language, required short term placement for rehab and was expected to discharge to the community within the next 3 months. R103 had impaired mobility care plan related to MVA, multiple fractures and weakness, and was to use a cane. A potential for self-care performance deficit. A potential for alteration in bowel and bladder related to disease process, unsteady gait, and cultural differences." The medical record was reviewed on 5/11/14, and lacked documentation of LOA (leave of absence) or discharge. Orders dated 4/16/14 state may LOA unsupervised with medications. On 4/20/14 at 9:48 p.m. Pt went on LOA. The chart lacked documentation of return to the facility. On 5/10/14 at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on	{F 514}		

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{F 514}	Continued From page 336 LOA. On 5/11/14, at 10:00 a.m. the facility was asked if the resident had been discharged, or was on LOA and had returned to the facility. HUC checked to see and resident was in room. He had signed in at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had notes for R103, but knew he had been working with a relocation worker. R71 was admitted to the facility on 5/17/10, with admission diagnosis of CVA (stoke) with hemiplegia (loss of all or part of one side of the body), chronic pain syndrome, depression, and diabetes. R71 was seen by the physician on 4/16/14, labs were ordered, and new medication orders dated 4/16/14, included: bendadryl 25 mg (milligrams) give 1-2, every 4-6 hours as needed for itching, and to increase gabapentin to 300 mg, give 2 every bedtime (for persistent left sided pain). On 4/18/14, a physician order to increase atorvastatin (a cholesterol-lowering medication) to 80 mg daily, and Metformin ER (used to treat type 2 diabetes) 1000 mg daily with supper. An initial primary care physician (PCP) to establish primary care on 4/16/14: noted a history of CVA (stroke), left hemiplegia (loss of use of part or all of the left side), hypertension, dyslipidemia, Major Depressive disorder, diabetes	{F 514}		

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{F 514}	Continued From page 337	{F 514}		

type II, tobacco abuse, and neuropathic pain. A review of medication list, and laboratory tests were ordered Hbg A1c (a indicator of diabetic compliance over a three month period), lipid panel (cholesterol testing) alt (liver test), lytes and BUN (kidney function tests).

On 5/6/14, a review of the medical record revealed no results for the lab tests that had been ordered on 4/16/14.

On 5/7/14, at 3:14 p.m. the health unit coordinator (HUC) verified the medical record lacked results of the 4/16/14, ordered labs, and also lacked the new PCP initial visit notes, assessment, or plan for patient treatment.

R9's medical record lacked laboratory results since 7/30/13.

On 5/13/14, at 9:30 a.m. during review of R9's medical reviewed it was revealed R9 had been to the primary physician's office several times for routine visit since 7/30/13, but lacked laboratory results for all the tests completed during the office visits.

When interviewed on 5/13/14, at 10:58 a.m. the HUC verified there were no labs in the resident chart since 7/30/13. The HUC stated the particular clinic the resident went to "always" had given her a hard time getting the notes and labs. The HUC indicated she had been told in the past that she had to call the day of the appointment to request for the information or write a note in the facility referral sheet but still nothing was being sent back with resident.

Copies of R34's care plan were requested from

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{F 514}	Continued From page 338	{F 514}		

the record. The vulnerable adult care plan for R51 was provided that had been in R34's chart. R34 and R51 have the same last name with different first names.

Refer to 223: the facility failed to ensure R34 was free from verbal abuse from R36 and review of the medical records for R34 and R36, lacked documentation regarding the incident which was reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, R9). That resulted in harm for R129, R117, R41, R37.

Refer to F274: the facility failed to complete a significant change assessment (SCSA) for 2 of 3 residents (R56, R116) with a decline in functional status.

Refer to F275: the facility did not comprehensively assess 1 of 1 resident (R36) who required a comprehensive assessment at 366 days.

Refer to F280: the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter for 1 of 3 residents (R36); and for 1 of 1 resident (R116) on Hospice who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who allegedly had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 514}	Continued From page 339 substance abuse. Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F329: the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R36, R1, R89, R113, R29, R37, R91). Refer to F412: the facility failed to ensure residents were provided dental services for 1 of 3 residents (R36). In addition, the facility failed to ensure residents received recommended dental follow-ups for 1 of 3 residents (R9). Refer to F502: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Refer to F520: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.	{F 514}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		7/6/14

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{F 520}	Continued From page 340 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 44 (R34, R37, R129, R116, R41,R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1, E2, E3) reviewed during the initial survey; the facility failed to ensure nursing assistants (NA) received the required continuing education for 1 of 5 (NA-Z); and 5 of 11 employees (registered nurse (RN)-C, RN-D,	{F 520}		

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{F 520}	Continued From page 341	{F 520}		

licensed practical nurse (LPN)-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility.

Findings include:

Refer to F223: the facility failed to ensure one of one resident (R34) was free of abuse.

Refer to F224: an Immediate Jeopardy (IJ) was identified at F224 for neglect of care for R37 and R129, when residents were able to access drugs and alcohol and required hospitalization after the Immediate Jeopardy at F323 had been identified on 5/9/14.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (RN-C, RN-D, LPN-A, NA-U, NA-Q).

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these

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{F 520}	Continued From page 342 services for residents known to provide and use illegal drugs and alcohol in the facility for 11 of 11 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323). Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14	{F 520}		

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{F 520}	Continued From page 343 through 4/5/14. Refer to F490: an IJ was issued at F490 for administration failure to fully implement the March POC, and to act upon the IJ identified at F323 on 5/9/14, to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C. These had the potential to affect all 67 residents residing in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. facility staff stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services.	{F 520}		

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{F 520}	Continued From page 344 On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. "For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." On 5/19/14, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the Limited Liability Company (LLC) would make an accounting of the monies deducted from individual checks and put	{F 520}		

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{F 520}	Continued From page 345 together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 520}		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

June 24, 2014

Ms. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Number S5544023

Dear Ms. Killian-Smith:

On May 21, 2014, a Post Certification Revisit was completed at your facility to verify the status of Immediate Jeopardy level deficiencies. You have alleged that the deficiencies that remained in effect at the time of that onsite revisit by the Minnesota Department of Health, Licensing and Certification Program staff (F tags) have been corrected. We are accepting your plan of correction and presume that your facility will achieve substantial compliance.

We will be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained.

Sincerely,

Gloria Derfus

by MK

Gloria Derfus, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: 651-201-3792 Fax: 651-201-3790

cc: Licensing and Certification File

POCA HEALTH PCR.ORC

Approved MJK 08769
6/24/14

F000

Submission of this credible allegation of compliance by Camden Care Center is not a legal admission that a deficiency exists or that the statement of deficiencies were cited correctly. It is not to be construed as an admission against interest of the facility, its administrator, employees, agents or other individuals who draft or may be documented in this credible allegation of compliance. The preparation and submission of this document does not constitute an admission of agreement with the alleged deficiencies or conclusions made by the survey agency. This credible allegation of compliance is submitted due to state and federal law requirements as a condition to participate in the Medicare and Medicaid programs.

Date of Completion: 7/6/2014

F-157

It is the policy of Camden Care Center to immediately inform the resident; consult with the resident's physician, and if known, notify the residents' legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.

For resident #13 the physician and/or family were updated on 5/8/20124. A new evaluation regarding Vulnerable Adult Assessment, smoking evaluation and elopement risk was completed. Corresponding updates have been made to the care plan, care assignment sheet. The primary physician was informed of the results on 6/20/2014 and a review of the current physician orders was completed. Education will be provided for staff members regarding notification of physician and legal representative. The preceding will be completed by July 6, 2014.

For other residents who may be affected by this practice, a comprehensive review and update of individual resident assessments (current clinical status, Vulnerable Adult Assessment, medications or treatments regime, elopement risk, smoking (as applicable) and fall risk), corresponding care plans and care assignment sheets to accurately reflect current resident status. Primary MD, resident and legal decision makers will be updated upon completion of this process. Education will be provided for direct care staff related to individual plan of care revisions and notification protocols by 7/6/2014.

The policy of incident notification was reviewed and revised as necessary. The Medical Director will review and approve the revised notification policy by 7/6/2014. Staff will be trained as it relates to their respective roles and responsibilities for the revised policies and procedures by July 6, 2014.

Audits will be completed by review of the 24 hour report form, documentation notes and Incident/Accident reports. Audits will be completed daily x4 weeks, monthly for 3 months and then quarterly on notification protocols to ensure proper notification was provided and documentation meets the facility standard. Residents are monitored for changes in condition with the provision of care, shift to shift report and weekly IDT meetings. Staff will receive additional education as needed based on outcomes of audits. The results will be reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-221

It is the policy of Camden Care Center that each resident has the right to be free from any physical restraints for purposes of discipline or convenience, and those not required to treat the resident's medical symptoms.

For Resident #89 a new assessment for physical device/physical restraints was completed on. Corresponding updates have been made to the care plan, care assignment sheet. Primary physician, resident and legal decision maker will be notified of assessment results. Consents for the physical device were obtained as warranted. Direct care staff for resident #89 will be educated on revised care interventions by July 1, 2014.

For other residents who may be affected by this practice, a review of resident with restraints will be completed to ensure medical reason for the device. Based upon this review, care interventions were updated per policy. The facility will assess new residents and those readmitted prior to the utilization of a device which meets the definition of a physical restraint. The preceding will be completed by July 6, 2014.

The policy of procedure for physical devices (assessment, medical reason and application of device during meals) was reviewed and revised accordingly. The Medical Director will review and approve the revised notification policy by July 6, 2014. IDT staff members will be trained as it relates to their respective roles and responsibilities regarding the physical device policy by July 1, 2014.

Random observation audits related to physical device utilization in accordance to individual care plan will be completed weekly for 4 weeks and monthly for 3 months. Results of audits will be reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-223

It is the policy of Camden Care Center that each resident has the right to be free from mistreatment, neglect and misappropriation if resident property.

For residents #34 and #36, a Vulnerable Adult Assessment has been completed. Assessment results have been reviewed with the resident, legal decision maker and primary physician. Corresponding updates have been made to the care plan and care assignment sheet. Behaviors have been reviewed and targeted behaviors have been identified. Direct staff responsible for the care of residents #34 and #36 have been educated on care plan updates as indicated.

For other residents who may be affected by this practice, a record review of current residents related to vulnerable adult assessments will be completed. A new vulnerable adult assessment will be completed for each current resident. Upon this review, system revisions and/or staff education will be implemented. This will be completed by July 1, 2014.

The policy for Vulnerable Adult Assessment was reviewed and revised as warranted. The Medical Director has reviewed and approved Initiation of a standardized, carbon-copied 24 hour report form will be implemented to assist in the enhancement of the internal communication process as it relates to resident care and needs. Incident and accident report form has been revised to contain the necessary components. Staff members will be trained as it relates to their respective roles and responsibilities regarding implementation of 24 hour report format, targeted behaviors and Vulnerable Adult Assessment. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated.

Daily audits will be completed of the 24 hour report book to recognize any changes of condition, at risk potential for abuse/neglect for 4 weeks, monthly for 3 months, then quarterly. Audits will be completed 2x/week for one month, weekly x one month and then quarterly to observe care and staff to resident interactions.

Reviews will be completed on allegations of abuse, neglect and misappropriation of property will be completed to ensure facility protocols are followed to ensure the environment is free from abuse. Based on the audits care plans and assessments will be updated to reflect changes. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing/Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-224

It is the policy of Camden Care Center to prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

For residents #37, #129 a comprehensive assessment, a vulnerable adult assessment and elopement assessment will be completed. Care plans will be reviewed to identify risks and interventions. Corresponding updates will be made to the care plan and care assignment sheet. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly by July 1, 2014

Resident #116 expired on 6/1/2014

All residents will have a comprehensive assessment completed, care plan review and revision of the care plan and corresponding care assignment sheets as necessary along with a chart review. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. The preceding will be completed by 7/6/2014.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director will review and approve the updated policies by July 1, 2014. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations. A review of the internal communication process will be completed to determine/establish an effective interdisciplinary communication process.

On-going daily audits will be conducted of the 24 hour report, incidents and nursing documentation. This will be completed by the nurse manager on a daily basis. Audits will be completed 2x/week for one month, weekly x one month and then quarterly to observe care and staff to resident interactions. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing/Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-225

It is the policy of Camden Care Center to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

For resident(s) #129 a comprehensive assessment and drug regimen review were completed. For resident #37 a drug regimen review and comprehensive assessment was completed. For resident #13 a comprehensive elopement assessment was completed. For resident #41 a comprehensive assessment along with an assessment of resident's ability to operate a motorized wheelchair was completed. For resident #14 a comprehensive assessment has been completed. For resident #66 a comprehensive assessment will be completed. Corresponding updates have and will be made to the care plan, assignment sheet and communicated to the resident. A review of the current physician orders was completed with respective primary physicians based upon assessment results. Direct care staff responsible for providing care to the above residents will be educated on care intervention changes as indicated. The preceding will be completed by July 6, 2014.

Resident #116 expired on 6/1/2014

Education will be provided for staff members regarding abuse reporting, investigation, incident completion, timely notification and documentation in the clinical record by July 1, 2014.

All other residents who have the potential to be affected will have a new vulnerable adult assessment completed. All other residents who operate a motorized w/c will be assessed for their ability to operate a motorized wheel chair. Care plans and corresponding care assignment sheets will be updated as indicated. Notification of assessment findings will be completed per policy to attending physician, resident and decision makers. The preceding will be completed by July 6, 2014.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director has reviewed and approved the updated policies by July 6, 2104. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations.

Audits regarding 24 hour report, incident reports and corresponding assessments, interventions and documentation will be completed daily x4 weeks, then weekly x4 weeks, monthly for 3 months then quarterly to ensure continued compliance with facility protocol.

The Administrator and/or Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-226

It is the policy of Camden Care Center to develop and implement policies and procedures. The interpretative guidelines for this tag refer to seven key components to be reviewed by surveyors to determine if the facility is meeting the intent of F-226.

For resident(s) #37, #129, #66, #14, #41 and #13 vulnerable adult assessments along with elopement assessments will be completed. Corresponding updates will be made to the care plan and care assignment sheets. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff who are responsible for providing care for the residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

Resident #116 expired on 6/1/2104

The facility has reviewed and revised the policies and procedures for screening and training of employees, protection of resident and policies pertaining to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

All employee files have been reviewed to assure that the proper components are present including licensure, background checks and reference checks. Nineteen staff members have been suspended and/or terminated based on the checks. Facility is in the process of performing an 8 point background check on all employees. This will be completed by 6/16/2014.

For other residents who may be affected by this practice a review of the abuse policy and procedure was completed. Training of employees as it relates to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

The policy and procedure for resident protection was reviewed and revised. The policy was reviewed to ensure all components are present: screening, training, prevention, identification, investigation, protection and reporting and response. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director will review and approve the updated policies by July 1, 2104. Staff members will be trained as it relates to their respective roles and responsibilities for the policies and procedures by July 6, 2014.

New employee files will be reviewed on a continuous basis to verify licensure, background checks along with reference checks are present and appropriate action taken based on the result of the checks.

Daily review of the 24 hour report and incident reports with corresponding documentation to identify possible abuse, neglect, investigations for timeliness, reporting, documentation and notification will be completed for 4 weeks.

The results of the audits will be reported to the QA/QI committee monthly for three months for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan

The Administrator and/or Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-250

It is the policy of Camden Care Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

For resident #29, #386, #41, #37, #14, #56, #62, #9, #13, and #103 comprehensive assessments will be completed including vulnerable adult assessment, Risk of drug and ETOH assessment, smoking assessment, pain assessment, BIMs and elopement assessment. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

R#117 was discharged from the facility

For other residents who may be affected by this practice a comprehensive assessment including the following assessments; vulnerable adult, pain, smoking, BIMs, elopement, risk of drug and alcohol will be completed. Comprehensive care plan will be reviewed and revised as indicated based on the assessments. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and

decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents will been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2104.

The policy and procedures for Incident/Accidents and reporting, elopement, AMA, drug testing, LOA, smoking, controlled substance storage and documentation, 1:1 policy, change of condition were reviewed to ensure policies meet current standards of practice. The Medical Director will review and approve the revised policies and procedures by July 1, 2014. Education was provided for staff regarding revised policies and procedures and their respective roles and responsibilities. This will be completed by July 6, 2014

Daily audits for 4 weeks for the first month and weekly for two months will be completed of 24 hour report, incident/accident reports, physician orders and interdisciplinary progress notes to identify problems/concerns and follow up as needed for resolution. The audits will also review the completion of appropriate assessments, interventions and notification to physician and resident and family/legal representative as indicated.

The results of the audits will be reported to the QA/QI committee monthly for 3 months for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-274

It is the policy of Camden Care Center to conduct a comprehensive assessment of the resident when required.

For resident #56 a significant change MDS with an ARD of 4/28/14 was completed on 5/12/14. For resident #116 a significant change MDS was in progress with an ARD of 5/29/14-resident expired 6/1/2014. For resident #103 a significant change MDS has been initiated with an ARD of 6/12/2014. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals will be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

Education has been provided for staff members regarding significant change criteria, change in condition.

For other residents who may be affected by this practice a comprehensive assessment will be completed to ensure a significant change assessment was done or needs to be done when appropriate. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. The preceding will be completed by July 6, 2014.

The Significant Change policy was reviewed and revised as necessary. The Medical Director has reviewed and approved this policy and procedure by July 6, 2014. Clinical staff members were trained as it relates to their respective roles and responsibilities as it relates to changes of condition and necessary assessment completion.

Daily audits of 24 hour report, incident/accident reports, and interdisciplinary notes will be completed for 4 weeks, weekly x4 weeks, with results reported to the QA/QI committee for further review and recommendations for three months. Further system revision and staff education will be provided if indicated by audits.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-275

It is the policy of Camden Care Center to comprehensively assess each resident not less than once every twelve months

For resident #36 an annual MDS with an ARD of 5/16/2014 was completed on 5/28/2014. Corresponding updates have been made to the care plan and care assignment sheet. Education will be provided for staff members regarding MDS scheduling.

For other residents who may be affected by this practice, a review of the MDS schedule was completed. Upon this review, department notification, system revisions and/or staff education will be implemented as indicated. This will be completed by July 6, 2104.

The policy for MDS scheduling protocol has been reviewed and revised as necessary per RAI guidelines. Staff members have been trained as it relates to their respective roles and responsibilities regarding the completion of the MDS according to the MDS schedule and RAI guidelines. This will be completed by July 6, 2104.

MDS audits will be completed weekly for 4 weeks, monthly for 2 months, with results reported to the QA/QI committee for review and further recommendation. Further system revision and staff education will be provided if indicated by audits.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-280

It is the policy of Camden Care Center to develop a comprehensive care plan within seven days after the completion of the comprehensive assessment.

For residents #36 and #62, corresponding care plans were reviewed and revised by the interdisciplinary team. Corresponding updates have been made to care assignment sheets. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2104.

Resident #116 expired on 6/1/2014

For other resident who may be affected by this practice, an audit of all resident care plans will be completed. Upon this review, care plan revisions and/or staff education will be implemented if indicated. Primary care physician, resident and decision maker will be notified of updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

The policy of comprehensive care plans was reviewed and revised as necessary. Medical Director has reviewed and approved the policy by July 6, 2104. Staff members will be trained as it relates to their respective roles and responsibilities regarding the updating/revision of care plans.

Care plan audits will be completed 1 x per week for 4 weeks based upon the 24 hour report status, incident/accident reports, and interdisciplinary progress notes to address identified issues/concerns. Care plan to be updated with needed interventions. The results of the audits will be reported monthly for three months to the QA/QI committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-282

It is the policy of Camden Care Center to provide care and services by qualified persons in accordance with each resident's written plan of care.

For resident's in the deficiency, the care plans were reviewed and revised by the interdisciplinary team. Corresponding updates have been made to the comprehensive care plan and care assignment sheets.

Resident #89 has been clinically reassessed for antipsychotic use and targeted behaviors. Resident #9, #22 and #36 have been clinically reassessed for smoking safety and assistance. Additionally, resident #9 has been assessed and seen by the dentist. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident will be educated on the updated care interventions. The preceding will be completed by July 6, 2014.

Resident #1 was discharged from the facility on 5-21-2014.

For other residents who may be affected by this practice, a record audit of psychotropic medication and behavior monitoring, smoking safety and assistance as well as the need for dental services will be completed to reflect current resident status. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2104.

The following policies and procedures have been reviewed and revised to reflect current standards of practice: comprehensive care plan completion, smoking safety assessment, and dental services. A review of the revised policies by the Medical Director will be conducted to determine if policies meet current standards of practice. Clinical staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by July 6, 2014.

Care plan audits will be completed weekly for 4 weeks and monthly for 3 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to

the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-309

It is the policy of Camden Care Center to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

For resident #56 POLST was reviewed. Advance directive was discussed with resident and husband on 5/12/2014 and the correct advance directive was placed in the chart. Corresponding updates have been made to care plans and care assignment sheets. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2104.

For other residents who may be affected by this practice, an audit of all current medical records was conducted to review resident's advance directives care and advanced care planning. This was completed on June 9, 2014. Upon this review, care plan revisions and/or staff education will be implemented if indicated.

The policy for Advance Directives and Advanced Care Planning was reviewed and revised as necessary. The Medical Director has reviewed and approved the policy by July 6, 2014. IDT staff members were trained as it relates to their respective roles and responsibilities regarding advance directives and advanced care planning.

Advance Directive audits along with physician order audits will be completed weekly for 4 weeks for current residents and new admissions for one month and monthly for 2 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-314

It is the policy of Camden Care Center to ensure that based on the comprehensive assessment of a resident, a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident have pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Resident #123 expired on 4/21/14.

For other residents who may be affected by this practice a comprehensive record review of skin will be completed by July 1, 2104. Upon completion of the review, treatment and care intervention updates will be made as appropriate for each resident identified. Upon this review, care plan revisions and/or staff education will be implemented if indicated. Primary physicians have been informed of assessment results and a review of the current physician orders has been completed. Staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2014.

Wound Prevention policy and procedure was reviewed and revised as necessary. The Medical Director has reviewed and approved the revised policy for implementation by July 1, 2014. Nursing staff will be trained as it relates to their respective roles and responsibilities regarding wound documentation as it relates to wound location, staging as appropriate and documentation. This was completed by July 1, 2014.

Daily audits will be completed of weekly skin checks completed on bath day for one month. In addition, weekly audits x 4 weeks will be completed for wound documentation to include location and staging as necessary then monthly x3 months. The results of the audits will be reported to the QA/QI committee for 3 months for review and further recommendations.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-319

It is the policy of Camden Care Center that a resident assessment which did not reveal a mental, psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdraw, anger, depressive behaviors, unless the clinical condition demonstrates that such a pattern is unavoidable.

For resident #41 is showing no signs and symptoms of depression. A Vulnerable Adult, elopement, cognitive assessments have been completed. Corresponding updates have been made to the care plan, care assignment sheet. Primary physicians, resident and decision maker have been informed of assessment results and care plan updates. All staff members responsible will be educated on the Resident Leave of Absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

For other residents who may be affected by this practice, a comprehensive record review of mental and psychosocial functioning, cognitive status, and indicated behavior monitoring will be completed. A Behavioral Health Management program will be implemented. After the review, updates will be made as appropriate for each resident identified. Respective primary physicians, residents and decision makers have been informed of assessment results and care plan updates. Staff members responsible have been educated on the Resident Leave of Absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

The policy and procedure for elopement risk, psychotropic drug use and monitoring, vulnerable adult assessment, including respective processes for new and readmissions, were reviewed and revised as necessary. The Medical Director will review and approve the updated policies. Staff members will be trained as it relates to their respective roles and responsibilities on policies and procedures for leave of absence.

Audits of vulnerable adult assessment completion, psychotropic drug use and monitoring and elopement assessment completion for new and readmissions will be completed weekly x4 weeks, monthly for 3 months and then quarterly to ensure continued adherence to policies. The results will be reported for 3 months to the QA/QI committee for review and further recommendation.

The Director of Nursing, Director of Social services, or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-323

It is the policy of Camden Care Center that each resident receives adequate supervision and assistance to prevent accidents.

For resident #37, #129, #13, #41, #9, #36, #22, #14, #62, #86 and #113 the following assessments were completed to reflect current status: vulnerable adult assessment, elopement risk assessment, ETOH and Drug Abuse potential, smoking safety assessment, psychosocial assessment

and fall risk assessment. Corresponding updates were made to the care plan and individual care assignment sheet. Attending physicians, residents and legal decision makers were notified of assessment results respectively. Staff members responsible will be educated on fall risk, elopement risk, vulnerable adult risk, and smoking assessment policy and procedures.

Resident #117 was discharged on 5/9/2014
Resident #116 expired on 6/1/2014
Resident #1 was discharged on 5/21/2014

For other residents who may be affected by this practice, a comprehensive record review and updated of assessments related to fall risk, vulnerable adult, smoking safety and supervision, ETOH and Drug Abuse potential, elopement risk to reflect current status of residents residing in the facility. Corresponding updates have been made to the individual care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Respective primary physicians have been informed of assessment results and a review of the current physician orders has been completed. The facility will obtain additional psych and ETOH/ADOA professional services as indicated. Staff responsible for care for each resident has been educated on the updated care interventions. The preceding has been completed by July 6, 2014.

The policy and procedures for vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been reviewed and revised. The Medical Director has reviewed and approved the policies by July 6, 2014. Additionally, the facility has reviewed admission and readmission processes to include updates to resident's status related to the aforementioned policies and procedures. All staff members will be trained as it relates to their respective roles and responsibilities regarding the above policies and procedures. This will be completed by July 6, 2014.

DON and or designee will conduct audits for all new admissions within 24 hours of admission/readmission to ensure vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been completed per policy for 30 days. Weekly review and audit of the 24 Hour Report, significant change of condition and Incident reports will be conducted for 2 months to ensure vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been completed per policy with corresponding care plan and care assignment updates.

Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing and NHA or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-329

It is the policy of Camden Care Center that each resident's drug regimen is free from unnecessary drugs.

For resident #91 review of physician orders has been completed with parameters established for administration of prn pain medication.
For resident #36 review of physician orders has been completed with parameters established for administration of prn pain medication.
For resident #37 drug regimen review has been completed. Side effect monitoring in in progress and GDR has been reviewed.
For resident #89 drug regimen review has been completed. Targeted behaviors have been identified along with monitoring of side effects for psychotropic medication.
For resident R113 a review of physician orders has been completed with parameters established for the administration of prn pain medication.
For resident #29 a review of physician orders has been completed with parameters for use of prn pain medication. Pain monitoring has been implemented.

For those residents identified, inclusion of the updates in the facility Behavior Management and Pain Management programs, as individually indicated, has been completed. Corresponding care plans and corresponding care assignment sheets have been updated as indicated. Resident attending physicians have been notified of the updates. The preceding was completed by July 6, 2014.

For other residents who may be affected by this practice a comprehensive pain assessment has been completed. Based on the assessment review of physician orders will be reviewed with parameters established as necessary for the use of prn pain medication. Pain monitoring will be reviewed for those residents receiving pain medication. For other residents who may be affected receiving psychotropic medication, drug regimen review was completed on 6/6/2013, targeted behaviors have been identified and GDR potentials have been considered. Review of appropriate indicators for the use of psychotropic medication has been completed. Corresponding care plans and care assignment sheets have been updated as necessary. Resident primary physicians have been informed of assessment results. Treatment recommendations have been obtained as indicated. The preceding steps have been completed by July 6, 2014.

The policy and procedure for pain management (including PRN medications, pain resolution and break through pain management) and psychoactive medication management (including GDR, targeted behaviors and documentation) has been reviewed and revised. The Medical Director has reviewed and approved the revisions by July 6, 2014. Clinical staff members were trained as it relates to their respective roles and responsibilities regarding pain management and psychotropic medication review and monitoring by July 6, 2014.

Audits of the 24 Hour Reports and new Physician orders will be completed monthly x3 months and then quarterly to ensure continued adherence to pain management and psychoactive medication management policies as indicated. The results will be reported to QA/QI committee for review and further recommendation.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-353

It is the policy of Camden Care Center to have sufficient nursing staff to provide nursing and related services to attain or maintain practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

For Residents # R22, R129, R1, R41,R37, R13, R86, R116, R36, R113, R117, R9, R14, R62, R 129, R1, RR22 - comprehensive clinical assessments will be completed to accurately reflect current status and care needs. Corresponding care plan, care assignment sheets and physician orders will be reviewed and updated per policy. Attending physician, resident and legal decision maker will be notified of assessment results. **Please refer to corresponding POC for F tags 224 and 323.

The nursing schedule will be reviewed and revised to include staffing ratios that are within industry standards. The policy for staffing of 1:1 was reviewed and revised. In-service on staffing policies was presented to staff members on 6/4/2014. The facility has implemented a Staffing Manager who is responsible for the time keeping and policies. Attendance and punctuality was addressed at the in-service on 6/4/2014.

Daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing levels.

The staffing patterns, scheduling coordination was reviewed and revised as warranted. Staff members were trained as it relates to their respective roles and responsibilities.

Staffing pattern audits will be completed daily for 4 weeks, monthly for 3 months and then quarterly to ensure continued compliance. The results will be reported to QA/QI committee for review and further recommendation.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-412

It is the policy of Camden Care Center to provide or obtain from an outside resource dental services to meet the needs of each resident.

For resident #9 a consent was obtained and resident was seen by the outside dental service agency on 6/4/2014. For resident #36 resident states he has found his dentures. He has adamantly refused to see the outside dental service agency that was present in the facility on 6/4/2014.

For other residents who may be affected by this practice a record review and brief oral exam of all residents will be completed regarding dental referrals, dental concerns, eating problems or nutritional concerns. Residents with dental concerns will be identified by the chart review and brief oral exam and will be placed on the list to be seen at the next dental facility visit. After the review the physician will be notified of the request for dental services for each resident identified.

The protocols/practices/contract for dental services will be reviewed and revised as necessary/warranted. The Medical Director has reviewed and approved the contract and protocols by July 6, 2014. Staff members will be trained as it relates to their respective roles and responsibilities. This will be completed by July 6, 2014.

The DON and or designee will conduct monthly record review audits for 3 months to ensure dental services are provided per revised policy. After three months, dental service audits will be conducted quarterly basis to coincide with the MDS schedule to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-428

It is the policy of Camden Care Center that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

For residents #1, #36, #37, #89, #91 and #113, a new pharmacy consultation/medication regime review was completed on June 6, 2014. Additionally, the consultant pharmacist will conduct specific reviews as indicated: Resident #91, #113 and #36 – pain medication, PRN medication parameters and break through pain management, Resident #37 and #89 - resident specific target behaviors and monitoring for

antipsychotic medication, Resident #1 for unnecessary medication and GDR. Resident Parameters for pain medication will be determined and addressed on the MAR and care plan. Behavior monitoring will be initiated if necessary along with a sleep study for those residents receiving hypnotic medication. Care plans will be reviewed for indicators of use for psychotropic medication. The attending physicians will be notified of pharmacy consultant recommendations and updated will be completed as indicated. The preceding will be completed by July 6, 2014.

For other residents who may be affected by this practice a medication regimen review will be completed by a licensed pharmacist for all residents on pain medications and antipsychotics. Upon completion of the review, the pharmacy recommendations will be reviewed with the respective attending physicians. Updates will be completed as indicated. The facility has obtained the services of a new pharmacy consultant.

The protocol/practices/contract for consultant pharmacy services will be reviewed and revised by July 6, 2014. The Medical Director will review and approve the policies by July 6, 2014. Licensed nursing staff will be trained as it relates to their respective roles and responsibilities regarding consultant pharmacy recommendations.

The facility will conduct biweekly for 3 months pain management, hypnotic and antipsychotic use drug regimen audits to ensure adherence to facility policies and procedures. This audit will include a review of pharmacy recommendations and physician response to recommendations. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-431

It is the policy of Camden Care Center to labeled drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility, in accordance with State and Federal laws will store all drugs and biologicals in locked compartments under proper temperature controls, while keeping medication and treatment carts clean.

The storage and dating of resident's # R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88 medications and biologicals were reviewed for expiration and cleanliness of medication cart. Residents R73, R37, R83, R115 medications and treatments are stored in the appropriate locked compartments in accordance to state and federal regulations.

Medication cart audit and organization/cleaning of the carts will be completed by June 16, 2014. The facility has developed and implemented a cleaning schedule for the medication carts will be completed by June 16, 2014.

Education to be provided to the licensed staff as it pertains to cleanliness/organization/ of the medication cart. Pharmacy representative to provide training to the licensed staff on labeling, dating of opened vials, multi -dose containers, eye drops, diskus inhalers, proper storage of insulin vials before and after opening. This will be completed by June 19, 2014.

The DON and or designee will conduct Medication cart and medication room audits to include appropriate dating and storage of medications per policy and regulations on a weekly basis for 4 weeks, monthly for 2 months. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-465

It is the policy of Camden Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Resident # 56 has been relocated to another room. The carpeting in Resident #56 original room the carpet has been cleaned. Resident #22 the carpet has been cleaned by a professional cleaner.

Resident #33 has been discharged from the facility.

For other residents who may be affected by this practice room to room environmental audit for all resident rooms will be completed. Upon completion of the audits, the facility will clean and repair any carpet and/or furniture found in disrepair or in need of cleaning will be fixed

and/or cleaned by the maintenance/housekeeping team. Outside services to clean the carpets has been scheduled to be completed by 6/17/2014. The facility NHA and or designee will conduct a review of all mechanical lifts to ensure they are well maintained. Any identified repairs will be completed prior to utilization by nursing staff.

Policy for the mechanical lifts has been developed/reviewed/revised. Review of the process of identifying and reporting to maintenance issues in need of repair or fixing has been developed/reviewed/revised. Lock-out/Tag-out policy will be reviewed and revised as necessary. Resident room cleanliness and repair request policies have been reviewed and revised. Staff will be educated on the reporting process of items that need repair, cleaning, fixing by the maintenance department. Staff will be in-serviced on Lock-out/Tag-out process for items that need to be taken out of service due to malfunction, safety issues. This will be completed by July 6, 2014.

The NHA and Maintenance/Housekeeping will conduct resident room environmental cleanliness and repair audits will be completed weekly for 4 weeks. Additionally, Maintenance will conduct weekly mechanical lift safety checks. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-469

It is the policy of Camden Care Center to maintain an effective pest control program so that the facility is free of pests and rodents.

Resident #56 room has been treated by Pest control. No additional infestations have been noted since treatment.

The Pest control contractor was at the facility on 6/9/2014 and completed routine pest control and monitoring. All insect lights traps were serviced and all entrances were treated. All traps were checked and no evidence of mice. Exterior face of building was also treated. Contract signed 6/9/2014 includes an increase in frequency of visits to service weekly for the month of June and bi-weekly for the month of July. Pest Control contractor was at the facility on 5/7/14 and performed treatment to specific rooms and exterior of the south wing.

Facility has purchased disposable food saver containers made available for the residents to store snack, food and other small food items in their room. This was reviewed with Resident Council on 6/16/2014.

The policy for pest control will be developed/reviewed/revised. All staff members will be trained as it relates to their respective roles and responsibilities regarding storage of food items in resident rooms and the use of covered containers. This was completed by July 6, 2014.

The Director of Maintenance/Environmental Services will conduct room to room environmental rounds related to pest control on a weekly basis for 4 weeks and monthly for 3 months. Results of audits will be reported to QA/QI committee for further review and further recommendation.

The Director of Maintenance/Environmental Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-490

It is the policy of Camden Care Center that our facility be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

The new managing agent has removed the NHA from the facility. A new Interim NHA with related experience and expertise with this resident population is in place effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. The INHA has notified all facility staff of the outstanding citations and serious and immediate issues that are being addressed. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC.

7/6/2014

For residents #37, #129 a comprehensive assessment, a vulnerable adult assessment and elopement assessment will be completed. Care plans will be reviewed to identify risks and interventions. Corresponding updates will be made to the care plan and care assignment sheet.

All other residents have the potential to be affected by this practice.

-F223 (see related POC for this F Tag)- For other residents who may be affected by this practice a record review will be completed regarding vulnerable adult assessment. A new vulnerable adult assessment will be completed for each current resident. Upon this review, system revisions and/or staff education will be implemented.

The policy for Vulnerable Adult Assessment was reviewed and revised as warranted. Initiation of a standardized, carbon-copied 24 hour report form will be implemented to assist in the enhancement of the internal communication process as it relates to resident care and needs. Incident and accident report form has been revised to contain the necessary components. Staff members will be trained as it relates to their respective roles and responsibilities regarding implementation of 24 hour report format, targeted behaviors and Vulnerable Adult Assessment.

Daily audits will be completed of the 24 hour report book to recognize any changes of condition, at risk potential for abuse/neglect for 4 weeks, monthly for 3 months, then quarterly. Audits are being completed to determine if staff are assessing and planning for "at risk behavior". Reviews will be completed on allegations of abuse, neglect and misappropriation of property will be completed to ensure facility protocols are followed to ensure the environment is free from abuse. Based on the audits care plans and assessments will be updated to reflect changes. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

-F-224 (see related POC for this F Tag)- All residents will have a comprehensive assessment completed, care plan review and revision of the care plan as necessary along with a chart review.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations. A review of the internal communication process will be completed to determine/establish an effective interdisciplinary communication process

On-going daily audits will be conducted of the 24 hour report, incidents and nursing documentation. This will be completed by the nurse manager on a daily basis. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

-F-225(see related POC for this F Tag)- Education will be provided for staff members regarding abuse reporting, investigation, incident completion, timely notification and documentation.

All other residents have the potential to be affected. Other residents who may be affected by this practice will have a vulnerable adult assessment completed. All other residents who operate a motorized w/c will be assessed for their ability to operate a motorized wheel chair.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations.

Audits regarding 24 hour report, incident reports and progress notes will be completed daily x4 weeks, then weekly x4 weeks, monthly for 3 months then quarterly to ensure continued compliance with facility protocol.

-F-226 (see related POC for this F Tag)- The facility has reviewed and revised the policies and procedures for screening and training of employees, protection of resident and policies pertaining to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

All employee files have been reviewed to assure that the proper components are present such as licensure, background checks and reference checks. Nineteen staff members have been suspended and/or terminated based on the checks. Facility is in the process of performing an 8 point background check on all employees.

For other residents who may be affected by this practice a review of the abuse policy and procedure was completed. Training of employees as it relates to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

The policy and procedure for resident protection was reviewed and revised. The policy was reviewed to ensure all components are present: screening, training, prevention, identification, investigation, protection and reporting and response. Staff members were trained as it relates to their respective roles and responsibilities for the policies and procedures.

New employee files will be reviewed on a continuous basis to verify licensure, background checks along with reference checks are present and appropriate action taken based on the result of the checks.

Daily review of the 24 hour report along with nursing notes to identify possible abuse, neglect, investigation for timeliness, reporting, documentation and notification.

The results of the audits will be reported to the QA/QI committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan

F-250 (see related POC for this F Tag)- For resident #29, 386, #41, #37, #14, #56, #62, #9, #13, and #103 comprehensive assessments will be completed including vulnerable adult assessment, Risk of drug and ETOH assessment, smoking assessment, pain assessment, BIMs and elopement assessment. The comprehensive care plan will be reviewed and revised and the NAR assignment sheets will be updated to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated.

R#117 was discharged from the facility

For other residents who may be affected by this practice a comprehensive assessment including the following assessments; vulnerable adult, pain, smoking, BIMs, elopement, risk of drug and alcohol will be completed. Comprehensive care plan will be reviewed and revised as indicated based on the assessments. Appropriate referrals to be made to other professional resources as indicated.

The policy and procedures for Incident/Accident an reporting, elopement, AMA, drug testing, LOA, smoking, controlled substance storage and documentation, 1:1 policy, change of condition were reviewed to ensure policies meet current standards of practice. Education was provided for staff regarding revised policies and procedures and their respective roles and responsibilities.

On-going daily audits will be completed of 24 hour report, incident/accident reports, physician orders and interdisciplinary progress notes to identify problems/concerns and follow up as needed for resolution. Completion of appropriate assessments, interventions and notification to physician and resident and family/legal representative as indicated.

F-309 (see related POC for this F Tag)- For resident #56 POLST was reviewed. Advance directive was discussed with resident and husband on 5/12/2014 and the correct advance directive was placed in the chart. Corresponding updates have been made to care plans and care assignment sheets.

For other residents who may be affected by this practice, an audit of all resident's advance directives care and planning will be completed. Upon this review, care plan revisions and/or staff education will be implemented if indicated.

The policy for Advance Directives was reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities regarding advance directives.

Advance Directive audits along with physician order audits will be completed weekly for 4 weeks, monthly for 3 months, then quarterly to ensure compliance with results reported to QA/QI committee for review and further recommendations.

F-314 (see related POC for this F Tag)- Resident #123 expired on 4/21/14.

For other residents who may be affected by this practice a comprehensive record review of skin will be completed by June 13, 2014. After review, updates will be made as appropriate for each resident identified.

Wound policy and procedure was reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities regarding wound documentation as it relates to wound location, staging as appropriate and documentation.

Daily audits will be completed of weekly skin checks completed on bath day. Weekly audits x 4 weeks will be completed for wound documentation to include location and staging as necessary then monthly x3 months and then quarterly to ensure compliance. The results of the audits will be reported to the QA/QI committee for review and further recommendations.

-F-319 (see related POC for this F Tag)- For resident #41 a Vulnerable Adult, elopement, cognitive assessments have been completed. Corresponding updates have been made to the care plan, care assignment sheet. All staff members responsible have been educated on the Leave of absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

For other residents who may be affected by this practice a comprehensive record review of mental and psychosocial functioning and behavior monitoring will be completed. After review updates will be made as appropriate for each resident identified.

The policy and procedure for elopement risk, psychotropic drug use, and vulnerable adult assessment were reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities as it relates policies and procedures relating to leave of absence.

Audits of vulnerable adult assessment, comprehensive care plans and psychotropic drug use will be completed weekly x4 weeks, monthly for 3 months and then quarterly to ensure continued compliance. The results will be reported to the QA/QI committee for review and further recommendation.

F-323 (see related POC for this F Tag)- For resident #37, #129, #13, #41, #9, #36, #22, #14, #62, #86 and #113 a vulnerable adult assessment, elopement risk assessment, smoking assessment, psychosocial assessment and fall risk assessment will be completed. Corresponding updates will be made to the care plan, care assignment sheet. All staff members responsible will be educated on fall risk, elopement risk, vulnerable adult risk, and smoking assessment policy and procedures.

For other residents who may be affected by this practice, a comprehensive record review of fall risk, vulnerable adult, smoking, elopement risk will be reviewed and completed. After review, updates will be made as appropriate for each resident identified.

The policy and procedures for vulnerable adult, smoking, elopement, fall risk have been reviewed and revised. Staff members will be trained as it relates to their respective roles and responsibilities regarding the above policies and procedures.

Audits will be completed for all new admissions within 24 hours of admission/readmission, with a significant change in status, and quarterly to ensure all assessments are completed with appropriate changes made to comprehensive care plan and nursing assistant assignment sheets. The results will be reported to the QA/QI committee for review and further recommendations.

F-353 (see related POC for this F Tag)- The nursing schedule was reviewed and revised to include staffing ratios that are within industry standards. The policy for staffing of 1:1 was reviewed and revised as necessary. In-service on staffing policies was presented to staff members on 6/4/2014. The facility has implemented a Staffing Manager who is responsible for the staffing and scheduling. Attendance and punctuality was addressed at the in-service on 6/4/2014.

Daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing level.

The staffing patterns, scheduling coordination was reviewed and revised as warranted. Staff members were trained as it relates to their respective roles and responsibilities.

Staffing pattern audits will be completed daily for 4 weeks, monthly for 3 months and then quarterly to ensure continued compliance.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

F-492 Prior to working in the facility, each agency person will have a file that verifies that the appropriate screenings were completed prior to working in the facility. This verification process will include the completion of a master file which includes a two -step TB test and results prior for each agency personnel to the start of their first shift at Camden Care Center. This information will be provided from the staffing agency. This was implemented on 6/6/2014.

Development and implementation of an agency orientation has been completed on 6/6/2014. The DON and/or designee will assure that all proper paperwork is present in supplemental staff files.

The facility will conduct a daily audit of scheduled contracted staff files, to ensure all required and necessary paperwork and screenings are present prior to start of their first scheduled shift. Results of this monitoring will be presented to QA Committee for further review and further recommendation

F-497 The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision employee annual training requirements and annual review process policies and procedures. A review of the revised policies by the Medical Director will be conducted by July 6, 2014 for approval. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by July 6, 2014.

The facility has audited and reviewed all nursing assistant employment and training files for evidence of required annual training and annual performance evaluations. Those files requiring improvement have been identified and actions for adherence to annual training requirements and annual performance evaluations will be completed by 7/1/2014.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

F-499 The facility has completed license verification for employees (LPN)-A and registered nurse (RN)-C) and filed those results in accordance to policy.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision of license and certification verification (upon hire and annually) process policies and procedures. A review of the revised policies by the Medical Director will be conducted by July 6, 2014 for approval. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all employees in a position requiring license or certification for evidence of license/certification verification. Those files requiring improvement have been identified and actions for adherence to license verification will be completed. All new employee files will be reviewed with the NHA for license/certification verification in accordance with applicable State laws.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the

corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Administrator or designee will be responsible for compliance.

Date of Correction: 7/6/14

F-520 **CORRECTIVE ACTION**

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC. The INHA has revised the Quality Assurance and Performance Improvement processes to meet current professional standards. Education for all F Tags identified in this SOD will be completed for staff members. Documentation of individual education will be completed. Competency testing, as indicated in respective F Tags, will be documented. As indicated in corresponding F Tags, the NHA and or designee has reviewed and revised employee orientation as well as agency staff orientation programs to reflect the updated policies and procedures.

All current residents clinical records will be reviewed as indicated in F Tags notated in this statement of deficiency. Updates to individual care plans, care assignment sheets for direct care staff will be completed. Notification of assessment results/record review results will be completed specifically for residents, responsible parties and primary care physicians. Physician orders will be updated as indicated. All staff responsible for those residents identified for revisions will be completed to ensure care and services are being delivered per current clinical functional level.

The Administrator and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – QAA (Quality Assessment and Assurance) program protocols based on the new guidelines to include, but not limited to: Overview of QAA Program (serves as a management process that is ongoing, multi-level, and facility wide. It encompasses all managerial, administrative, clinical, and environmental services, contracted entities. The purpose of the program is to continuously evaluate the facility systems for clinical, financial and operational focuses to provide the highest level of care and services to the residents and staff of the facility);

- Keeping facility systems in accordance with current industry standards of practice;
- Prevent deviations from care processes from arising;
- Discerning issues and concerns as identified with facility systems and utilizing root cause analysis
- protocols to determine necessary action steps;
- Facility process for identification of quality deficiencies;
- Description of QAA facility team composition; additional committee members may include the facility administrator, Medical Director –
- Description of QAA Committee functions;
- Frequency of meetings and recording processes utilized;
- Monitoring processes for action plan implementation and determination of quality improvement of necessary changes for improvement.

A review of the revised policies by the Medical Director and Quality Assurance/Compliance Committee will be completed to determine if policies meet current standards of practice.

All facility staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures related to quality assessment and assurance activities. Staff will be educated by the NHA on the QAA committee responsibility to have oversight and monitoring of the plan of correction for the recertification survey. The facility Managing Agent and INHA have added additional external consultants to assist with the facility's response to the statement of deficiency as well as QAA/monitoring activities to ensure compliance with respective regulations.

The Administrator and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including:

Development of peer review committee to assess current QAA functionality including identified QAA improvement plans and effectiveness of implemented action plans. This will be completed monthly for 4 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions for the overall Statement of Deficiency (track, trend and analysis) will be reported to the facility QA Committee monthly for 4 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA and Managing Agent will be responsible for compliance.

Date of Correction: July 6, 2014

F 492

It is the policy of Camden Care Center to operate and provide services in compliance with all applicable federal, state and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

Prior to working in the facility, each agency person will have a file that verifies that the appropriate screenings were completed prior to working in the facility. This verification process will include the completion of a master file which includes a two -step TB test and results prior for each agency personnel to the start of their first shift at Camden Care Center. This information will be provided from the staffing agency. This was implemented on 6/6/2014.

Development and implementation of an agency orientation has been completed on 6/6/2014. The DON and/or designee will assure that all proper paperwork is present in supplemental staff files.

The facility will conduct a daily audit of scheduled contracted staff files, to ensure all required and necessary paperwork and screenings are present prior to start of their first scheduled shift. Results of this monitoring will be presented to QA Committee for further review and further recommendation

The Administrator/Director of Nursing or designee is responsible for compliance.

Date of correction: July 6, 2014

F493

It is the Policy of Camden Care Center to have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and

implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC.

All residents identified in this citation (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) have been clinically reassessed and plans of care have updated as indicated in the correlating F Tag citations indicated in the SOD. Employees (E1, E2, E3) annual evaluations have been completed. Staff (NA-Z) has completed the required education. License/certification verification for RN-C, RN-D, LPN-A, NA-U, NA-Q) has been completed. Facility vendors have been notified of the receivership and vendor payment processes and needs.

Refer to specific Plan of Correction actions for F223, F224, F 225, F 226, F250, F 309, F 314, F319, F 323, F 353, F 412, F 490, F 492, F497, F 499, F500, and F520 related to resident specific changes, policy revisions and updates, staff education and monitoring activities.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA and Managing Agent will be responsible for compliance.

Date of Correction: July 6, 2014

F-497

It is the policy of Camden Care Center to complete a performance review of every nurse aide at least once every 12 months, and provide regular in-service education based on the outcome of these reviews. The in-service training will be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

Employees (E1, E2, E3) annual evaluations have been completed. Staff (NA-Z) has completed the required education.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision employee annual training requirements and annual review process policies and procedures. A review of the revised policies by the Medical Director will be conducted. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all nursing assistant employment and training files for evidence of required annual training and annual performance evaluations. Those files requiring improvement have been identified and actions for adherence to annual training requirements and annual performance evaluations will be completed.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F499

It is the policy of Camden Care Center to employ professional staff who are licensed, certified, or registered in accordance with applicable State laws.

The facility has completed license verification for employees (LPN)-A and registered nurse (RN)-C) and filed those results in accordance to policy.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision of license and certification verification (upon hire and annually) process policies and procedures. A review of the revised policies by the Medical Director will be conducted. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all employees in a position requiring license or certification for evidence of license/certification verification. Those files requiring improvement have been identified and actions for adherence to license verification will becompleted. All new employee files will be reviewed with the NHA for license/certification verification in accordance with applicable State laws.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F500

It is the policy of Camden Care Center that if the facility to employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an approved arrangement.

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. Facility vendors, including contracted Social Services Agency, have been notified of the receivership and vendor payment processes and needs.

The facility INHA is currently working with the contracted social services vendor and external social services resources for the provision of medically related social services. Refer to F 250 for the specific plan of correction actions for those residents identified in the citation, all residents potentially affected by this practice, revision and implementation of policies and procedures, staff orientation changes , staff education as well as monitoring activities. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect.

The INHA and new Managing Agent will review accounts payable on a weekly basis for 3 months to ensure vendor invoices are processed and paid in accordance to the individualized agreements.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F 502

It is the policy of Camden Care Center to provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services

Resident #37 labs were obtained while in the hospital.

For other residents who may be affected by this practice a comprehensive review of laboratory orders was completed for all residents residing in the facility. Review results were discussed with the corresponding attending physicians for updates or revisions as indicated.

A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the policy and procedures.

Lab audits will be completed weekly for 4 weeks and monthly for 2 months compliance with laboratory services policies and procedures. Monitoring results will be reported to the QA/QI Committee for review and further recommendation for 3 months.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F514

It is the policy of Camden Care Center to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. The clinical record contains sufficient information to identify the resident, record of the resident's assessments, plan of care and services provided, and the results of any preadmission screening conducted by the State.

Residents (R103, R116,R86, R71, R9, R34, R51, R129, R13, R117, R41,R62, R37, R56, R36, R123, R1, R113, R29, R91) identified in this statement of deficiency clinical records have been reviewed for completion of all applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. Updates have been completed as indicated per record review. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders will be completed. All staff responsible for care for each resident identified has been educated on updated care interventions.

For other residents who may be affected by this practice, an audit of all current resident records for completion of applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. Updates have been completed as indicated per record review. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders will be completed.

The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – medical record protocols including - completion of applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. A review of the revised policies by the Medical Director will be conducted to determine if policies meet current standards of practice was completed.

Clinical staff were trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures .

The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Conduct random record review to ensure the aforementioned policies and procedures are in place and practice. This will be completed 3 times per week for 4 weeks.

In addition, a weekly review of new/re admission records will be completed to ensure the aforementioned policies and procedures are in place and practice per new and re admission processes. This will be completed one time per week for four weeks.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F520

It is the policy of Camden Care Center that the facility maintains a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility and at least 3 other members of the facility staff. This meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develop appropriate plans of action to correct identified quality deficiencies.

CORRECTIVE ACTION

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC. The INHA has revised the Quality Assurance and Performance Improvement processes to meet current professional standards.

As of July 6, 2014 education for all F Tags identified in this SOD was completed. Documentation of individual education is completed. Competency testing, as indicated in respective F Tags, is documented as indicated. As indicated in corresponding F Tags, the NHA and or designee has reviewed and revised employee orientation as well as agency staff orientation programs to reflect the updated policies and procedures.

All current residents comprehensive records will be reviewed as indicated in respective F Tags notated in this statement of deficiency, have been completed. Updates to individual care plans, care assignment sheets for direct care staff have been completed. Notification of assessment results/record review results were completed specifically for residents, responsible parties and primary care physicians. Physician orders have been updated as indicated. All staff responsible for those residents identified for revisions was completed to ensure care and services are being delivered per current clinical functional level.

The Administrator and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – QAA (Quality Assessment and Assurance) program protocols based on the new guidelines to include, but not limited to: Overview of QAA Program (serves as a management process that is ongoing, multi-level, and facility wide. It encompasses all managerial, administrative, clinical, and environmental services, contracted entities. The purpose of the program is to continuously evaluate the facility systems for clinical, financial and operational focuses to provide the highest level of care and services to the residents and staff of the facility);

- Keeping facility systems in accordance with current industry standards of practice;
- Prevent deviations from care processes from arising;
- Discerning issues and concerns as identified with facility systems and utilizing root cause analysis
- protocols to determine necessary action steps;
- Facility process for identification of quality deficiencies;
- Description of QAA facility team composition; additional committee members may include the facility administrator, Medical Director –
- Description of QAA Committee functions;
- Frequency of meetings and recording processes utilized;
- Monitoring processes for action plan implementation and determination of quality improvement of necessary changes for improvement.

A review of the revised policies by the Medical Director and Quality Assurance/Compliance Committee will be completed by July 6, 2014 to determine if policies meet current standards of practice. QAA meeting is scheduled for the week of June 23, 2014.

All facility staff was trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures related to quality assessment and assurance activities. As of July 6, 2014 staff will be educated by the NHA on the QAA committee responsibility to have oversight and monitoring of the plan of correction for the recertification survey. The facility Managing Agent and INHA have added additional external consultants to assist with the facility's response to the statement of deficiency as well as QAA/monitoring activities to ensure compliance with respective regulations.

The Administrator and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including:

Development of peer review committee to assess current QAA functionality including identified QAA improvement plans and effectiveness of implemented action plans. This will be completed monthly for 4 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions for the overall Statement of Deficiency (track, trend and analysis) will be reported to the facility QA Committee monthly for 4 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This revisit was conducted only to verify removal of the immediate jeopardy (s) at F224, F323 and F490 which were cited during a federal revisit survey exited on 5/13/14. As a result of this revisit, it was determined that the immediate jeopardy (s) at F224, F323 and F490 were removed on 5/21/14. Although the immediate jeopardy (s) was removed, substantial non-compliance remains at F224 at a s/s of G level; substantial non-compliance remains at F323 at a s/s of H; substantial non-compliance remains at F490 at a s/s of F. Only deficiencies that were cited at the immediate jeopardy level were reviewed during this survey. Thus, all other deficiencies from the 5/13/14, federal revisit survey remain as written on the 5/13/14, statement of deficiencies.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	{F 157}		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 157}	Continued From page 1	{F 157}		

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the physician and family member(s) was promptly notified for 1 of 1 resident (R13) observed to elope from the building during the survey on 5/6/14.

Findings include:

On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 exited the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of

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{F 157}	Continued From page 2 the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly observed to be smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to finish smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair using her feet to propel the wheelchair towards 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving	{F 157}		

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{F 157}	Continued From page 3 rapidly (posted speed limit was 30 miles per hour). The smoking monitor was observed to be behind a pillar with his back to the street and R13. - At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor that R13 had been observed on the city sidewalks. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, assisted her to wheel back to the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility. R13's Diagnosis Report dated 2/4/09, identified diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease. The Vulnerable Adult Assessment dated 6/24/13, identified R13 had a history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples' belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, the assessment indicated R13 was required to have supervised LOAs (Leave of Absences) only, and that R13 had a past history of drug abuse. A LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and that the resident was unable to leave the facility unsupervised.	{F 157}		

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{F 157}	Continued From page 4	{F 157}		

A Camden Care Center Care Conference form dated 10/1/13, included; "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of daily living (ADLs).

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist

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{F 157}	Continued From page 5	{F 157}		

resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, indicated R13 had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "WanderGuard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision."

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on.

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{F 157}	Continued From page 6 The receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident." Although the note indicated a message had been left for the NP, the NP and family member(s) were not called until three days after the incident. On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, did O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. registered nurse (RN)-C stated she was in the room when O-C had reported R13 had eloped. RN-C stated the	{F 157}		

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{F 157}	Continued From page 7 announcement was made and RN-C, licensed practical nurse (LPN)-E, LPN-A and dietary manager (DM) was present for the announcement. RN-C stated she had not reported the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; and would be responsible to notify the family and physician regarding the elopement.	{F 157}		
{F 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) reviewed for restraint, was free of physical restraints while directly supervised by staff during meals. Findings include: On 5/7/14, at 8:28 a.m. R89 was observed to be at a meal in her wheelchair (W/C) with the right break locked. Anti-rollbacks (devices which engage and keep wheelchair from rolling back when a resident stands) were observed to be applied to the back of the W/C. A nursing assistant (NA)-V was observed to be sitting directly to R89's left and assisted R89 to eat.	{F 221}		

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{F 221}	Continued From page 8 When asked why the W/C brake was locked, NA-V stated "we lock one brake," and verified the left brake was unlocked. NA-V explained "brakes" needed to be locked "to protect her [R89]." NA-V further explained R89 needed to protect from "falling." NA-V was unclear why the left brake was left unlocked. The right side of the W/C was observed to be flush to the table. During the observation, R89 was observed to stand repeatedly, had worried expression on her face and repeated in an anxious voice, "I gotta go!" On 5/8/14, at approximately 8:30 a.m. R89 was observed to be at the dining room table in the same location. R89 was observed to have both W/C brakes locked; the anti-rollback device remained appropriately applied to the W/C. R89 attempted to stand multiple times, appeared worried when standing, then immediately sat back down. - From 8:30 a.m. until 9:40 a.m. R89 remained at the breakfast meal. NA-V was observed to provide R89 her breakfast, set up the breakfast and sit directly next to R89 and assist her to eat. At no time were W/C brakes unlocked. R89 was observed to stand repeatedly throughout the meal, pushing back slightly with her legs as she stood. The W/C was flush to the top of the table, preventing R89 from leaving the table. The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a W/C and had "N/A [non-applicable]" written by hand in the section. Review of the	{F 221}		

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{F 221}	Continued From page 9 clinical record lacked evidence R89 was assessed for restraints. R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint. The Care Area Assessment (CAA) for activities of daily living (ADLs) Function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease.	{F 221}		

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{F 221}	Continued From page 10 The clinical record lacked evidence R89 had been assessed for restraint use, including locked W/C brakes and having the W/C pushed flush to the table. R89's care plan dated as last reviewed on 3/28/14, identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and did not include direction to place R89 against a desk or table. The care plan was updated on 4/30/14, to include, "Anti-roll back brakes installed onto wheelchair to prohibit wheelchair from rolling backwards when resident offloads independently. Least restrictive safety device while in wheelchair." On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E stated R89 "was not restrained" and stated "anti-rollback brakes were placed on the wheelchair." LPN-E stated R89's W/C was "looked at by therapies" and therapies had assessed R89 for the use of the anti-rollbacks on the W/C. LPN-E was unclear whether the locking of R89's W/C brakes had been assessed as a form of restraint. - At 9:28 a.m. LPN-E stated the therapy department had only made a "recommendation" and since R89 was not on the therapy case load, they "didn't document the evaluation." LPN stated direct care staff had been "educated" not to lock R89's brakes or restrain her against a desk or table. LPN-E verified if R89 was directly supervised by a staff person, the W/C brakes should not have been locked.	{F 221}		

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{F 221}	Continued From page 11 On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of anti-rollbacks and the use of potential restraints, such as having both brakes locked and the W/C pushed flush to a table. DON repeatedly stated he thought "physical therapy assessed the use of the anti-rollbacks" but was unclear if R89 was assessed for restraints. DON verified therapy assessments should have been documented in R89's clinical record. On 5/12/14, at 12:28 p.m. the physical therapy assistant and rehab manager (PTA), occupational therapist (OT), and physical therapist (PT) were interviewed together in the therapy gym. All denied having assessed R89 for the use of the anti-rollbacks, W/C brake locking, or restraints. PTA stated the anti-rollbacks had been an idea that had been "brought up" in the morning meeting as "a way to keep her [R89] safe without locking the brakes." The OT stated therapy staff had "helped maintenance order the device," and stated since maintenance had not seen the device before, therapy staff had assisted him to "apply it." The PT stated no therapy staff had actually assessed R89 because there was no "physician's order" and because R89 "was not on case load." All therapists verified they would not "assess" a resident without a physician's order and stated they were unclear when they should "get involved." All verified they were employees of Videll Healthcare Limited Liability Company (LLC), but then stated, "The facility doesn't have polices to let us know our responsibilities." On 5/12/14, at 12:23 p.m. R89 was observed to be in her W/C at the lunch meal. NA-V was observed seated directly to the left of R89. NA-V	{F 221}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 12 was interacting with R89 before the meal. R89 was observed to have the W/C pushed up flush against the table and both W/C brakes were observed to be locked which caused R89 to be restrained. The left anti-rollback arm was observed to be twisted off R89's left W/C tire (rendering the anti-rollback ineffective). The surveyor alerted NA-V to the anti-rollback being ineffective. - At 12:26 p.m. R89 was observed to be provided her meal. NA-V setup the meal and remained with R89. R89 was observed to remain in the dining room throughout the meal with the brakes locked. NA-V sat next to R89 until approximately 1:20 p.m. NA-V then unlocked both brakes and wheeled R89 away from the table and into the activity room on the South unit. On 5/13/14, at 9:03 a.m. LPN-E verified R89 should not have been restrained at the table while supervised during the meal. The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lap buddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking a resident's W/C brakes, seating a resident up against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DON or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each	{F 221}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 13 shift and released according to physician's orders. The policy did not address the release of restraint devices, such as releasing the restraint every two hours, during supervised activities, or while the resident was supervised at a meal.	{F 221}		
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse from another resident (R36). Findings include: On 5/6/14, at 9:49 a.m., 5/6/14, at 11:32 a.m., 5/6/14, at 2:48 p.m., 5/7/14, at 1:40 p.m., 5/8/14, at 9:29 a.m., 5/8/14, at 2:08 p.m., 5/10/14, at 12:45 a.m. R34 and R36 were both observed on the smoking patio. The annual Minimum Data Set (MDS) dated 4/1/14, for R34 included a Brief Interview of Mental Status (BIMS) score of nine which indicated moderate cognitive impairment and a Patient Health Questionnaire (PHQ-9) score of five which indicated mild depression. The MDS	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 223}	Continued From page 14 indicated R34 did not have delusions or hallucinations. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/3/14, lacked a summary regarding R34's cognitive status. A Vulnerable Adult Assessment date 3/18/14, indicated R36 was verbally abusive and condescending towards others. A Vulnerable Adult Assessment dated 4/4/13, indicated R34 had behaviors which made her susceptible to abuse by others. A Social Service Note dated 4/17/14, indicated R34 had reported on 4/15/14, R36 was verbally abusive towards her. The note indicated when R36 was interviewed on 4/16/14, he stated he calls R34 "a parasite every time I see her because that is what she is." The note indicated R36 was told calling other residents names was verbal abuse and verbal abuse was not tolerated. A Progress Notes dated 4/17/14, indicated the contracted licensed social worker (CLSW) met with R34 on 4/16/14, and R34 indicated R36 "calls her every name in the book, he is just mean." A Progress Notes dated 4/17/14, indicated social services met with R36 and R36 stated he was going to "do what he wants" and would continue to call R34 a parasite. R36 was informed calling R34 names was verbal abuse and R36 responded "I don't care." The Admission Record dated 4/28/14, indicated R34 was admitted to the facility on 3/28/13, with	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 15 diagnoses which included dementia and depressive disorder. A copy of an Incident/Accident Report dated 5/5/14, was provided on 5/8/14. The Incident/Accident Report indicated R34 had reported R36 had pushed her into a patio chair and R34 had become stuck when the patio chair fell over. It was noted the incident had occurred on 5/4/14, at night with no exact time. R36 was noted to have denied the incident; the police were called and spoke with R34. On 5/7/14, at 3:10 p.m. a copy of the facility investigation was requested. The Incident/Accident Report lacked any additional investigation into the incident. A Progress Note dated 5/9/14, indicated R34 reported she did not like R36 because "he is an old drunk." The note indicated R34 had agreed to stay away from R36 and that R34 had stated she was used to handling old drunks, and had showed staff an old scar she reported was from when her late husband broke her leg. When interviewed on 5/7/14, at 2:41 p.m. R34 stated R36 called her names "all the time." When asked how being called names made her feel, R34 stated she had filed a police report because R36 had "assaulted her" two nights ago. When asked what she meant by assaulted, R34 stated R36 waited until nobody was around and then pushed her. R34 reported the director of operations helped her file a police report. Review of the medical records for R34 and R36, lacked documentation regarding the incident which was allegedly reported on 5/5/14, and lacked indication of how R34 would be protected from R36.	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 223}	Continued From page 16	{F 223}		

When interviewed on 5/7/14, at 3:10 p.m. the director of operations reported he was aware of the incident which had occurred during the evening of 5/5/14, and confirmed he'd helped R34 call the police. During the interview, the administrator stated he was aware of the incident and that it had been reported to him on 5/6/14. The administrator reported R34 and R36 "spar all the time."

Upon interview on 5/8/14, at 11:36 a.m. the director of nursing (DON) reported he had received the Incident/Accident Report on 5/8/14. The DON stated he was not sure whether the incident was reportable because it had occurred on 5/5/14, and it was a "resident to resident altercation."

The director of operations was interviewed on 5/12/14, at 9:20 a.m. and stated R34 was very upset about the incident from 5/5/14, and had wanted the police called because it was not the first time, and that R34 had felt assaulted and wanted to press charges.

Upon interview on 5/12/14, at 9:24 a.m. the administrator stated the incident on 5/5/14, had been reported to the state agency and that he would provide documentation regarding the report made.

R34 was interviewed on 5/12/14, at 1:31 p.m., R34 stated R36 was abusive to her every day but that she'd heard he had gotten sent to another nursing home. R34 stated she felt what R36 was doing to her was both verbal and physical abuse.

When interviewed on 5/12/14, at 1:52 p.m. the administrator and consultant administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 223}	Continued From page 17	{F 223}		

reported R34 and R36 have had an ongoing fight going on. The administrator stated R34 and R36 allege physical things and then change their stories. The consultant administrator stated that although the police had been called regarding the incident on 5/5/14, R36 had denied it happened and R34 had no visible injuries noted. The administrator stated when allegations of abuse are made, an incident report was to be filled out and a supervisor consulted to determine whether a report was needed. The administrator said the residents would be separated, an assessment would be made, the incident would be reported to the Common Entry Point (CEP) if appropriate, would be presented at their stand-up meeting the next day, and an investigation would be started. The administrator stated incidents were reported to the administrator, DON or CLSW but verified, "that system has not always been working." The administrator stated the incident form 5/5/14, had not been reported to the State Agency (SA) or to the CEP and acknowledged things needed to be reported right away and then investigated.

Minneapolis Police Department officer (MPD)-E was interviewed on 5/12/14, at 3:38 p.m. and confirmed the police department had come to the facility regarding the incident between R34 and R36 on 5/5/14. MPD-E stated the facility was aware the residents called each other names and stated it was a facility problem.

The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated May 2012, indicated staff must not permit "anyone" to engage in verbal or physical abuse. The policy indicated the facility would implement policies and procedures to ensure that residents are not subjected to abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 223}	Continued From page 18 by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. The definition of verbal abuse was described in the policy as, "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." The policy indicated the facility would protect residents from harm during the investigation and would "report allegations to the state survey and certification agency and any other state agencies pursuant to state regulations."	{F 223}		
{F 224} SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to neglect of supervision for residents was identified during the revisit survey on 5/12/14. The immediate jeopardy began on 5/10/14, and was removed on 5/21/14. However, noncompliance remained at the lower severity level of G, isolated actual harm that is not immediate jeopardy (IJ). Based on observation, interview and document review, the facility neglected to provide adequate	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 19	{F 224}		

supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. The IJ was not removed by exit of the 5/13/14 survey.

Findings include:

The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety.

On 5/9/14, the facility had been informed of serious and immediate safety of the residents related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present.

R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. According to documented progress notes, R37 had been found with ETOH/vodka on 2/21/14, 2/22/14, 2/27/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 20 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14 and 5/10/14. The record also indicated R37 had required hospitalizations related to the use of alcohol and or drugs on 2/22/14, 4/23/14, and 5/10/14. During observations of R37 the following was observed: -On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility. - On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was "crazy". - On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and speak to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left rear pant pocket. - On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two. - On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused. - On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 21	{F 224}		

good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. Nursing assistant (NA)-L approached R37 and stated she was with him today. NA-L verified she was assigned to provide the 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken out of the facility to an ambulance.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, R37 removed the WanderGuard (departure alert system) and refused a new one to be placed.
- On 5/3/14, R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 22	{F 224}		

appearance. R37 was noted to have continually gone outside, stated he had called a limousine and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a notation had been made indicating it was a late entry for 5/5/14, at 6:00 p.m., the note indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 23	{F 224}		

appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on one to one (1:1) [to be within arm's length at all times] observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from leave of absence (LOA) accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's Orders and Nurse Practitioners (NP) Orders were reviewed and the following was noted:
- On 1/8/14, included a diagnosis of ETOH abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 24 - On 2/28/14, directed to discharge R37 to another facility (that allowed drinking). - On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's ETOH, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14,	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 25 ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain, and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision but was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending Alcoholics Anonymous (AA) or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 26	{F 224}		

R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the WanderGuard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH use, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 27 noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated the resident had received a first offense of the facility's smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 had obtained the ETOH from. The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money for ETOH, and stated he has heard about exchanges but could not remember who he'd heard about it from. The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. The HUC said R37 had told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14, or 5/6/14, she had observed R37 in the parking lot, and had been told there was nothing they could do about it by the facility administrator. She said she'd requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested that the safety monitor put R37 on every 15 minute checks but	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 28	{F 224}		

knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of ETOH withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 had refused to go to the bank with R37 and that friend-A had signed R37 out. The DON said the consultant administrator had been going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 29	{F 224}		

stated during a room search a quart bottle of ETOH and three plastic containers with the labels removed, which nursing indicated were methadone containers, had been found in R37's room.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on LOA and that R37 had returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and stated the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 having left on LOA, she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and that she'd told friend-A that R37 could not go there. CLSW-A said friend-A had reassured her he had been sober for ten years and would never take R37 to a liquor store. The CLSW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and had informed her that friend-A was R1's drug dealer. CLSW-A stated it would have been nice to know the information before she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 30	{F 224}		

allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing did not find the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

R129 was identified by the facility to have a history of drug seeking and ETOH dependency. Although the facility had determined R129 required a 1:1 staff member since at least 3/18/14, according to a Vulnerable Adult (VA) assessment, the appropriate supervision was not implemented and/or effective.

According to review of the progress notes in R129's record, on 5/3/14, R129 had reported to the facility that she had obtained and consumed cocaine. The documentation indicated R129 had a staff assigned as a 1:1 at the time of the incident.
An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 31	{F 224}		

light." The note indicated the nurse asked R129 what she had taken and indicated R129 then "confessed" to having taken cocaine. The report documentation indicated R129 had been sent to the emergency room (ER) and included, "She said, 'I knowingly took cocaine'.. Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1...remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others."

A North Memorial Medical Center (NMMC) Emergency Department (ER/ED) note dated 5/3/14, identified R129 had reported she'd taken cocaine at the nursing home. The ER note indicated R129 had taken the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED." The Clinician History of Present Illness section of the form identified R129 had reported to hospital staff she had snorted cocaine "5 hours ago."
On 5/11/14, at 4:00 a.m. the progress notes indicated R129 had obtained and consumed a life threatening amount of ETOH, causing her to require hospitalization in an intensive care unit (ICU) with subsequent intubation (mechanical ventilator assisted breathing) as a result of a blood ETOH level of 0.323. (According to Minnesota Statute 169A.20, 0.08 is considered impaired for driving). A 1:1 staff was supposed to have been in place at the time of the incident.

The resident's record included a note documented by the facility's HUC on 5/11/14, at 10:09 a.m. which indicated NMMC had called the facility "requesting" R129's medication administration records (MARs). The note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 224}	Continued From page 32	{F 224}		

indicated the registered nurse (RN) from the hospital had notified the HUC that R129 had been admitted to the ICU, and had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of 0.323."

The record also included a note documented by the director of nursing (DON) on 5/11/14, at 10:55 a.m. The DON's note recapitulated R129 had been sent to the hospital, identified the time of transport as "around 4 a.m." on the night shift, and identified R129 had been sent in "for intoxication." The DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the nursing assistant (NA) staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but that she had not noticed any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident [R129] is visiting." In addition, the DON's documentation indicated R14 had denied giving or knowing how R129 had obtained the ETOH, and documented R14 had "mentioned that resident had alcohol overnight."

An additional progress note, dated 5/11/14, at 2:49 p.m. had been written by the DON indicating NMMC had been contacted to request updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 33 the hospital for snorting cocaine." Additional record review revealed an admission MDS dated 2/1/14, that indicated R129 had a BIMS score of 15, indicating R129 was cognitively intact. The MDS identified R129 was independent with all ADLs. The MDS identified R129 rejected cares and wandered one to three days during the assessment period. R129's comprehensive assessment analysis (CAA) for mood state dated 2/7/14, identified R129 as having intact cognition, with poor decision making and as having diagnoses of "substance induced psychotic disorder, opiate dependence, and ETOH dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug ETOH use" and depression. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAA lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment. A Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had behaviors including a history of rummaging through others' belongings and "drug use." The assessment indicated R129 had been placed on 1:1 due to rummaging in other resident rooms. R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 34	{F 224}		

history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and required a "1:1" which was spelled out in large bold print.

On 5/12/14, at 10:26 a.m. DON was interviewed about R129 having obtained ETOH and/or drugs while on a 1:1. The DON verified the 1:1 should have been within arm's length of R129 at all times. The DON denied having any knowledge of how R129 had obtained ETOH.

On 5/13/14, at 2:21 p.m. the administrator stated during interview that the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and ETOH use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 35 On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224}	Continued From page 36 The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed: "If staff have reasonable suspicion that a resident has used, has in their possession, or has distributed to other residents in the facility ETOH, street drugs, or other pharmacological substances not prescribed by treating physician the facility staff, under the direction of administration, shall: · Search the residents room and remove such substances · Notify the physician and obtain an order for blood and urine drug testing · Notify the family and/or responsible party of the event If the tests return positive the resident with the positive results will be immediately discharged for placing the resident population at risk for abuse. If ETOH, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified." The facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 37 policy also included "Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision." Appendix A of the policy included examples of neglect including: "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision) which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety." According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14. On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance." A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 224}	Continued From page 38	{F 224}		

experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 224}	Continued From page 39 outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 224}	Continued From page 40	{F 224}		

was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door.

On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby.

On 5/13/14, at 1:00 p.m. the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 224}	Continued From page 41	{F 224}		

administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door.

The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed. The ombudsman stated she wanted to be sure the state agency surveyors were aware that resident's of the facility were purchasing ETOH and drugs. The ombudsman reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 224}	Continued From page 42 chemical dependency problems had been drinking, room checks were being completed and staff were finding ETOH bottles. In addition the ombudsman reported R37 had been found intoxicated several times and she was involved in discussing abuse prevention planning and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. The ombudsman stated the police had been notified and had been to the facility "quite often". She also stated she was aware R129 was on a 1:1 and had somehow obtained and consumed an "illegal drug [cocaine]" in the facility. On 5/7/14, at 10:05 a.m. the administrator verified during interview that the ombudsman had been called 5/6/14, to speak with the facility regarding R37 having given his credit card to R117 to purchase ETOH because R37 had been "drunk for days." The IJ that began on 5/10/14, was removed on 5/21/14, when the facility had implemented an IJ removal plan that included: The development and/or revision of policies related to obtaining a drug and alcohol free facility and policies related to prevention of elopements. The facility initiated assessments for reisdents who had been identified at risk for drug/alcohol issues and elopements; The facility also developed a system for investigation of ongoing incidents; Staff were educated to their responsibilities for how to supervise, care for and protect residents; Direct care staff and licensed nursing staff were	{F 224}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 224}	Continued From page 43 interviewed and were able to explain their responsibilities for identification of residents who were elopement risk. Administration convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate concerns. However, non-compliance remained at the lower scope and severity (s/s) of a G (isolated harm but not an immediate jeopardy) because two residents had required medical treatment and hospitalization after the facility had been informed of the failures of their systems, however there were no new hospitalizations identified for residents due to illicit drug and/or alcohol use at the time of the revisit on 5/21/14. In addition, although the facility had initiated assessments and policy implementation, they had not completed all assessments for all residents related to elopements at the time of the re-visit on 5/21/14.	{F 224}		
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 44 involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Findings include: R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 225}	Continued From page 45 that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated. R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 46 the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 47	{F 225}		

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into

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{F 225}	Continued From page 48 facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 225}	Continued From page 49 a.m. and 11:52 a.m. R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated. R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 50	{F 225}		

indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk."

The clinical record lacked evidence R13's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 51	{F 225}		

elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 52	{F 225}		

being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified.

On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified.

On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 225}	Continued From page 53 unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."	{F 225}		
{F 226} SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 226}	Continued From page 54 policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their Prohibiliton of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Propery policies for immediate reporting and thorough investigation were implemented for 8 of 9 residents (R37, R66, R70, R14, R41, R13, R129, R116) reviewed with allegations of such; the facility also failed to screen new employees for reference checks, back ground studies and license/certification verification for 6 of 6 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q, NA-W). Findings include: The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 55	{F 226}		

by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency (SA) and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."

R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 56 members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 57	{F 226}		

and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 58 was unclear why it had not been reported to him until then. A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk." The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. On 5/9/14, at 1:43 p.m. LPN-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the form did not identify when the administrator or SA was notified. On 5/12/14, at 10:26 a.m. director of nursing (DON) stated he was not in the facility at the time of R13's elopement and had not been informed until 5/8/14. The DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with a WanderGuard were at risk for elopement and leaving the facility without supervision was a	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 59	{F 226}		

safety concern. The DON also verified the incident had not been thoroughly investigated.

R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated.

R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 60	{F 226}		

problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 61	{F 226}		

being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified.

On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified.

R116 had eloped and the facility did not report to the administrator or SA in a timely manner.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 62 writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 63 Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m. On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 64	{F 226}		

above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

EMPLOYEE SCREENING:
On 5/12/14, at 10:00 a.m. the employee files were reviewed and the following was observed:

Licensure verification:
Licensed practical nurse (LPN)-A's employee file folder lacked verification of the LPN's license. The administrator verified at 12:45 p.m. there had been no proof of nursing licensure obtained for LPN-A from the Minnesota Board of Nursing.

Registered nurse (RN)-C's employee personnel file indicated RN-c had been hired on 4/8/14, and that a back ground study request had been submitted on 4/8/14, however there were no results yet. In addition, no licensure verification completed, only a copy of a license with expiration of 10/4/13.

Background study:
RN-D's file indicated RN-D had been hired 4/16/14, and that a background Study Request had been submitted on 4/14/14. However, the background study incorrectly indicated NA-U's background study information.

Nursing assistant (NA)-U's file was reviewed and was found to include a statement that NA-U had a Minnesota Department of Human Services Background Study (MN DHS BS) form dated 5/25/14, which indicated NA-U "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 65	{F 226}		

administrator verified that NA-U could not provide care but had been providing care unsupervised, from 4/23/14, through 5/12/14.

NA-U had RN-D's BS in NA-U's employee file. Also, RN-D's BS was in NA-U's employee folder. RN-D's BS indicated that RN-D could not perform cares unsupervised. However, during the survey the administrator obtained the blue BS form which indicated RN-D could perform cares unsupervised.

NA-Q was hired on 3/6/14. The facility received a yellow MN DHS BS on 3/10/14, which indicated NA-Q "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The white BS computer genreated copy request indicated the form was submitted on 3/6/14, and passed as of 3/10/14, however the employee file lacked the information as the facility provided the information during survey. The facility did not have system in place to ensure BS were being monitored for the employees ability to work unsupervised.

Reference checks:
RN-C was hired on 4/8/14, and no reference checks had been completed.

RN-D was hired 4/16/14, and no reference checks, could be located in the employee file.

LPN-A's file lacked a hire date and no reference checks were completed as the facility policy had directed staff to complete.

NA-W hired 4/23/14, had no reference check

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 226}	Continued From page 66 completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge of doing license verifications and background checks for new employees. The administrator further stated the HR person had been terminated two weeks ago and no one else had been designated to follow-up on background checks that had been flagged. The administrator acknowledged the facility had not ensured tracking for new employees' license verification and background checks. On 5/13/14, at 8:10 a.m. NA-U verified during interview that she was a NA and had started orientation on 4/23/14. When asked if she worked under supervision, NA-U stated she had received "a couple of days training" and had started working on her own on 4/28/14. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, but stated she had been working full time on her own since 4/16/14.	{F 226}		
{F 250} SS=H	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 observation, interview and document	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 67 review, the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) for alleged substance abuse, and for 2 of 11 residents (R13, R103) who allegedly eloped from the facility. Findings include: Alleged substance abuse: On 5/8/14, at 8:02 a.m. a list of residents allegedly bringing drugs and alcohol (ETOH) into the facility, as well as a list of residents known to use drugs or alcohol in the facility was requested. A list provided by the administrator at 11:00 a.m. included R129, R86, R41, R37, R14, R56, R117, R62 and R9 as alleged substance users. R129 was not provided consistent medically related social services to address ongoing drug seeking behaviors and sustained harm. Although R129 was assigned a one to one (1:1) as of 3/14, the clinical record lacked evidence of social service assessment and interventions. On 5/3/14, R129 reported to facility staff, that she had obtained and consumed cocaine while under 1:1 supervision. On 5/11/14, at 4:00 a.m. R129 had obtained and consumed ETOH while supervised 1:1 by facility staff. This resulted in harm when R129 required hospitalization in an intensive care unit (ICU) where she was intubated (mechanical ventilator assisted breathing) for a blood ETOH level of 0.323.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 68	{F 250}		

R129's admission Minimum Data Set (MDS) dated 2/1/14, revealed a Brief Interview of Mental Status (BIMS--a tool to determine cognitive status) score of 15, indicating the resident was cognitively intact. In addition, it was noted R129 was independent with all activities of daily living (ADLs), rejected cares, and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R129 displayed poor judgment, and had impaired cognition and poor decision making skills. The CAA identified diagnoses including "substance induced psychotic disorder, opiate dependence, and alcohol dependence," as well as hepatitis C, "Hx [history] of drug alcohol use" and depression. Although the history of drug and ETOH dependence was identified, the CAAs lacked documentation of interventions to promote sobriety, such as but not limited to offering chemical dependency (CD) treatment.

The Vulnerable Adult Assessment (VAA) dated 3/18/14, identified R129 had a history of ETOH abuse and "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse related to substance use and required supervision with leaves of absence (LOAs) from the facility. It was noted R129 had a history of rummaging through others belongings and "drug use," and 1:1 staffing was initiated due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, directed staff to "monitor for ETOH use or over sedation."

A Pain Evaluation and Management Plan dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 69	{F 250}		

5/1/14, identified R129 had daily chronic pain, and a history of pain and seeking drugs. "Resident is on a restricted recipient program [where only one pharmacy may fill narcotic prescriptions to deter drug seeking behavior] due to drug seeking...MD [medical doctor] is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." R129 was described as "very sweaty, weak and tired...she looked very sleepy," and pupils were "large and nonreactive to light." When the nurse asked the resident what she'd taken, she "confessed" to taking cocaine. The report noted, "She said, 'I knowingly took cocaine'...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The resident's history of drug use and receipt of drugs from others was noted, as well as the fact that the resident had current 1:1 staffing. Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14.

An Emergency Department Chart [from the hospital ER] dated 5/3/14, identified R129 reported to have taken cocaine while residing at the facility to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "'5 hours ago.'" Although R129 was identified as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 70	{F 250}		

requiring the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use, only pain. The laboratory (lab) reports indicated various pertinent lab values were checked, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of Dilaudid (narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the designated State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug had been obtained while the resident had 1:1 staff supervision.

A unlabeled typed page insert in the front of R129's paper chart dated 4/15/14, read "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program...All scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their on call MD."

On 5/7/14, at 10:24 a.m. the a return call was made to the ombudsman who had requested contact. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she visited the facility on 5/6/14, and spoke with various residents as well as management staff regarding drug, alcohol and discharge planning concerns. The ombudsman, facility staff, and residents were "suspicious

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 71	{F 250}		

residents may be giving money or credit cards to another [resident] to go out and purchase things [cigarettes, alcohol and drugs] for them." The ombudsman stated the police had been notified and responded "quite often." Allegedly residents who were chemically dependent were drinking in their rooms and facility staff were conducting room checks each shift and "finding empty alcohol [vodka] bottles" in resident rooms, and residents had been found "intoxicated." The ombudsman specifically reported R129 had 1:1 staffing, yet had "somehow" obtained and consumed an illegal drug (cocaine). Although the facility had employed "three temporary social workers, social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified the resident was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated 4/11/14, directed staff to provide "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru [sic] their personal belongings."

Review of the undated Group 7 nursing assistant (NA) assignment sheet (for quick reference guide providing care-related direction) indicated R129 was independent with ADLs and "1:1" was noted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 72 in larger bold print. Pertinent Nursing Progress Notes read as follows: 1) On 3/14/14, at 6:18 p.m. R129 "had an appointment yesterday and was immediately transferred to the hospital...while on the way home [unclear on prior destination] stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams (mg) (a narcotic and Tylenol pain medication)...failed to alert staff and stated that there were no new orders." The hospital, on call MD and triage nurse were updated on R129's "history of narcotic use." 2) On 3/16/14, at 6:34 a.m. R129 was "caught going through another resident's belonging...opening her purse." The note indicated R129 admitted going in the room but denied taking "any money." 3) On 3/17/14, at 3:34 p.m. "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the record lacked documentation when the 1:1 staffing was initiated. At 10:17 p.m. "called on call [physician]," reported two incontinent episodes, "lower extremities [sic] hurts" and edema (abnormal build up of fluid in the tissues). Was encouraged to "sit and rest the leg" but refused and reported the pain was "unbearable." R129 wanted to be evaluated at the hospital, and "called 911 herself." Although a previous note indicated R129 required 1:1 staffing, it was noted R129 planned to "take care of her own transportation to ER...left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. 4) On 3/18/14, at 3:56 a.m. R129 returned from the ER at 3:30 a.m. with a "New order. No new concern at this time." At 2:31 a.m. R129 reported	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 73	{F 250}		

to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
5) On 3/20/14, at 10:08 a.m. the physician R129 identified as her new primary care physician (PCP) was contacted to inform the provider R129 lived in a health care facility, and orders needed to be coordinated with the facility. The PCP was provided an update regarding R129 changing her PCP, trips to the ER and drug seeking behavior. The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "Went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (hypnotic used to promote sleep). "Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. Patient will be monitored for increased sedation." Although the previous note indicated the transportation company was directed not to make any stops during transport, R129 had been brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription had been written and a report the script was lost had been reported by R129. The physician denied taking R129 on as a patient, however, and referred the facility to R129's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 74	{F 250}		

current PCP.
6) On 3/28/14, at 11:52 a.m. R129 met with social services and "Also spoke with resident regarding her drug seeking. [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
7) On 4/4/14, at 7:11 p.m. R129 met with psychologist, as well as the DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's...informed her she was on 1:1's because of her frequent drug seeking...admits that she has urges to seek medications to manager her pain...denies addiction." Inpatient treatment was discussed such as drug and emotional counseling, which R129 rejected. The note indicated the psychologist agreed with the need for treatment, "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
8) On 4/7/14, at 10:47 a.m. R129 remained, but requested she be removed from 1:1 supervision, which was noted as required "for going into other resident rooms."
9) On 5/4/14 12:03 a.m. R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [R1's room number]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to the ER for evaluation. "The nurse requested for toxicology screen and a copy should be send [sic] to the nursing home per the administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 75	{F 250}		

order." Although the note indicated R129 obtained cocaine from another resident and identified R129's involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified,and toxicology screening was obtained. Although R129 had an assigned 1:1, the record lacked evidence as to how the resident obtained and ingested the drugs, the incident was not immediately reported to the administrator and SA, nor was it investigated. In addition, the record lacked evidence R129 had received a CD evaluation or were immediate changes made in the monitoring and supervision provided for the resident's safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice...remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.

10) On 5/4/13, at 12:12 p.m. an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they were only accepting on-call emergencies. Staff would notify doctor the morning of 5/5/14. The resident returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, she immediately requested pain medication upon return to the facility (the note was not closed or signed by the writer).

On 5/5/14, during the initial tour of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 76	{F 250}		

NA-K was observed to be sitting in a chair directly outside R129's room. The door was open and R129 was dressed and was lying in bed with her eyes closed. NA-K reported she was assigned as a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

The following day at 8:30 a.m. NA-M (1:1 staff) followed R129 down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length and looking in the opposite direction from R129 and talked with another staff person in the smoking area. R129 stood with other residents and smoked out of direct sight of NA-M. At 8:33 a.m. R129 sat on a bench with another resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same staff person. NA-M was not near enough to R129 to intervene should there have been a concern. At 8:37 a.m. staff spoke to each other and then NA-M turned his back on all smokers (including R129) and spoke to a male who was in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the staff directly. NA-M was not within arm's length or direct eye sight of R129. At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind her into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 77	{F 250}		

hallway. At 9:34 a.m. R129 pushed R62 in her wheelchair out of the facility and onto the smoking patio. R62 held out a cigarette for R129 ask she pushed the chair, and R129 concealed the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. At 9:35 a.m. a staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents who were unsupervised. At 9:37 a.m. R117 came out of the facility, lit a cigarette at the front entrance, jumped up onto the cinder landscape block planter with ease, and walked across the top of the planters with a skipping gait. Neither the smoking monitor nor another female staff in the area intervened. R117 was observed to speak briefly with the female smoking monitor, approached R36, pulled out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter. NA-M was not within arms reach nor eyesight of R129, and was not supervising the resident. NA-M remained with the other female staff, with his back to R129. At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 78	{F 250}		

of the facility. R129 pushed the wheelchair down the hallway with NA-M walking beside R129. At 10:19 a.m. R120 walked out to the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retrieved a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make eye contact with R129 and was not in arms reach as he spoke with the smoking monitor. At 10:25 a.m. NA-M and R129 went inside with NA-M walking within arms reach of the resident.

On 5/8/14, at 11:22 a.m. R129 was observed lying in bed, NA-E was making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, which she had reported to facility staff. When asked when this occurred, R129 stated it was "on Saturday" (5/3/14)." When asked where she snorted the the cocaine, R129 replied, "not in the facility...down the block." When asked if she received the cocaine from another resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember the person's name, description, or gender. R129 said she snorted "about $20 worth." When asked what happened then R129 stated, "They sent me

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 79	{F 250}		

to the hospital...They accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day by the 1:1 assigned to her that day. R129 stated the 1:1's name (NA-G) who was to be with her at all times. She said the reason for the 1:1 was because she was accused of "rummaging" in other residents rooms. R129 reported she had a 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 said she was "a recovering addict," but denied social services had been provided by facility staff, including assistance to obtain CD treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the ER, but was given two shots of Dilaudid. R129 explained she "thought" that was going to happen, yet admitted she was "surprised" to have received the narcotic pain medication. Although R129 was relaxed during the interview, she was hesitant to answer some questions and did not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified the responsibility of the 1:1 staff was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated was unaware of alcohol or drugs were being exchanged on "my shift," but stated was aware of situation "weeks ago" when she came to work and noticed R14 was not in his room. NA stated she asked where he was and a NA "who was [R129's] 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 80 sent to the hospital for "eating something." Stated had not witnessed any exchanges and stated if she had she would have reported it to the nurse. On 5/8/14, at 11:40 a.m. NA-S reported seeing alcohol bottles in residents' rooms and smelled alcohol on a resident and reported it to a nurse, but was unclear when it had occurred. NA-S "heard rumor" of a resident dealing drugs in the facility, and recalled seeing a resident with marijuana in January or February, and "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she overheard residents talk about it. NA-S believed R117 was a drug dealer, as the resident left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was from an "agency" and told her the resident "could have it." On 5/8/14, at 11:55 a.m. housekeeper (H)-A when asked, reported she had seen "empty pint bottles" of vodka in the trash by the front doors. The last time had been, "a few months ago," and she had reported any bottles she found. " H-A was unsure which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew how the bottles had been obtained, she was unsure, but thought they may have been brought in by family members. On 5/8/14, at 12:03 p.m. LPN-H stated she had confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, as well, but it was	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 81 unclear how it was being provided. LPN-H verified R129 was on 1:1 which meant within arms reach. LPN-H was unaware R129 had obtained cocaine in the facility. On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. The HUC stated there was "always hearsay between residents...their selling [drugs and alcohol] to each other...it's always stories," including hearsay stories regarding heroin and cocaine. The HUC had put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program, and R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." R129 "refuses to tell" about the prescriptions, and the HUC went to the social worker to report these concerns. R129 denied having pills, "but I know she did get them...every week" R129 was finding a new doctor, and not providing the correct paperwork, or altering paperwork. The HUC was aware residents consumed alcohol in the facility, and some became intoxicated, however, it was unclear how they had obtained it. "I feel like we're supposed to do something, 'cuz no one will take charge." The HUC was aware R129 obtained cocaine and was sent to the ER, but was unsure if a toxicology screen had been done, although she had asked for them in the past. The HUC said she and other staff believed R129's (making quotation gestures) "son" was R129's dealer, and described him as a man she referred to as her son, who was at the facility at the time the resident snorted the cocaine. Further review of the nursing progress notes also revealed indicated the following:	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 82 1) On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (narcotic pain medication) refills and determined 110 Percocet tablets had been delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information. 2) On 5/11/14, at 10:09 a.m. a note written by the HUC indicated North Memorial Medical Center (NMMC) called "requesting" R129's Medication Administration Records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 had been able to obtain and ingest a life threatening amount of alcohol. Although the administrator was updated, the clinical record lacked evidence the SA was also immediately notified of the incident. The record lacked documentation at the time of the incident, as well as pertinent assessment information such as vital signs and symptom descriptions. In addition, the record lacked evidence of an immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time. 2) On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." R129 had "become weak" and needed to be lowered to the floor." Two LPNs were contacted and the NA staff assigned to the 1:1 was called. The NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 83 exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting...." R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained the alcohol. 3) On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine." 4) On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait." R129 was identified at risk for falling, was verbally aggressive to staff and stated, "'I'm drunk.'" The room was checked and no evidence of alcohol was found. R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m. On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening that was "reducing her hours to once a week." Both verified they had not specifically worked with R129 regarding CD treatment and verified was last offered to R129 on 4/4/14 and had not revisited CD treatment options after R129	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 84 reported cocaine use on 5/3/14. Neither was aware R129 had been hospitalized for alcohol toxicity and said they "should have been notified." CLSW-A and B had not worked the previous few days, as facility had not paid the contracted company's bill. CLSW-B expressed concern for the residents, and said R129 should have been reassessed after she had obtained and used cocaine, and both SWs felt R129 had been harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." R86 was committed as mentally ill and chemically dependent per Hennepin County Commitment papers dated 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. R86 was placed at harm as R86 was hospitalized due to alleged substance abuse. On 3/16/13, R86 was admitted to the facility per the Admission Record. Diagnoses include hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 85	{F 250}		

drunkenness.
A care conference dated 1/2/13 [sic -2014], lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.
A progress note dated 2/22/14, at 11:00 p.m. "Pt was found smoking 'pot' in his room. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."
A progress note dated 2/23/14, at 10:33 a.m., "Resident left with family member in a VAN for unknown destination at this time, hoping to return today. We will follow up with resident safe returned."
A progress note dated 2/23/14, at 10:23 p.m., "Resident returned from visiting with a family. The nurse checked resident. No injury observed."
A progress note dated 2/24/14, at 4:38 a.m., "Resident had been very confused and having difficulty to settled [sic] down in bed. judgment [sic] has been non-intact [sic] and appeared restless with a lot of tremor. He attested to this writer that when he goes LOA he smokes marijuana but never drink alcohol at all. He state [sic] "If I drink I will die". His platelet has been dangerously lower [sic] thus posing him at a risk for bleeding. Update on call doctor about resident change in condition, who then mandate this writer to send resident to the emergency room for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. " The resident was admitted to the hospital.
A progress note dated on 2/24/14, at 3:32 p.m., " Writer called PCP and updated on his current use of marijuana, as well as updating that he is in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 86 hospital." A progress note on 2/27/14, at 3:59 p.m."Nurse from U OF M,updated writer about resident current status, stating that, resident is alert and oriented x 3, appear to be quiet stable, but a little restless" and that R86 will "arrive at 1445 at facility, will pass this info to p.m. nurse." A progress note dated 3/4/14, at 6:11 a.m., "While executing initial nursing rounds this shift, this writer smell [sic] and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staffs [sic] that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinue. He had flexeral [sic- Flexeril (cyclobenzaprine) is a muscle relaxant used to treat skeletal muscle conditions] with some benefit noted. He want [sic] another sleeping pills [sic] at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg [milligrams] of Trazodone [an antidepressant], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment." A progress note dated 3/15/14, at 09:48 a.m., "[R86] having behaviors which are not in line his norms. Behaviors like going into other resident's room and sitting on their bed, coming in the hallway half naked. Patient at time have uncontrolled coughing as well." A progress note dated 3/15/14, at 10:22 a.m., "Resident left the facility this morning around 10:20 am for the Fairview ER [emergency room]. He was escorted by two paramedics and admitted to the hospital." A progress note dated 3/17/14; at 8:21 p.m. R86	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 87 came back from hospital at 3:45 p.m.., "Resident is alert and oriented. A progress note dated 5/10/14 at 10:04 p.m. R86 did not sign out when leaving facility. Writer called resident. Resident states he will be back by 11 p.m.." A progress note on 5/11/14, at 6:30 p.m., "Writer not able to assess and talk to resident in relation to his h/o [sic history of] chemical dependency due to resident being LOA at this time. Writer will approach at a later time." A progress note dated 5/19/14, at 1:37 a.m. indicated: at about 11:00 p.m. " Res noted with increased confusion, coughing constantly, and emesis X 2 [two times]. Cough meds admin per HSO [house standing orders] with no relief. Refused VS [vital signs]. Call placed to on-call MD at 12:10 a.m. Returned call from [MD ' s name] with an order to send resident to UMFH for eval [evaluation]. MPD [Minneapolis Police Department] non-emergency called at 12: 30 a.m. to request for transportation. " A progress note dated 5/21/14, at 5:05 p.m., "Resident readmitted to facility from Fairview Medical Center. LOA safety assessment completed. Resident assessed to be appropriate to leave the facility unsupervised without medications and supervised with medications except narcotics due to history of chemical abuse. MD faxed for LOA orders and clarification of all other admitting orders. Resident is able to make needs known and removed himself from unsafe situations. Able to verbalize steps to take should a situation arise while out in the community. Able to verbalize LOA policy. Risk of drug/alcohol assessment/re-assessment completed. Resident is at risk for drug/alcohol abuse. Has a dx of depression and ETOH abuse. Was recently discharged from the hospital. Has had no room or other significant changes in	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 88	{F 250}		

routine since return to the facility. Medication side effects remain on MAR. Offered and resident refused social service visits, spiritual counseling, in house psych, outside psych, and AA/NA. Bio-psychosocial assessment of drug and alcohol use in the facility completed. Resident denies any drug/alcohol use and reports using only his prescribed medications. Declined all resources offered. Repeatedly said throughout interview, 'If I drink it will kill me.' Smoking assessment completed, resident denies any tobacco use. Risk of elopement/wandering assessment completed. Resident is not at risk for elopement/wandering. Has no history of elopement/wandering. Is alert and oriented x 3. Able to make needs known. Uses call light appropriately. Katherine Leslie, responsible party, called and updated on assessments and residents readmission to facility at 1635. Care plan updated to reflect assessments."
A vulnerable adult assessment dated 3/18/14, noted "past and recent chemical abuse. Fluctuating cognitive deficits related to liver damage, chemical use. Needs supervised LOA due to fluctuating cognition and chemical use."
A smoking assessment dated 3/18/14, indicated "reports of smoking marijuana outside, and recent drug use reported by resident."
A LOA safety assessment dated 3/18/14, indicated "mental illness, fluctuating cognition related to liver disease. Needs supervised LOA due to fluctuating cognition and chemical use. (Lacked mention of committed to the facility related to substance abuse and mental illness."
An annual MDS dated 3/22/14, had a "BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares."
On 4/13/14, a care conference indicated: "long

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 89 term placement waiting for liver transplant. Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past." The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. Per CLSW-B, "tried to build report with him. He had been given 30 day notice for Marijuana in his room, but it was not a proper notice and he had not been given another." R86 planned to stay in the facility until he received a liver transplant. CLSW-A stated, "I thought people would not be eligible for a liver transplant if they were actively doing drugs." R86's The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. R86 was committed to prevent exposure to alcohol and chemical substances of abuse. The facility lacked coordination of care between departments and lacked review of facilities own progress notes, which verified substance abuse, and failed to provide an environment free of chemical/alcoholic	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 90	{F 250}		

substances, or to transfer R86 to a secured environment where appropriate care could be provided.

R41:
The facility failed to provide supervision to prevent ingestion of alcoholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m., 5/9 at 3:00 p.m., 5/10 at 2:30 p.m., 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m. On 5/11/14, at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 91	{F 250}		

behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 92	{F 250}		

narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 93 because he was depressed. The facility placed a WanderGuard on his w/c. Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as alcoholics anonymous (AA) or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist. The medical record lacked evidence that social service intervention had been put into place since his last MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression was identified at 7 out 15. The Care Area Assessments indicated he would be seeing the house psychologist and R41 had not been seen by the house psychologist. The medical record also lacks any staff intervention for providing information for his drinking such as like AA and referral to any place for help. Therefore, he was still drinking for depression and left the facility unsupervised. R41 remains at harm. The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. #. Participate	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 94	{F 250}		

in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required.
R37's Progress Notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism.

Observations of R37 revealed the following:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the HUC and in a loud voice stated he was crazy.
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 95	{F 250}		

bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 was intoxicated, when he was friendly and chatting.

The Nutritional Status CAAs dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 96 - On 5/3/14, indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas. - On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait. - On 5/5/14, at 10:25 p.m. indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, which indicated it was a late entry for 5/5/14, at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 97 pressure due to alcohol withdrawal and demanded medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated. - On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time. - On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 98	{F 250}		

The Physician's Orders and NP Orders were reviewed and the following was noted:
- On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered.
- On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 mg orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 99	{F 250}		

elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 100 no other unsupervised LOA. - A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37's alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA. The quarterly MDS dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.	{F 250}		

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{F 250}	Continued From page 101 A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been "drunk for days."	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 102	{F 250}		

On 5/8/14, at 11:51 a.m. LPN-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN-B stated she did not know where R37 got alcohol from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:19 p.m. the consultant administrator was approached after several staff reported they had not been informed of the immediate jeopardy (IJ) that was called on 5/9/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 103 at 2:02 p.m. The consultant administrator stated she wanted the administrator to indicate why staff was not informed of the IJ and asked "are we in trouble?" The administrator approached and stated, yesterday when the IJ was called, by the time we were done with a meeting with our boss, the nurse managers had gone for the day. The administrator stated he thought they would come up with a plan and would have an all staff meeting 5/10/14, to inform staff of the IJ. The administrator further stated a meeting was scheduled at 1:45 p.m. and verified staff had not been informed of the IJ. On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes). On 5/12/14, at 8:59 a.m. RN-B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check. The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and friend-A signed R37 out. The consultant administrator was going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 104	{F 250}		

decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. CLSW-A stated during a room search a quart bottle of alcohol had been found in R37's room and three plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A and had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and R37 could not go there. Friend-A reassured her he had been sober for ten years and would never take R37 to a liquor store. The SW-A stated after R37 left, nursing (did not

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 105	{F 250}		

remember who) told her R37 had orders for no LOA and friend-A was R1's drug dealer. She stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping alcohol under the edge of his mattress and she could not understand why nursing did not find the alcohol when they made the bed. R37 remained at harm as he did not receive the requested services to assist him with the self-reported drug/ETOH abuse.

R14 was not provided medically-related social services to address known illegal drug use in the facility as recently as 5/3/14.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knee amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others one to three days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA was all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. The CAAs did not identify any history of drug use.

R14's Vulnerable Adult care plan dated as revised on 4/26/14, defied R14 had a "History of chemical abuse, including marijuana and heroin. The care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 106	{F 250}		

plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility.

A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a NA reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician was notified and R14 was sent to the ER for evaluation.

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified R14 had the lab for "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, but not limited to: immediate notification of the administrator and SA, thorough investigation of the incident to determine potential source(s) R14 may obtained the illegal drug from, notification of law enforcement, follow up assessment of R14's safety, evaluation of R14's access to leave the facility, such as to smoke; documentation of how they would prevent potential future instances of

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 107 R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically-related social services. On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "epileptic." R14 denied awareness of illegal drug and alcohol activity in the facility. When asked what R14 would do if she observed illegal drug or alcohol activity in the facility, R14 stated he would "tell the resident not to do it," but would not notify staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, verified had not read the plan of correction and did not know what the plan was. DON verified he was not aware of changes made and reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. Stated he read the survey results from 2013 and stated he was not given an accurate picture of the facility problems. Verified there was no system for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 108 CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R56 had conflicting advanced directives dated 4/21/14 and 4/26/14, in her record. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband. A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of intravenous (IV)/intramuscularly (IM) antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56. The annual MDS dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact). Review of the facility care plan dated 4/23/14,	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 109 indicated R56 was DNR/do not intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Physician's Order dated 4/18/14, directed ok for hospice to evaluate and treat and ok for in-house psych to see. A nurse practitioner progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56 about her POLST. R56 reported to CLSW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. CLSW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares. On 5/13/14, at 8:41 a.m. a review of the Physician's Orders signed 4/9/14 continued to	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 110 direct "Full Code." On 5/7/14, at 9:31 a.m. RN-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. LPN-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. CLSW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care. On 5/7/14, at 12:14 p.m. the HUC verified the facility did not have a hospice care plan for R56.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 111 On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. NA-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14 with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14 and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. CLSW-B stated she had followed up with hospice and the intent is for R56 to be DNR and CLSW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the Physician's Orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 112 each resident." A hospice policy was requested and was not provided. R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents. R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression. The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility. R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.	{F 250}		

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{F 250}	Continued From page 113	{F 250}		

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called."

The progress notes were reviewed and noted:
- On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator."
- On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility."
- On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to

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{F 250}	Continued From page 114 fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware." - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours." - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident."	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 115 - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding." - On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning." - On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives,	{F 250}		

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{F 250}	Continued From page 116 multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks." - On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen." - On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated. - On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer	{F 250}		

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{F 250}	Continued From page 117 and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 250}	Continued From page 118 - On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a DM did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket. - On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 119	{F 250}		

charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).
- On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on."
- On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility."
- On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
- On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
- On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 120	{F 250}		

residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic."
- On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office."
- On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital."
- On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 121 have been called to back up EMS, since he is not cooperating." - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and CHF condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 122	{F 250}		

appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" resident stated "yes." Police and EMT then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 123 was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time." - On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified." - On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information." - On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 124 MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present." - On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road. - On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called." On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed. When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 125	{F 250}		

facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

R62 had documented drug use on the facility grounds without any social service interventions developed to address substance abuse.

R62 was admitted on 8/31/13, with diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 126 address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the most recent Social Services Quarterly review dated 2/25/14, indicated no changes to the LOA Safety, Vulnerable Adult and Smoking Assessment. Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes. Review of R62's Progress Notes revealed the following: -On 1/24/14, at 5:03 p.m. indicated "a resident approached writer alerting us that another resident is sitting out front smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 127 denied having any." - On 1/24/14, at 5:17 p.m. indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor." During an interview on 5/13/14, at 10:18 a.m. the DM stated, "I did what the 1/24/14, progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were un-aware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14, identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month." CLSW-B stated she has been at the facility since 3/19/14, a day after the Vulnerable Adult Assessment had been completed. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 verified she was smoking 'weed' and told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume that administrator would take care of it because she was there." RN-B verified the care plan was not	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 128 updated and that she "didn't think" R62 was offered chemical dependency assistance. No social service interventions had been developed for R62 for assistance for services associated with substance abuse even though it had been identified and verified by the facility. R9 had been identified as "Known pot smoker" but was not provided medically-related social services to address known illegal drug use at the facility. On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke. -At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area. At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 129 -At 10:19 a.m. R9 returned back to the building. R9's significant MDS dated 3/24/14, identified R9's diagnoses included Schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease (COPD). The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with ADL's. The nutritional status CAA dated 3/25/14, had identified R9 had history of tobacco abuse. R9's Vulnerable Adult care plan revised 10/20/11, identified R9 was a vulnerable adult related to cognitive limitations and physical limitations. The care plan goal indicated R9 would "remain safe within Camden Care Center at all times." The care plan identified R9 required supervision for LOA's from the facility. The care plan lacked to indicate R9 was a "Known pot smoker" A Vulnerable Adult assessment dated 3/18/14, indicated R9 had history of aggression to others, had mental illness/poor judgment, had no history of chemical abuse and "Cannot leave the facility unsupervised." The assessment did not indicate R9 was a "Known pot smoker." When asked on 5/13/14, at 8:36 a.m. regarding smoking "Pot" R9 stated "It's a deem lie that am using any pot" and kept repeating same statement to the surveyor. Social Service Notes were reviewed which revealed: -Social Service Note dated 4/23/14, indicated R9 had gone to social worker (SW) requesting to get her tobacco materials that had been taken from her roommate side back and had indicated they were hers. SW's reported to R9 the materials	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 130 taken from the room were not on her side of the room and was informed her family was encouraged to come and get the plastic bag of smoking things as well as the cigarette roller "since her roommate would no longer be able to do this for her." Note indicated social service would follow as deemed necessary. -Social service Note dated 4/30/14, per request of director of maintenance both social workers accompanied him to R9's room. Neither R9 nor her roommate was in the room. "Per regulations, the bottle of "Shout" was removed from the room." R9 was outside the room and the director of maintenance had reported to R9 the bottle of "Shout" was taken. R9 was upset and turned her w/c away from staff and the bottle of "Shout" along with R9's raw tobacco & other materials (for the tobacco to be rolled) were placed in the Administrators office so it was more convenient for the family to pick up when they visit. Note indicated social service would follow as deemed necessary. When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 131	{F 250}		

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Elopements:
R13 eloped from the facility on 5/6/14, after staff allowed the resident to transport to and from the designated smoking area without staff. R13 was not provided with medically-related social services to address her elopement risk and smoking.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 132	{F 250}		

smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly 30+ miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 133	{F 250}		

immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, R13 was identified to require supervised LOAs only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a wanderguard [sic-departure alert system] to alert staff if she attempts to leave the building. She also has a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 134	{F 250}		

history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs.

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard [sic] in place." An

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 135	{F 250}		

intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 136 desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and dietary manager (DM) were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or State agency (SA) would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 137 administrator or SA. RN-C was unclear if this occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview. On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement. RN-C provided a copy of a corresponding nursing progress note dated 5/8/14 On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident. R103 was admitted to the facility on 7/29/13, per the Admission Record with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident. A progress note on 1/5/14, at 5:30 a.m. "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility."	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 138	{F 250}		

An MDS quarterly assessment dated 1/31/14, indicated R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

Physician's Orders dated 4/16/14, indicated R103 may have a LOA unsupervised with medications.

A progress Note dated 4/20/14, at 9:48 p.m. read, "Pt went on LOA." The chart lacked documentation of return to the facility. The medical record was reviewed on 5/11/14, and lacked documentation of LOA or discharge. The facility could not locate the Patient Sign In/Sign Out log sheet for that date.

On 5/10/14, at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA.

On 5/11/14, at 10:00 a.m. facility staff were asked whether the resident had been discharged, was on LOA, or had returned to the facility. The HUC checked to see and resident was in room. He had signed out on the Resident Sign Out sheet on 5/10/14, and R103 had signed in on the Resident Sign Out sheet on 5//11/14, at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility.

On 5/11/14, at 10:10 a.m. RN-A was interviewed and was unaware R103 had left the building for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 139 ten and a half hours. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had any documented notes for R103, but knew he had been working with a relocation worker. They verified R103 had not received any social service interventions for planning for discharge. The Videll Healthcare Limited Liability Company (LLC) Elopement policy dated as effective 5/2012, identified, "Videll Healthcare LLC facilities shall provide a safe environment for resident who are assessed at risk for elopement." The policy defined elopement as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure directed if exit seeking behavior was identified to immediately implement interventions to "manage exit seeking behaviors" such as applying "personal security devices such as WanderGuard..." The procedure to directed staff to complete a "thorough" investigation of the event, document a factual account of the occurrence in the medical record and to update/complete an elopement risk evaluation. Although the policy included pertinent direction for searching if a resident eloped, the policy did not address risks such as smoking and access to the designated smoking area.	{F 250}		
{F 274} SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 274}	Continued From page 140	{F 274}		

resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 residents (R56, R116) who had sustained a decline in functional status; and for 1 of 3 residents (R103) who had experienced a significant improvement in activities of daily living (ADLs).

Findings include:

R56's record was reviewed. A SCSA minimum data set (MDS) assessment was initiated with an assessment reference date (ARD) of 4/26/14, and when reviewed on 5/7/14, at 9:00 a.m. the MDS was noted as in progress with an expected completion date of 5/12/14, twenty-two days after the change in status had been identified.

When interviewed on 5/7/14, at 10:40 a.m. registered nurse (RN)-C stated the SCSA MDS was scheduled to be completed on 5/12/14, and the care plan would be completed seven days later on 5/19/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 274}	Continued From page 141 When interviewed on 5/13/14, at 9:53 a.m. RN-C stated she had never done MDSs before and had only received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS policy was requested and was not received. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The admission MDS dated 1/26/14, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which showed no cognitive deficit, and a Patient Health Questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. According to the admission MDS, R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. On 4/15/14, at 10:49 p.m. a nursing Progress Note indicated, "Pt is declining. He is very weak and needs a lot of assistance." The quarterly MDS dated 4/24/14, depicted R116 as needing assist of one person for bed mobility, ambulation in and out of room, dressing toilet use and hygiene. R116 had also deteriorated and required supervision for eating and transfers.	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 274}	Continued From page 142 On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that "a significant change MDS should have been done when it had been determined his condition declined in two areas of functional status." Although the resident had declined in bed mobility, transfers, toileting, dressing, ambulation and personal hygiene, no significant change MDS had been conducted. The quarterly MDS (ready to export, but not exported) did show the extensive assist that R116 now required but interim MDS coordinator verified "it should have been a significant change MDS." R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident. The progress note dated 1/5/14, at 5:30 a.m. indicated R103 was oriented X 3, able to communicate needs and wants. In addition, the notes indicated R103 was independent with movement and bed mobility, and currently utilized a Foley catheter. An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter was in use. R103 was assessed as independent in all functional activities of daily living. Although R103 had improved in more than two	{F 274}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 274}	Continued From page 143 functional areas, no significant change MDS had been completed as a result of the improved status. According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident 's condition is not expected to return to baseline within two weeks."	{F 274}		
{F 275} SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 3 residents (R36) who required an annual comprehensive assessment. Findings include: The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12. On 5/13/14, at 9:52 a.m. the electronic record (Point Click Care) was reviewed and revealed R36 had an admission Minimum Data Set (MDS)	{F 275}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 275}	Continued From page 144 completed on 5/29/13. The Quarterly MDS's were completed on 8/29/13, 11/21/13, and 2/18/14. A fourth quarterly MDS had been initiated with an assessment reference date of 5/14/14. An annual comprehensive MDS was not initiated as required. When interviewed on 5/13/14, at 9:53 a.m. registered nurse (RN)-C verified she had initiated a quarterly MDS instead of the required annual MDS and confirmed that an annual MDS should have been implemented. RN-C stated she had never done MDSs before and received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS scheduling and completion policy was requested and was not received.	{F 275}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 145 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter use for 1 of 3 residents (R36); for 1 of 1 resident (R116) who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who had substance abuse issues. Findings include: Review of R36 ' s quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 did not have a Foley catheter in use. Review of the care plan for R36 dated 3/18/14, identified a focus topic; " alteration in elimination". The care plan further indicated R36 had a temporary indwelling Foley catheter in place due to diuretic use. Interventions listed; change R36 catheter as needed per Physician ' s Orders and to irrigate the catheter as needed. When interviewing R36 on 5/7/14, at 7:41 a.m. he stated he did not have a catheter and used the toilet independently. During interview on 5/7/14, at 1:45 p.m. with registered nurse (RN)-A, she confirmed R36 did not have an indwelling Foley catheter.	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 146 During interview on 5/13/14, at 11:41 a.m. with RN-B, she indicated R36 previously had an indwelling Foley catheter but no longer used one. RN-B confirmed the care plan should have been updated to reflect R36's current status. A care plan policy was requested and was not provided. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. R116 was receiving hospice care since 1/21/14, the resident was independent in self-cares, transfers, and mobility. The admission MDS dated 1/26/14, identified a brief interview for mental status (BIMS) score of 15/15, which showed no cognitive deficit, and a patient health questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. The MDS further indicated R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. Review of the quarterly MDS dated 4/24/14, indicated R116 as requiring 1assistance with bed mobility, ambulation in and out of room, dressing, toileting and hygiene. The MDS further indicated R116 required supervision for eating and	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 147 transfers. Review of the progress notes for R116 on 4/15/14, at 10:49 p.m. indicated R116 condition was declining and requiring more assistance with ADL's. Review of R116 ' s care plan with a revision date of 5/2/14, indicated, "Cognition intact and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis." The care plan had not been revised to depict the changes in ADLs. On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that R116 care plan was not current to reflect R116 decline in health status that required assistance with ADL's updated with the needed assistance with ADLs. R62 was admitted to the facility on 8/31/13, with diagnoses that included; memory loss, dementia and cerebrovascular accident (CVA) per the Admission Record. Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, verified that she had smoked marijuana, denied having more marijuana and verbalized understanding regarding discharge if she continued this behavior. Review of the most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the residents health status Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 as having "past/recent substance abuse" and a history of risky behaviors	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 148 and being in an abusive relationship. R62 required supervised LOA (leave of absence) except for appointments with scheduled transport. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, R62 denied she was smoking marijuana Review of R62's care plan with a revision date of 4/26/14, identified R62 having a history of being in an abusive relationship, and as having impaired cognitive function/dementia. Interventions included "approach resident in a calm manner, assess and report any change in mood/behavior and provide the resident with resources as needed. R62 has been assessed and may not leave the facility without supervision." The care plan had never been revised to include R62's known alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment dated 3/18/14, and documented in the nursing progress notes on 1/24/14. During an interview with the facility contracted licensed social worker (CLSW)-A and CLSW-B confirmed the plan of care had not been revised to reflect R62's substance abuse.	{F 280}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 149 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed and target behaviors were monitored for the use of Zyprexa (olanzapine-an antipsychotic medication) for 1 of 1 resident (R89), and failed to ensure smoking interventions were followed in accordance with the care plan for 4 of 4 residents who smoked (R36, R1, R9, R22), and failed to ensure the care plan was followed for 1 of 3 residents (R9) who required dental services. Findings include: R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 as having a physician order for Zyprexa (an antidepressant) related to "potential injury to self or others, dementia, agitation and pick [sic] disease." The care plan directed the staff to administer the medication as ordered, monitor/document for side effects and effectiveness of the medication. The care plan further directed the staff to "discuss with MD [physician], family regarding ongoing use of the medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of target behaviors such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.	{F 282}		

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{F 282}	Continued From page 150 Review of the clinical record indicated R89 was not monitored for target behaviors. Review of the Consultant Pharmacist Recommendations dated 4/17/14, identified olanzapine (Zyprexa) 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist (CP) review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. Observations of R36 on 5/6/14, at 11:32 a.m. the resident was observed retrieving a cigarette from the inside of his coat and lit it with a lighter from his right pocket. The smoking monitor personal was directed away from the resident and approximately 20 feet away. Observations of R36 on 5/7/14, at 7:07 a.m. the resident was observed smoking a cigarette without a smoking apron on. The smoking monitor personal was approximately ten feet away from the resident. Observations of R36 on 5/7/14, at 7:41 a.m. the resident was observed to have multiple burn holes in his gloves.	{F 282}		

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{F 282}	Continued From page 151 Observation of R36 on 5/7/14, at 8:18 a.m. the resident obtained a cigarette from inside his coat and a lighter from his right pocket and lit the cigarette. R36 did not have a smoking apron on. The smoking monitor personal did not offer R36 a smoking apron. Observations of R36 on 5/7/14, at 9:21 a.m. the resident was observed smoking without a smoking apron on and the smoking monitor personal was approximately 20 feet from R36 and was focused on the street and not the resident. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed in his room with a pack of eight cigarettes in his shirt. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed smoking without a smoking apron. The smoking monitor personal was approximately 15 feet from R36. Observations of R36 on 5/7/14, at 3:15 p.m. the resident was observed smoking without a smoking apron and the smoking monitor personal was not within arm's reach. Observations of R36 on 5/8/14, at 9:29 a.m. the resident was observed smoking a cigarette; the smoking monitor personal offered a smoking apron to R36 but the resident refused. The staff did not encourage the resident to wear. Observations of R36 on 5/8/14, at 2:08 p.m. the resident was observed smoking without a smoking apron on. The smoking monitor personal was approximately 15 feet away and was looking in the opposite direction.	{F 282}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 152 Observations of R36 on 5/9/14, at 7:15 a.m. the resident was approached by facility staff to wear a smoking apron. R36 stated he wouldn't wear one after what happened yesterday. R36 stated when staff put a "bib" on R34, R34 took it off and threw it on the ground. R36 stated if she (R34) did not have to wear one, he did not either. R36 wheeled to the smoking patio and smoked a cigarette without an apron on. Observations of R36 on 5/12/14, at 11:38 a.m. the resident wheeled by the smoking monitor personal and lit a cigarette and smoked without an apron on. The smoking monitor personal did not offer R36 a smoking apron. Review of R36 ' s care plan dated 6/14/13, identified R36 as having impaired cognitive function/dementia, alteration in decision making, and/or impaired thought processes. The care plan further indicated R36 required supervision when smoking, and that the resident was to smoke only in designated areas utilizing adaptive equipment apron for safety. An undated list of facility smokers indicated R36 was a supervised smoker and indicated staff keeps smoking material with directions to wear a smoking apron and stay within arm's reach. When interviewed on 5/7/14, at 7:33 a.m. nursing assistant (NA)-B stated she offers to lock the cigarettes in the facility locked box for residents who are unsafe to keep them on their person. NA-B stated if a resident refuses to follow the smoking rules, such as refusing to turn in their smoking materials, refusing to wear aprons, or smoking in non-smoking areas, she makes a	{F 282}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 153 note in the smoking monitor log. R1 was observed on 5/5/14, and consecutive days 5/6/14, 5/7/14 and 5/8/14, smoking without wearing an apron, keeping her smoking material's on her and not smoking in the facility designated areas. When interviewed on 5/8/14, at 10:03 a.m. NA-E stated R1 had a pack of cigarettes and a lighter when she got off the transportation van. NA-E stated "She is very stubborn". When interviewed on 5/8/14, at 11:32 a.m. R1 indicated she had left to the appointment with five cigarettes and her lighter because it was going to be a long time without smoking and when she returned to the facility she had handed the cigarettes back to the smoking monitor. Review of R1's smoking evaluation dated 3/17/14, identified R1 as having a history of unsafe smoking practices when heavily medicated and or tired and falls asleep while smoking. R1 cannot safely utilize lighter/matches and cannot safely handle lit smoking materials and was a supervised smoker. The smoking care plan dated 3/12/14, identified R1 was a smoker. The goals were "Will follow all guidelines regarding smoking at Camden Care Center and will remain safe while smoking." The care plan directed R1 will smoke only in designated smoking areas, was a supervised smoker and had refused Cigarettes and lighter to be kept at nursing station for safety. When interviewed on 5/9/14, at 1:59 p.m. the director of nursing (DON) stated R1 had been educated about leaving her smoking materials in	{F 282}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 154	{F 282}		

the cart and had been asked to take the cigarettes one at a time. The DON confirmed the plan of care had not been followed.

On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to a covered ash tray. During observation NA-B noticed R9 smoking and covered her with a smoking apron at that time.

Observation at 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.

On 5/6/14, at 2:45 p.m. when interviewing R9, surveyor observed a cigarette box in each of her socks. When R9 was asked why she was storing the cigarettes in her socks she stated "You can leave now, go now".

The smoking care plan dated 10/20/11, identified R9 as a smoker. Goal "R9 will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker.

When interviewed on 5/6/14, at 3:06 p.m. the DON verified R9 was a supervised smoker which meant she should relinquish her cigarette and lighter. DON stated R9 should not have had any

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 155 tobacco products on her person, but did not have to wear an apron. . When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified R9 did not have cigarettes in the facility locked box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box. Observation on 5/6/14 at 8:05 a.m., staff was observed assisting R22 to the smoking area, applied a smoking apron and placed a blanket around his shoulders. Staff remained near but not within an arms-length as R22 held a handful of Kleenex while smoking. Observation on 5/7/14, at 9:27 a.m. R22 was observed outside in the designated smoking area sitting in his w/c next to the building pillar. R22 was holding a cigarette on the right hand and the other hand holding a the self-extinguishing ash tray. R22 was not wearing a smoking apron and had a blanket across his lap. R22 dropped his cigarette on to his shirt/blanket, was able to pick it up himself. The smoke monitor personal was not at arms-length and did not observe this happen. NA-B was standing approximately six feet away from the resident. At 9:31 a.m. R22 continued to smoke with no smoking apron, he dropped his cigarette for the second time on to his lap and was able to pick it up himself. NA-B was observed standing by the smoking cart approximately 5 feet away from the resident and was not at arms-length to quickly assist the resident. Review of R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "(R22)	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 156	{F 282}		

will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was wear smoking apron while smoking. Staff to intervene is resident displays unsafe smoking behaviors or refuses safety interventions, and R22 was a supervised smoker.

Review of R22's Smoking Evaluation dated 4/22/14, indicated R22 had a history of smoking in inappropriate places, burn holes in his clothing , was a supervised smoker and smoking materials were secured by staff.

When interviewed on 5/7/14, at 9:33 a.m. NA-B stated she had not witnessed R22 drop his cigarette at 9:27 a.m. and again at 9:31 a.m. even though she was standing near the smoking cart and designated to monitor resident during smoking.

When interviewed on 5/9/14, at 1:59 p.m. the DON confirmed the plan of care had not been implemented related to R22 smoking privileges and safety.

Review of the annual Minimum Data Set (MDS) dated 10/11/13, did not identify R9 dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene.

R9's care plan reviewed 4/9/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 157 Dental for their dental needs." R9 had diagnoses which included Schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and 12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful." On 5/6/14, at 2:45 p.m. R9 was observed to have missing teeth during an interview in her room. On 5/7/14, at 3:28 p.m. LPN-A was interviewed and stated "I went thru the progress notes and I don't see anything that addresses the dental exam. " During an interview on 5/7/14, at 3:30 p.m. household unit coordinator (HUC) stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this."	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 158	{F 309}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Findings include:

R56's annual Minimum Data Set (MDS) dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact).

A physician's order dated 4/18/14, gave approval for hospice to evaluate and treat and for in-house psychiatry services to be provided.

A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband.

Review of the facility care plan dated 4/23/14, indicated R56 was DNR/Do Not Intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice.

A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of IV/IM antibiotic treatment and IV fluid administration. The POLST dated 4/26/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 159 was signed by R56. A nurse practitioner (NP) progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Note dated 5/12/14, indicated contracted licensed social worker (CLSW)-B spoke with R56 about her POLST. R56 reported to SW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. SW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares. On 5/13/14, at 8:41 a.m. a review of the physician's orders signed 4/9/14, continued to direct "Full Code."	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 160 On 5/7/14, at 9:31 a.m. registered nurse (RN)-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. licensed practical nurse (LPN)-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, at 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. SW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care. On 5/7/14, at 12:14 p.m. the health unit coordinator (HUC) verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 309}	Continued From page 161 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. nursing assistant (NA)-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14, with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14, and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. SW-B stated she had followed up with hospice and the intent is for R56 to be DNR and SW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the physician's orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. On 5/13/14, at 1:50 p.m. RN-B provided a copy of the POLST signed by the hospice physician and stated the NP was aware of the code status	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 309}	Continued From page 162 because she had given orders for hospice. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided.	{F 309}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers at the time of admission to the facility. Findings include: R123's Hospital Nursing Progress Note dated 4/11/14, indicated R123 had three pressure ulcers which were connected to continuous wound vacuum (vac) suction and the dressings were intact. The pressure ulcers locations and stages were not identified.	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 314}	Continued From page 163 R123 was admitted to the facility on 4/18/14, and deceased on 4/21/14. R123's diagnoses included: spastic paralysis due to multiple sclerosis (MS), pressure ulcers, physical deconditioning, generalized weakness, abnormal pain, diabetes, cerebral palsy, and weakness of both legs obtained from the Discharge Orders and Plan dated 4/18/14. Admission Nursing Assessment dated 4/18/14, indicated a full skin assessment had been completed and a right hip pressure ulcer area with measurements 6.5 centimeters (cm) length (L) x 3 cm width (W) x 2.2 cm depth (D) and 2.5 cm tunnel at 6 o'clock position, right buttock with measurements 4.6 cm (L) x 2.0 cm (W) X 0.0 cm (D) cm and right heel area measured 1.2 cm (L) x 1.0 cm (W) x 2.0 cm (D) had all been identified. The form did not indicate if the areas were pressure related nor were the areas staged. Progress Notes dated 4/18/14, indicated a full skin assessment had been completed with measurements as noted on the Admission Nursing Assessment dated 4/18/14. On the right hip area a wet to dry dressing had been removed and wound bed consisted of moist yellow, pink, red tissue with moderate amount of yellow, red odorless drainage were observed and the surrounding wound tissue had no redness, warmth, or tenderness noted and wound vac dressing had been applied. On the right buttock foam dressing had been removed from with wound bed consisting of dry pink and red tissue, no drainage, no redness, warmth, or tenderness noted to the tissue surrounding the wound and non-adherent dressing applied. On right heel foam dressing had been removed ulcer observed with wound bed consisting of moist red and	{F 314}		

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{F 314}	Continued From page 164 yellow tissue with scabbing, large amount of odorless drainage noted, no redness or warmth noted to the tissue surrounding the wound and non-adherent dressing was applied. The Progress Note did not also indicate if the areas neither were pressure related nor were the areas staged. A Physician's Order dated 4/18/14, directed staff to "Apply non-adherent dressings to right ischial tuberosity wound and right heel until needed supplies are received." The facility Initial/Temporary Care Plan dated 4/18/14, identified R123 had pressure areas marked and indicated with wound vac. However, the medical record lacked evidence of any other interventions being put into place to prevent and/or minimize potential further skin breakdown such as turning and repositioning, wound care, and pressure relieving mattress. During document review it was revealed a Braden Scale-For Predicting Pressure Sore Risk dated 4/21/14, indicated R123 had a score of 11 which indicated R123 was at high risk and the Comprehensive Evaluation of Skin Risk Factors dated 4/21/14, identified the risk factors but lacked immediate interventions to minimize further potential skin breakdown. R123's admission Minimum Data Set (MDS) dated 4/21/14, indicated R123 required limited to extensive assist of one to two with activities of daily living (ADL's) including bed mobility and transfers; had impairment on one side on the lower extremity with limited range of motion (ROM) and had one Stage 1 (a Stage I pressure ulcer is an observable pressure related alteration	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 165 of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching) and two Stage 2 pressure ulcers (a Stage 2 is partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS noted R123 was not on a turning and repositioning schedule and did not have wound care treatments that were completed in the last seven days. When interviewed on 5/12/14, at 9:58 a.m. registered nurse (RN)-C MDS coordinator verified the temporary care plan had been developed but there without interventions to minimize further potential skin breakdown. RN-C further indicated "I believe there should have been more interventions listed than just the wound vac as resident had already pressure ulcers." On 5/13/14, director of nursing was unavailable for interview. The facility policy entitled Skin Integrity Management, dated 5/12, directed director of nursing services (DNS) or designee and the interdisciplinary team (IDT) were responsible to ensure the development and implementation of a comprehensive plan of care including prevention and wound treatments as indicated. The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin issues, maintain function and improve quality of life.	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 319} {F 319} SS=D	Continued From page 166 483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate treatment/services were offered for 1 of 1 newly admitted resident (R41) who had expressed difficulty with adjustment related to chemical dependency. Findings include: R41 was admitted to the facility on 2/4/14, according to the Admission Record from another long term care facility. The Admission Record indicated R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was	{F 319} {F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 319}	Continued From page 167 dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist. A LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff. A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were	{F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 319}	Continued From page 168 scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 had become intoxicated while off the facility property on a LOA. Upon his return to the facility, R41 had driven his electric w/c off the curb of the driveway to the facility. R41 had been found lying on the pavement on his right side and his speech was slurred, but R41 remained alert and oriented. The notes indicated, "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, documentation in the record indicated R41 had been readmitted to the facility from the hospital at 1:43 p.m. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. progress note documentation indicated facility staff had met with the resident to discuss the incident that occurred on 5/1/14, the facility had obtained an order for a supervised LOA. According to the progress note,	{F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 319}	Continued From page 169 R41 had stated he was drinking because he was depressed. The only new intervention was that the facility placed a WanderGuard on R41's wheelchair (w/c). Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk as the facility staff continued to silence the alarm at the front desk and let him out of the facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention to help with adjustment at the facility had been offered, even though staff were aware the resident had depression and had acknowledged he continued to drink related to depression. No referrals had been made to meet the resident's needs such as referral to alcoholics anonymous (AA), or referral to any other counseling services to help or support R41. The medical record lacked evidence that interventions had been developed or initiated since R41's MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression, scoring a 7 out 15 on the depression scale. The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. 3. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required.	{F 319}		
{F 323}	483.25(h) FREE OF ACCIDENT	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323} SS=H	Continued From page 170 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to neglect of supervision for residents was identified during the revisit survey on 5/9/14. The immediate jeopardy began on 5/1/14, and was removed on 5/21/14. However, noncompliance remained at the lower severity level of H, isolated actual harm that that is not immediate jeopardy (IJ). Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in an Immediate Jeopardy (IJ) for these four residents. A second IJ component was identified for 2 of 3 vulnerable residents at risk for elopement (R13, R116), due to the facility's failure to ensure adequate supervision and protection to prevent elopement from the facility. In addition to the resident(s) identified in the IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113) and failed to ensure 3 of 3 residents (R1, R36, R22) who smoked cigarettes did so in a safe manner as determined by their plans of care.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 171	{F 323}		

The IJ began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of the additional IJ concerns related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by exit of the 5/13/14 survey.

Findings include:

The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety.

Alleged substance abuse:
R37's progress notes indicated the resident had required hospitalizations 2/22/14, 4/23/14 and 5/10/14, related to ETOH/drug use. The Admission Record dated 1/14/14, indicated R37 had been admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and a history of alcoholism. Progress note documentation indicated R37 had been found with ETOH/vodka while in the facility on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14.

Observations of R37 revealed the following:
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. This surveyor was unable to see whether R1 took anything from the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 172 wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket. - On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident's wheelchair down the West hallway and was observed outside R9's room. There was no staff with R37 when during the observation. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and the HUC asked him where his partner was. Nursing assistant (NA)-L approached at that time and told the HUC she was the 1:1 for R37 today. - On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. Additional review of R37's record revealed these Progress Notes: - On 11/26/13, the notes indicated chemical dependency (CD) treatment/Alcoholics Anonymous (AA) was discussed. R37 had stated he'd participated in AA services in the past and he'd had success including three years of sobriety before a recent relapse. The note indicated nursing had reported two episodes of ETOH intoxication while in the nursing home since the last visit and R37 had acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no ETOH use with nursing to monitor. The NP indicated there were "clear dependency concerns."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 173 - On 1/8/14, the notes indicated the resident had a history of ETOH abuse which had also occurred since living at the facility. - On 2/21/14, the notes indicated R37 had been drinking vodka and that an empty bottle had been found. The notes also indicated R37 had been observed to be distributing money to staff and residents. When R37 had noticed he had no money to buy vodka, he had gone to the automatic teller machine (ATM) machine to get money. The notes indicated staff were concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. a note had been documented which indicated R37 was handing out his money to "anyone who would listen" and staff had taken $116.00 dollars from him to lock up. - On 2/22/14, at 10:14 p.m. the notes indicated R37 had called 911 to send himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift had taken a bottle of vodka from him. The notes indicated R37 had asked the p.m. shift to return the vodka or pay him $25.00. - On 2/27/14, at 1:13 p.m. the notes indicated R37 wanted to leave on a leave of absence (LOA), was advised he could not go on an unsupervised LOA, but had left the facility. - On 2/27/14, at 10:07 p.m. indicated R37 was "drunk" and had a blood pressure of 147/105. - On 3/2/14, indicated R37 was "drunk" and was noted to have a blood pressure of 176/98 and a pulse of 99. - On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital. - On 4/13/14, the notes indicated R37"seemed intoxicated" and one full bottle of vodka and one quarter full bottle were removed from the room.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 174 - On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37's room. At 12:04 p.m. staff checked R37's room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink ETOH at the facility. R37 was offered a transfer to a facility that allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of ETOH. R37 stated he would like to get help to have ETOH removed from his body. Staff called 911 and police escorted R37 to detox. - On 4/24/14, at 9:30 a.m. the notes indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of ETOH. At 12:01 p.m. on that day, the notes indicated R37 approached staff and "again was clearly intoxicated." The notes indicated the contracted licensed social worker (CLSW)-A and a police officer had entered R37's room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assaultive in any way. A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 had been observed earlier walking into and out of R117's room and "seemed to be like an exchange of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for ETOH consumption. Further the note indicated, "A few hours later" R37 was shouting and appeared "intoxicated" and a 75% emptied bottle of vodka was found in R37's room.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 175 - On 4/25/14, at 9:58 a.m. notes indicated R37 was "clearly inebriated", had slurred speech and could barely wake up. R37 refused to provide the source where he continued to get ETOH. - On 4/25/14, at 3:24 p.m. notes indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and still smelled like he had ETOH on his breath. - On 5/2/14, notes indicated R37 had removed a wander guard and refused a new one to be placed. - On 5/3/14, notes indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. the notes indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of ETOH and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and had said he was going to Las Vegas. - On 5/5/14, at 4:56 p.m. the notes indicated R37 had slurred speech, smelled of ETOH and had a staggering gait. - On 5/5/14, at 10:25 p.m. the notes indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, a note, which indicated it was a late entry for 5/5/14 at 6:00 p.m., indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 had stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 176	{F 323}		

he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.

- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. the progress notes indicated R37 had been placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, notes indicated R37 "was clearly intoxicated" and that an empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48

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{F 323}	Continued From page 177 hour span of time. - On 5/10/14, notes indicated R37 had been observed giving his credit card to R117 on 5/9/14. A second note indicated R37 had returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, the progress notes indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for Methadone. The Physician (MD) and Nurse Practitioner (NP) orders indicated they were aware of R37's alcohol use. Notes included: - On 1/8/14, included a diagnosis of ETOH abuse and a note the resident continued to have problems while living in the facility. - On 2/5/14, indicated R37 had recently been found with a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH. - On 2/28/14, an order directed staff to discharge R37 to another facility (that allowed drinking). - On 3/5/14, an order directed; "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, notes indicated R37 had been hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement. the notes indicated R37 had been treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 178 - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's use of alcohol, to encourage R37 not to use, and that even if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, an order directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, an order directed "no LOA-supervised or other". In addition, the NP included an order for a WanderGuard, and to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and ETOH counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 179 assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs. - The Depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 180 - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had a history of significant ETOH use when out on unsupervised LOA. The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions. Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of ETOH intoxication and ETOH withdrawal noted 9/23/13, and substance abuse noted 2/23/14. A Care Conference Summary dated 4/1/14, indicated a discharge plan of "discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37 had a history of drinking and bringing ETOH in the building or going on unsupervised LOA and R37 had stayed in the building with no ETOH use since 3/3/14. A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait	{F 323}		

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{F 323}	Continued From page 181	{F 323}		

and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing ETOH and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding ETOH bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase ETOH and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 182	{F 323}		

detox. LPN- B stated she did not know where R37 got ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or ETOH and stated he has heard about exchanges but could not remember who he had heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for Delirium tremens (DTs-significant withdrawal symptoms). During interview on 5/12/14, at 8:59 a.m., registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 183 The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy (stated name) a friend of R1" went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware of who R1's friend was. The DON stated the 1:1 had refused to go to the bank with R37 and that the friend of R1 had signed R37 out. The DON stated the consultant administrator was going to go with R37 and R1's friend to the bank until it was decided the facility was not comfortable with her (the consultant administrator) going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA, but stated the administrator, consultant administrator and the social worker had decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from. When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH had been found in R37's room and 3 plastic containers with the labels removed which nursing indicated were methadone containers. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on a LOA, and stated R37 had returned with a card from Walgreens so they knew he hadn't followed his agreement to only go to the bank. The administrator stated the friend of R1 would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOA and that he had believed CLSW-A and had not checked the chart himself.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 184 The administrator stated he was also not aware of R1's relationship with the friend and that the DON had not told him about the order for no LOA or the relationship between R1 and the friend. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she had been informed by nursing (she could not remember who) that R37 could leave the facility with supervision. CLSW-A reported she'd made it clear to the person taking R37 out, R1's friend, that R37 could only go to the bank and nowhere else. She stated she'd told R1's friend that R37 would try and talk him into going to the liquor store but that R37 could not go there. CLSW-A said R1's friend had reassured her he had been sober for ten years and would never take R37 to a liquor store. CLSW-A stated it was not until after R37 had left, that nursing (did not remember who) told her R37 had orders for "no LOA" and that R1's friend was a drug dealer. CLSW-A said it would have been nice to have known that information before she'd allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she'd trusted nursing to know the correct information. She also stated she was aware R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing hadn't been finding the ETOH when they made the bed. When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs or aware that R1's friend was her drug dealer prior to having allowed R37 to leave with R1's friend on an LOA.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 185	{F 323}		

R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times). R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed ETOH on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation (mechanical ventilator assisted breathing) for a blood ETOH level of .323.

The admission MDS dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's CAA for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with ADLs. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering CD treatment.

The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 186 susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms. R129's Smoking Evaluation dated 3/18/14, identified to "monitor for ETOH use or oversedation." The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking." A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 187	{F 323}		

sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the DON on 5/5/14.

An Emergency Department Chart [a form from the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or ETOH use. R129 was given two doses of Dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1.

A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res goes to the Hospital for any

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 188 reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD." On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, ETOH and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and	{F 323}		

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{F 323}	Continued From page 189 procedures in place." R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print. Nursing Progress Notes: - On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 mg [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 190 - On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money." - On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. - On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty. - On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 191	{F 323}		

stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP.

- On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
- On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her

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{F 323}	Continued From page 192 [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest." - On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms." - On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 193 drugs was identified, reported to the administrator immediately, reported to the SA or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring. - On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer]. On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 194 On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length from R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M. - At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern. - At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129. - At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway. - At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 195	{F 323}		

cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129.
- At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking

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{F 323}	Continued From page 196 beside (to the left) of R129. - At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. - At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor. - At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk. On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 197	{F 323}		

received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and ETOH treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 198 not make eye contact. On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times. On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of ETOH or drugs being exchanged on "my shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse. On 5/8/14, at 11:40 a.m. NA-S stated they had seen ETOH bottles in residents rooms and smelled ETOH on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January 2104 or February 2014. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 199 On 5/8/14, at 11:55 a.m. a housekeeper (H)-A was asked if they were aware of any residents drinking ETOH in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any ETOH bottles found in the facility "and has." H-A was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the ETOH bottles came from, H-A stated she was unclear, but thought they may have been provided by family. On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated ETOH from R37. LPN-H verified ETOH was provided to R37 and suspected to other residents of the facility, but was unclear how the ETOH was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility. On 5/8/14, at 12:10 p.m. the HUC stated she was aware of resident drug and ETOH use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the	{F 323}		

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{F 323}	Continued From page 200	{F 323}		

social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming ETOH in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the ETOH was coming from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and ETOH use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts

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{F 323}	Continued From page 201 provided. The note indicated R129 was informed of the information. - On 5/11/14, at 10:09 a.m. a note written by the HUC indicated NMMC called the facility "requesting" R129's medication administration records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough ETOH to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the ETOH and/or if the assigned 1:1 was interviewed at the time. - On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two LPNs were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of ETOH. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 202	{F 323}		

R129 ETOH, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her ETOH.
- On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."
- On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of ETOH was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."
- Was asked regarding R129 obtaining ETOH or drugs while on a 1:1, DON verified the

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{F 323}	Continued From page 203	{F 323}		

information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and ETOH while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained ETOH, but verified R129 was harmed by the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for CD treatment and verified was last noted to be offered to R129 on 4/4/14. Both verified they should have revisited CD

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{F 323}	Continued From page 204	{F 323}		

treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for ETOH toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. CLSW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much ETOH in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R41:
The facility failed to provide supervision to prevent ingestion of alocholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m. , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 205 the smoking patio. All observations were unsupervised. R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily function problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detected depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist. An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff. A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated	{F 323}		

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{F 323}	Continued From page 206 2/10/14, indicated independent with smoking and smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 9-1-1 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 207 status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c. Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as AA or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 208 R117: R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents. R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression. The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility. R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA. The care plan revised 4/27/14, indicated R117 did	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 209 exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called." The progress notes were reviewed and noted: - On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator." - On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility." - On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 210	{F 323}		

to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware."
- On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time."
- On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours."
- On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident."
- On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 211	{F 323}		

about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding."
- On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning."
- On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 212	{F 323}		

filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks."
- On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen."
- On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated.
- On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 213 discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. " - On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 214 the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket. - On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 323}	Continued From page 215 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker. - On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14). - On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on." - On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility." - On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only. - On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility. - On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 216 medical appointments. Awaiting return call from clinic." - On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office." - On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital." - On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating."	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 217 - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and congestive heart failure (CHF) condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 218	{F 323}		

substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" Resident stated "yes." Police and emergecnt medical technician (EMT) then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 219 was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time." - On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified." - On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information." - On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 220 MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present." - On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road. - On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called." On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed. When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 221	{F 323}		

facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

ELOPEMENT:
On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 222 on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 223	{F 323}		

wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly The speed limit was 30 miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 224 abuse. LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised. A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection." The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs. A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 225 The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision. An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 226	{F 323}		

received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then.

The SA form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk."

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 227	{F 323}		

area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At not time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building.

On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and DM were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or SA would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if that occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 228	{F 323}		

report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a WanderGuard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 229 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14. On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance." A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor." Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 230 one to one rotation to prevent him from falling." A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 231	{F 323}		

a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 232 at 11:30 a.m. On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 233 located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA). R9 was not supervised during smoking, was keeping smoking materials and was an alleged "Pot smoker." On 5/6/14, at 7:40 a.m. R9 was observed smoking cigarettes out front on the designated smoking patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area, she retrieved cigarettes and a lighter from her right sock and placed them on the table next to a covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. During observation, NA-B went over to the smoking cart to get a smoking apron, applied the apron on R9, and sat directly across from R9. -At 9:05 a.m. NA-B continued to watch R9 as she smoked. -At 9:08 a.m. R9 was observed wheeling herself into the building. No burn holes noted on the front of her shirt or clothing. On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 234 applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke. -At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area. At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked. -At 10:19 a.m. R9 returned back to the building. On 5/6/14, at 2:45 p.m. when interviewing R9 surveyor observed a cigarette box in each white sock on each inner leg. When R9 was asked why she was storing the cigarettes in the socks she stated "You can leave now, go now". Surveyor left the room as requested. When interviewed on 5/6/14, at 3:06 p.m., the DON stated he was not sure if R9 was supposed to be supervised during smoking, and indicated he had been given a list of smokers who required supervision just that day. Upon review of the list, the DON stated R9 was a supervised smoker which meant she should relinquish her cigarettes and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. Following the interview, the DON was observed to approach R9 at the smoking area and speak to her, and to return to tell the surveyor R9 had refused to give him the cigarettes she had in her socks. When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified after looking through the locked cigarette box on the cart R9 did not have cigarettes in box. NA-I stated he had been	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 235	{F 323}		

working at the facility for a month and R9 had never had cigarettes in the locked box.

When interviewed on 5/6/14, at 3:20 p.m. the administrator, DON and LPN-A (the resident care manager for R9) all stated if a resident was a supervised smoker they were supposed to relinquish all smoking materials but many refused. They said they couldn't force them to do it as the residents were part of the supervised program. LPN-A further stated "They have been told that they have to do this and we had a meeting with all smokers last week. They were given a copy of the smoking policy by social services and were supposed to sign it, but some refused. We have told them the rules and when they are or aren't allowed to keep them [their cigarettes], but they don't care. [R9] should be in there, but she won't give them to us."

When interviewed on 5/6/14, at 3:25 p.m. the DON stated, "We have a smoking policy updated and it does include that they should relinquish, are still supervised, the smoking monitor makes sure they are safe with their usage, that is why they are out there and we are still keeping them safe, we have tried to get her lighter and cigarettes on repeated effort but have not been able to do so."

When interviewed on 5/6/14, at 3:43 p.m. LPN-A stated "Problem is if I took her cigarette and lighter, she would just get the cigarettes from somewhere else probably gives someone money to go buy a pack of cigarettes. We tried this morning to take them from her and she stated "I'm not giving them to you because you will sell them to another resident". LPN-A stated the policy had been explained and R9 had asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 236	{F 323}		

what would happen if they did not abide and LPN-A had stated they were consequences. LPN-A further stated the NA who was monitoring the smoking had a book on the cart and documented when a resident refused or when they are not safe. When asked by surveyor if the smoking monitor had reported off to her LPN-A stated she was not sure maybe the social worker had been reported to.

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found on the roommate's side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family had been very upset about staff removing the roller from the room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not received the list of all the residents who had been thought to have substance abuse issues.

When R9 was interviewed on 5/13/14, at 8:36 a.m., and asked whether she smoked "pot', R9 stated "It's a lie that I am using any pot" and kept repeating same statement to the surveyor.

R9's MDS dated 3/24/14, identified R9's diagnoses included schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease. The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 237 transfers, dressing, hygiene, and R9 was did not use any mobility devices yet R9 used a w/c during the course of the survey around and off the unit for mobility. The nutritional status Care Area Assessment dated 3/25/14,, had identified R9 had history of tobacco abuse. The smoking care plan dated 10/20/11, identified R9 was a smoker. Goal "[R9] will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker. Smoking Evaluation dated 10/7/13, indicated R9 was independent with smoking and smoking materials. After concern was brought to the facility attention on 5/6/14, another Smoking Safety Assessment was completed which indicated R9 was to remain as a supervised smoker, facility was to store tobacco products but may choose to wear apron or not. Progress Note dated 4/30/14, indicated the director of facility operations and two social workers had been to R9's room and a bottle of "Shout", raw tobacco and other materials (for the tobacco to be rolled) had been removed from the room and placed in the Administrator's office for the family to pick up when they visited. The undated and untitled list of Unsupervised and Supervised Smokers, revealed R9 was identified as a supervised smoker,did not need to wear a smoking apron, but was supposed to be within an arms distance from the smoking monitor. R14 was observed to ingest an unknown substance, was sent to the hospital and tested	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 238	{F 323}		

positive for THC (the active substance in marijuana) on 5/3/14, R14 was not evaluated for substance abuse, assessed for safety or provided supervision to prevent potential future access to illegal drugs.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knew amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others 1-3 days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA were all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. CAAs did not identify any history of drug use.

R14's Vulnerable Adult care plan dated as revised on 4/26/14, indicated R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility.

A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a nursing assistant (NA) had reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 239	{F 323}		

noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician had been notified and R14 had been sent to the ER for evaluation.

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified the laboratory report had been obtained for R14 due to "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, investigation of the incident to determine potential source(s) R14 may have obtained the illegal drug from, notification of law enforcement, any follow up assessment of R14's safety, an evaluation of R14's access to leave the facility, such as to smoke; documentation of how to prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically related social services.

On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "eplileptic." R14 denied awareness of illegal drug and ETOH activity in the facility. When asked what R14 would do if she observed illegal drug or ETOH activity in the facility, R14 stated he would "tell the resident not to do it," but would not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 240 notifiy staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, and verified there was no current system in place for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R62 was identified by the facility to have past/recent substance abuse. R62 had diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the quarterly MDS, dated 2/25/14, indicated R62 had moderate cognitive impairment. Review of facility progress note dated 1/24/14, at	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 241 17:03, indicated "a resident approached writer alerting us that another resident (res) is sitting outfront smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any". Review of facility progress note dated 1/24/14, at 17:17, indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor". Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address ETOH and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 242 progress notes. Review of a facility provided list of residents with questionable or known ETOH and drug use dated 5/8/14, at 8:02 a.m. identified R62 for drugs. During an interview on 5/13/14, at 10:18 a.m., the DM stated "I did what the 1/24/14 progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were unaware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14 identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month". SW-B stated she has been at the facility since 3/19/14. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 had verified she'd been smoking 'weed' but had told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume the administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 had ever been offered any chemical dependency assistance. R86 had been committed as mentally ill and chemically dependent on 10/31/12, which was amended on 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 243	{F 323}		

participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker.

According to the Admission Record dated 3/16/13, R86 had been admitted to the facility with diagnoses including: hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness.

A care conference dated 1/2/13[sic] (2014), lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.

A progress note dated 2/24/14, at 4:38 a.m. " Resident had been very confused and having difficulty to settled down in bed. judgement [sic] has been non intact and appearing restless with a lot of tremor. He did attested [sic] to this writer that when he goes LOA he smokes marijuana but never drink ETOH at all. He state "If I drink I will die. " His platelet has been dangerously lower thus posing him at a risk for bleeding. Update DR smiley about resident change in condition, which then mandate this writer to send resident to the emergency for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. "

A progress note dated 2/24/14, indicated at 11:00 p.m. "Pt was found smoking 'pot' in his room. His roommate was in the room at that time. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 244	{F 323}		

nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."

A progress note dated 3/4/14, at 6:11 a.m. noted, " While executing an initial nursing rounds this shift, this writer smell and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staff that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinued. He had flexeral [sic]with some benefit noted. He want [sic] another sleeping pills at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg of Trazodone [sic], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment. "

An annual MDS dated 3/22/14, had a BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares. A vulnerable adult assessment dated 3/18/14, noted past and recent chemical abuse. R86 had fluctuating cognitive deficits related to liver damage, chemical use and needed supervised LOA due to fluctuating cognition and chemical use.

A smoking assessment dated 3/18/14, indicated reports of smoking marijuana outside, and recent drug use reported by resident.

A LOA safety assessment dated 3/18/14 indicated mental illness, fluctuating cognition related to liver

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 245 disease. R86 needed supervised LOA due to fluctuating cognition and chemical use (no mention of committed to the facility related to substance abuse and mental illness. On 4/13/14, a care conference indicated: long term placement waiting for liver transplant. " Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past. " The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. R86 was committed to prevent exposure to ETOH and chemical substances of abuse. The facility lacked coordination of care between departments, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided. R113 was a known alleged narcotic seller by the facility staff. On 5/12/14, at 12:36 a.m. R113 was observed ambulating across the nursing station with his walker as he conversed to both residents and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 246 staff as he ambulated to his room down the hallway. On 5/12/14, at 1:53 p.m. R113 was observed sitting on his bed back facing the door and was observed rolling cigarettes using a cigarette roller. R113 asked if it was okay to continue to roll the cigarettes as surveyor talked to him. -At 1:54 p.m. R113 stated he knew exactly who started the rumor about the narcotics. R113 indicated he is currently trying to resolve his marriage and his wife who would not allow him to come out to her house for visits if she found out he had ETOH and drugs issues. R113 stated he remembered the incident when the therapy staff had intervened when he had been approached by another resident for cigarettes and he remembered being talked to by the administrator and social worker about the policy. R113 further stated he also took his medications in front of the nurses as he knew this was going to be a concern/issue and also indicated he knew of ETOH being used at the facility by other residents but because he was a recovered alcoholic he kept his nose out of all trouble to get back with his wife. When interviewed on 5/12/14, at 1:57 p.m. RN-A stated he always watched R113 take all his medications and made sure he swallowed them then took the medication cup out of the room. When interviewed on 5/12/14, at 2:18 p.m. both CLSW-A and CLSW-B stated they were not aware of R113 using any illicit drugs at the facility. CLSW-A stated she remembered talking to R113 for less than ten seconds when he had asked if he would continue to roll the cigarettes and had told him not to until he was told otherwise.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 247 R113's significant MDS dated 2/14/14, indicated R113's diagnoses included acute ETOH hepatitis, ETOH withdrawal, ETOH dependence and insomnia. The ADL Functional/ Rehabilitation Potential CAA dated 2/14/14, indicated R113 had history of ETOH abuse. The mood/Behavior care plan dated 4/28/14, identified R113 had history of ETOH abuse, had history of depression and had recent amputation of toes due to frost bite. Resident List Report dated 5/8/2014, provided by the administrator indicated R113 was selling narcotics. Smoking Evaluation dated 3/17/14, indicated R113 had no history of unsafe smoking practices and was independent with smoking and smoking materials. Vulnerable Adult Assessment dated 3/17/14, indicated R113 had history of chemical abuse but no recent history. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. Progress Notes review revealed the following: -Progress note dated 4/24/14, indicated R113 was in therapy when another resident approached him and asked to buy rolled	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 248	{F 323}		

cigarettes from him. Therapist stopped transaction to check facility policy. R113 and therapist approached social services to ask about policy and were directed to the administrator but the administrator was unavailable and a note was left for administrator to please visit with R113 regarding policy. R113 was instructed not to sell any rolled cigarettes until cleared by administrator.
-Social Services Progress Note dated 5/2/14, indicated R113 had declined to attend the smokers meeting to be updated on the facility policy and procedure regarding smoking. The administrator and social worker had met with R113 and was given a copy of the facility policy and discussed the rules regarding smoking. R113 was also educated on rolling cigarettes for other residents and informed until further notice he could not be not allow to give, sell, trade, or buy cigarettes with other residents which R113 acknowledged.

R1 was not smoking at the designated area, was not wearing an apron, had known alleged drug involvement at the facility and was keeping her smoking materials.
On 5/5/14, at 1:50 p.m. during the initial tour R1 was observed to be assisted to light a cigarette while outside on the smoking patio. At 1:52 p.m. staff provided R1 with a smoking apron and attempted to apply but R1 was observed to shake head no. At 1:54 p.m. R1 still had no smoking apron applied but continue to smoke in the front designated smoking area and staff was within arms-length reach of R1.

On 5/7/14, at 7:34 a.m. R1 was observed with a lit cigarette right outside the front door with no smoking apron on. NA-E got into the front seat of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 249 the transport van and R1 was observed throwing her cigarette over her shoulder prior to getting into the van. On 5/7/14, at 8:47 a.m. R1 was asked to look at her clothing for burn holes, since she was observed smoking	{F 323}		
{F 329} SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 250 review, the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R91, R36, R37, R89, R1, R113, R29). Findings include: R91 had physician orders for PRN Tylenol, Ibuprofen and Oxycodone (pain medications) without identified parameters for when to use which medication. Review of the Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13 with a diagnosis of osteoporosis. The significant change in status Minimum Data Set (MDS) dated 4/1/14, indicated R91 had frequent pain rated at a six. Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain and lacked parameters for use. Review of the Medication Administration Record (MAR) dated 4/1/2014-4/30/2014, revealed R91 did not receive any PRN Tylenol and Ibuprofen and received multiple doses of PRN Oxycodone. R36 had physician orders for PRN Tylenol and Oxycodone without identified parameters for when to use which medication. The Admission Record dated 4/28/14, indicated	{F 329}		

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{F 329}	Continued From page 251 R36 was admitted to the facility on 5/26/12 with diagnoses of femur fracture and alcoholic cirrhosis of the liver. The quarterly MDS dated 2/18/14, indicated R36 had occasional pain rated at a four. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (tid) as needed and Oxycodone 10 mg tid both for pain and lacked parameters for use. Review of the MAR dated 4/1/2014-4/30/2014, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. When interviewed on 5/7/14, at 1:51 p.m. registered nurse (RN)-A reported he would usually do a pain assessment for PRN pain medications and for a pain level below three he would not give Oxycodone. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. On 5/9/14, at 8:46 a.m. licensed practical nurse (LPN)-B was interviewed and stated when there is multiple PRN pain medications ordered, she would assess pain level and start with the lowest pain medication unless the resident's pain was "really bad" or something else worked for the resident. Upon interview on 5/12/14, at 9:40 a.m. RN-B stated she would start with Tylenol first and see if it works, then would document if it was ineffective	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 252 and then try Oxycodone unless there was a specific physician order. The facility Pain Management policy revised May 2013, lacked direction regarding parameters for PRN pain medication. R37 had physician orders for Seroquel (an antipsychotic medication) without adequate indications for use, without side effect and symptom monitoring and lacked evidence of a gradual dose reduction (GDR) or documentation of a clinical contraindication. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/7/13, indicated R37 was receiving antidepressant and antipsychotic medications; however, lacked a comprehensive assessment summary regarding the medications in use. A Psychotropic Medications care plan revised on 3/16/14, included Seroquel was used for psychoses and directed to monitor for side effects and consult with pharmacy and physician to consider dosage reduction when clinically appropriate. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. Review of the Physician's Order Sheet dated	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 253	{F 329}		

5/1/14, lacked a diagnosis for the medication. The Information and Consent for Psychotropic Medications dated 9/19/13 and 2/26/14, indicated the diagnosis to support use were "agitation/sleep."

A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur.

Physician and nurse practitioner notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist (CP) stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident.

Upon interview on 5/12/14, at 3:57 p.m. the nurse practitioner (NP) stated R37 received Seroquel for psychosis, verbal outbursts and generalized anxiety which were mainly problematic when R37 was drinking. The NP stated she believed a different medication was used when R37 was in the hospital prior to admit and was unsuccessful because of liver disease. The NP stated she had not reviewed R37's medications because he had been in the hospital frequently and she tries to do dose reductions quarterly.

When interviewed on 5/13/14, at 8:46 a.m. LPN-A

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{F 329}	Continued From page 254 stated the indication for use for Seroquel was not listed and she would have to check with the physician. LPN-A stated she was not sure what target behaviors were being monitored for Seroquel. LPN-A stated orthostatic blood pressures were recorded in the electronic record. After review of the Weights and Vitals Summary, LPN-A verified there were no orthostatic blood pressures recorded for R37 since December 2013. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received. The facility Psychoactive Medication Management policy revised May 2013, directed the DNS [director of nursing services] or designee was responsible to ensure timely medical consultation when a psychoactive medication requires a medical review. R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic medication). In addition, R89 was not monitored for potential side effect of orthostatic hypotension (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position). R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions,	{F 329}		

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{F 329}	Continued From page 255	{F 329}		

and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects."

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and

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{F 329}	Continued From page 256	{F 329}		

document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg.

The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis.

A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 257 Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg [milligrams] daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident."	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 258 Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective." The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more." The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia. On 5/5/14, at approximately 1:40 p.m. R89 was observed to be laying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Observations of R89 on 5/7/14, at 8:28 a.m.; 5/8/14, at 8:30 a.m.; and 5/12/14, at 12:23 p.m. Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the LPN-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 259 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of antirollbacks and restraints. DON verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 260	{F 329}		

"Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the consultant pharmacist was called and a message left. The consultant pharmacist did not return the call.

R1 was not monitored for potential side effects related to use of Trazodone and Venlafaxine (an anti-depressants) and Zolpidem (a hypnotic).

Findings include:

R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day.

The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 261 dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 Milligrams (mg) by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. RN-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 262 we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. The Psychoactive Medication Management policy dated as reviewed 5/2013, indicated the care plan	{F 329}		

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{F 329}	Continued From page 263 would identify side effects of the use of any psychoactive medications but lacked monitoring of side effects of anti-depressants and sleep study/logs for resident who were taking medication to aide sleep. R113 lacked parameters for as needed pain medication Oxycodone. R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. Physician's Order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. Pain Assessment dated 4/25/14, indicated R113 had pain daily and was predictable and the pain	{F 329}		

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{F 329}	Continued From page 264 did not prevent resident from doing or results in mood or behavior. The assessment indicated the pain was worse and/or breakthrough pain with therapy and dressing change. Summary indicated the pain was from the amputation sites to his both feet toes and was aggravated by therapy and wound care but was relieved by treating with PRN medications prior to treatment and resident reported current pain regime was effective. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider. When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." DON was not unavailable to interview on 5/13/14, regarding pain medication parameters. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided. R29 had physician orders for PRN morphine (pain medication) with no parameters for use, in addition no pain monitoring was completed.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 265 Review of the Admission Record dated 4/28/14, indicated R29 was admitted on 1/15/14, with diagnoses that included chronic pain, diabetic polyneuropathy (nerve damage) and adult failure to thrive. The quarterly MDS dated 4/17/14, indicated R29 had frequent pain rated at a pain level of six. The CAA dated 1/28/14, indicated R29 "has chronic back pain, she gets Neurontin, OxyContin and oxycodone PRN, it has been effective at time". The CAA did not indicate diseases or conditions that may cause the pain, characteristics or frequency of the pain, but indicated it adversely affects mood. During observation on 5/12/14, at 9:10 a.m. R29 was observed to be very thin, awake in a darkened room, in bed and when surveyor asked to enter room, resident stated "no". During observation on 5/12/14, at 2:01 p.m. R29 was in darkened room, in bed sleeping. During observation on 5/13/14, at 850 a.m. R29 was observed lying in bed, dressed in a hospital gown in a darkened room. R29 stated "I am not doing well today, the pain is constant, the meds help for a while, then it starts again". R29 stated she does go to a pain clinic. Review of the physician's order sheet dated 5/9/14 included an order for morphine 30 mg four times daily as needed. Review of the MAR dated 4/1/14 to 5/31/14, revealed R29 received multiple doses of PRN morphine. Review of the pain evaluation and management plan dated 4/17/14, indicated R29 had occasional	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 266	{F 329}		

pain in back and feet, current pain regimen was effective and nursing would continue to monitor and update MD/NP as needed.

R29's care plan with revision date of 4/12/2014, identified R29 was on pain medication therapy due to foot surgery and chronic back pain. Interventions included: pain assessment per facility policy, administer medication as ordered and to frequently review for pain medication efficacy.

During an interview on 5/12/14 at 3:29 a.m., LPN-E stated that for R29, "some days are good, some days are bad, she is on quite a bit of meds for pain" and that on 5/9/14 R29's primary physician increased some meds, "that may be why she is sleepy". LPN-E stated R29 was not on her caseload, but she would have put short term implementations of pain monitoring in place when there is a change in meds. LPN-E verified that it looks like every three to four hours the morphine is given and that the order should be more specific "like every 4 or 6 hours [hrs]". LPN-E verified there was no pain monitoring being completed, "it must have fallen thru the cracks when we went from paper to the computer".

During an interview on 5/13/14, at 10:58 a.m. LPN-G stated he had not given any morphine yet today and would ask the resident if she has any pain. LPN-G further stated he would expect the order to be more specific such as "every 4 or 6 hrs" in addition to PRN, but would ask the nurse manager for more clarification.

Review of Medication Administration General Guidelines, section 7.1, page 3 of the facility Nursing Care Center Pharmacy Policy &

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{F 329}	Continued From page 267 Procedure Manual date 2007, indicated that medications are administered in accordance with written orders of the prescriber. If a dose seems excessive....or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. The DON was not available to interview on 5/13/14, regarding pain medication parameters and monitoring. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.	{F 329}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 353}	Continued From page 268	{F 353}		

section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide adequate staff to meet the individual needs for safety, supervision and care for 13 of 44 residents reviewed during the revisit (R22, R129, R1, R41, R37, R13, R86, R116, R36, R117, R9, R14, R62). In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect each of the 67 residents who resided at the facility.

Findings include:

The facility has started using agency staff, licensed nursing and nursing assistants (NA) from Soul Care LLC 1521 Como Ave Southeast Minneapolis, 55414. On 5/6/14, orientation was requested for any agency staff that has worked since the last survey. A review of the orientation files verified that the facility did not ensure staff had background checks, and had received the required tuberculin skin testing (TST).

A review of the facility schedules dated from 4/5/14 through 5/17/14, indicated the facility staffing plan called for on the day shift: two licensed nurses with 13 nursing assistant (NA's); on the evening shift: two licensed nurses with 13 NA's and on the night shift: two licensed nurses with 6 NA's.

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 353}	Continued From page 269 Open nursing and NA shifts in the two week block of time from 5/4/14 through 5/17/14, included nine nursing day shifts and 53 NA's open day shifts, 17 open evening shifts, and 30 open night shifts. Two additional staff was being used for 1:1's for R1 who was alleged by the facility to both ingest and provide illicit substances to residents within the facility and R129 after she had obtained and ingested cocaine within the facility and required hospitalization. An undated facility typed document titled 1:1 Observation Staff Responsibilities indicated: only one staff person performs the 1:1 observation with only one resident during the assigned time, and follows the resident wherever he/she goes and maintains a distance no further than arm's length at tall times. When the resident is in the room, staff will be either sitting outside or inside his/her room and make sure that they maintain residents visual at all times. Notify nurse/supervisor with any suspicious activity observed on resident. Will accompany resident if he desires to go out and smoke and make sure that appropriate clothing is worn, and oxygen is removed 5 minutes before going out to smoke. Nursing was to oversee the 1:1 observations and respond to concerns reported. One additional staff per shift was used as a smoke monitor. The Smoking Monitor Responsibilities (undated document) directed the monitor to ensure the smoking areas are monitored at all times, carry a list of smokers, and the smoking assessment results at all times. The monitors were to use the list to determine which residents require close supervision or other	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 353}	Continued From page 270 interventions and ensure the interventions are in place. "Supervised smokers must be within direct line of sight at all times. Those requiring assistance with smoking materials must be within reach of the smoking monitor.... Direct all smokers to the designated smoking areas only... No smoking will be allowed in front of the building. Notify supervisor immediately if: a resident not on the list is smoking. A resident refused indicated interventions, such as wearing a smoking apron or staying within the designated smoking area." On 5/7/14, at 9:27 a.m. and again at 9:31 a.m. R22 (a resident identified by the facility as a supervised smoker required to wear a smoking apron) was observed by surveyors to drop a lit cigarette onto his shirt, both times the resident was able to pick it back up. When interviewed at 9:32 a.m. the smoke monitor NA-B stated she had not observed R22 dropping the cigarette at 9:27 a.m. or 9:31 a.m. and verified that she had been more than an arm ' s length away from the smoker. R22's clothing was checked and no burn holes were noted in his shirt, or in the blanket that had been covering his lap. NA-B stated that R22 was supposed to be a supervised smoker with a smoking apron, but the resident had refused to wear the smoking apron. NA-B verified she had given R22 a cigarette to smoke, even though she knew he was assessed to require a smoking apron. NA-B stated when R22 or any resident refused to wear the smoking apron, or follow the rules; they would record it in the smoke monitor notes. The smoke monitor notes were reviewed and revealed that notes started on 3/15/14, and were present for March 16th through 21st, 24th through 27th, 28th was blank, 29th and 30th, and the 31st was blank. On April 28th and 30th and	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 353}	Continued From page 271 May 2nd-3rd, and 4th were left blank. On all of the days listed residents had refused to wear smoking aprons, and/or relinquish the smoking materials. The administrator stated he thought the other logs had been collected, but stated he had not reviewed them for compliance with the smoking policy. Residents within the facility were able to obtain, ingest and allegedly sell alcohol and drug substances within the facility while the smoking monitor, safety monitor and 1:1 staff were in place for R129 and R1. Immediate Jeopardy (IJ) was identified at F323 for lack of supervision to prevent alcohol and drug use that lead to hospitalization for (R41, R129, and R37) and elopement by R13, a resident with a WanderGuard (an alert system that lets the facility know a resident has left the building) who was let outside to smoke and went from there to the public sidewalk, the facility had to be notified by surveyors of the elopement) Refer to F323 on 5/9/14. After the IJ was identified on 5/9/14, two Residents (R129 and R37) who both had one to one (1:1) staff (defined by the facility administrator as being within arm's length of the resident to prevent incidents from occurring) were able to obtain and ingest alcohol and drug substances on 5/10/14. On 5/10/14 at 1:07 p.m. R37 was taken to North Memorial Medical Center for intoxication. R37 was animated and chatting with the medics as he was taken, and the health unit coordinator (HUC) stated that is how you know he is intoxicated, he was friendly and chatting, when not intoxicated he was usually very quiet. It was reported from the	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 353}	Continued From page 272	{F 353}		

hospital that the resident had alcohol and methadone (a drug he had not been prescribed) in his system. The administrator stated the 1:1 staff assigned to R37 should have been able to prevent him from obtaining and consuming alcohol and methadone.

On 5/11/14, at 10:55 a.m. the administrator notified surveyors he had not been notified that R129 was sent to emergency room, at 4:00 a.m., after she had reported to a staff member that she was intoxicated. A blood alcohol level was determined to be .323 (more than three times the legal limit) and R129 was in the intensive care unit, intubated and assisted to breath by a mechanical ventilator. The administrator stated the 1:1 staff assigned to R129 should have been able to prevent her from obtaining and consuming alcohol. After investigation it was noted by contracted licensed social work (CLSW)-A that R1 accelerated away from her 1:1 staff at a high rate of speed in her electric w/c and was able to make an exchange with R117 (a former resident), R1 and R129 were noted to make an exchange later in R129's room, both had 1:1 staff who did not report the exchange, and failed to protect the residents on 1:1 observation.

A special Staffing - One to One Assignment policy dated May 2012 and revised May 2013 included: one to one staffing assignments are in place based on an assessed need until appropriate permanent alternative arrangements can be made reasons may include, but are not limited to: treat of suicide by a resident, altered mentation that may dislodge treatment lines or devices, escalating exit seeking behavior, altered cognition in an agitated state that is not easily redirected., or not respected the boundaries of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 353}	Continued From page 273 other residents. The procedure stated "to keep the one to one within arm's reach at all times. (if not suicidal may have visual privacy for toileting). Alternatives to one to one assignment are investigated as timely as possible. (alternative care setting, medical evaluation), family or responsible party are notified to see if they are available to provide this heightened level of supervision. Documentation of the one to one assignment is made in the clinical record; appropriate care plan/review/revision is made during the one to one assignment. IDT [interdisciplinary team] will meet to determine the appropriateness of removing a one to one and under what circumstances it may be reinitiated." The one to one staff, and safety monitor were not effective in preventing residents from obtaining and consuming drugs and alcohol within the facility, the facility lacked an analysis of that staffing failure and lacked additional interventions to safe guard residents. Refer to F224: the facility failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, the facility failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents (R13). These facility failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. This had the potential to affect all 67 residents in the facility.	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 353}	Continued From page 274 F323: the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in Immediate Jeopardy (IJ) on 5/9/14, at 2:03 p.m. Also a second IJ was identified for 2 of 3 residents (R37, R129) on 5/12/14, at 2:51 p.m. In addition, the facility failed to ensure residents with WanderGuard were supervised when leaving the facility for 2 of 3 residents (R13, R116) observed to elope from the facility. R13 was observed on 5/6/14, to leave the facility with a WanderGuard attached. This resulted in IJ on 5/9/14, at 2:03 p.m. R116 was observed to leave the facility on 5/11/14, at 9:30 a.m. This resulted in IJ on 5/12/14, at 2:51 p.m. In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113). Also, the facility failed to ensure residents were smoking safely according to the plan of care for 3 of 3 residents (R1, R36, R22).	{F 353}		
{F 412} SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 412}	Continued From page 275 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed without dentures during the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m. When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s) (edentulous); maintained oral care independently and R36 had reported he had dentures at home not at the facility.	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 412}	Continued From page 276	{F 412}		

Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him.

Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums.

The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..."

The Camden Care Center Quarterly Care Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet.

R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns.

The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or dentures and is able to chew adequately without his teeth and noted weight as stable.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 277 Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested. When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care. When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms. When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him. When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..." On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a while ago and would like new ones if his old ones	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 278 could not be found. On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones. The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided. The facility plan of correction indicated by 4/28/14, social service and nursing would coordinate getting R36 fitted with dentures and these activities would be clearly documented in the clinical record to include any and all communication with the guardian. Review of R36's record on 5/7/14, at 1:50 p.m. lacked evidence of a dental visit. When interviewed on 5/7/14, at 2:10 p.m. the health unit coordinator (HUC) stated reported she had spoken to R36 and he stated his dentures were in a storage locker and he did not want new ones and stated the information was in the progress notes. The HUC was again interviewed on 5/8/14, at 8:17 a.m. and she stated she was unable to locate any documentation regarding her conversation with R36 regarding his dentures and she verified she had not offered R36 a routine dental exam. At 2:32 p.m. the HUC reported R36 had agreed to a dental visit and would be scheduled for one. When interviewed on 5/13/14, at 2:29 p.m. licensed practical nurse (LPN)-E stated the facility did not have a dental policy and the corporate consultant stated it was on a case by case basis. The facility Medical Services policy dated May	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 279 2012, indicated the social services director or designee was responsible to arrange dental services to meet the needs of the residents. R9 had a dental exam on 2/27/14, which indicated that more dental treatment was needed, however had not received dental follow up as recommended. The annual MDS dated 10/11/13, did not identify R9 had any dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene. Review of R9's care plan dated 4/10/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." The careplan indicated R9 had diagnoses that included schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC (limited liability company) Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and #12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful. Res was cooperative, though has difficult time holding her mouth still, and her tongue is very active."	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 280 During an interview on 5/6/14, at 2:45 p.m. R9 stated "I can chew. I saw a dentist here. I'm missing some teeth but he said they have to fall out before I can get dentures." During an interview on 5/7/14, at 3:28 p.m. LPN-A stated "I went through the progress notes and I don't see anything that addresses the dental exam." During an interview on 5/7/14, at 3:30 p.m. HUC stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this." Review of the facility Medical Services policy with revision date of May 2013, indicated the facility will ensure each resident has access to dental/vision/hearing/podiatric services to meet their individualized needs, resident needs are identified at the time of admission and additionally through the RAI [resident assessment indicator] process and daily assessment/monitoring of resident condition and change in condition also alerts staff to the need for medical services.	{F 412}		
{F 428} SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 281	{F 428}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the consultant pharmacist failed to identify lack of medication parameters for as needed (PRN) pain medications for 2 of 7 residents (R91, R36), failed to identify a lack of adequate indication for use, resident specific target behaviors and monitoring for antipsychotic medication for 2 of 7 residents (R37, R89) and failed to identify a lack of side effect monitoring and sleep monitoring for antidepressant medications for 1 of 7 residents (R1) reviewed for unnecessary medications.

Findings include:

R91's Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13, with a diagnosis of osteoporosis.

Review of the Medication Regimen Reviews (MRR) for R91 from 10/17/13 through 5/7/14, lacked evidence the missing parameters for PRN pain medications were identified.

Review of the Medication Administration Record (MAR) dated 4/1/14 through 4/30/14, revealed R91 did not receive any PRN Tylenol (a mild amalgesic) and Ibuprofen (an anti-inflammatory medication) and received multiple doses of PRN Oxycodone (a narcotic).

Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 282 every six hours PRN all for pain. R91 had orders for multiple PRN pain medications which lacked parameters for use. R36's Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12, with diagnoses of femur fracture and alcoholic cirrhosis of the liver. Review of the MRR for R36 from 4/22/13 through 5/6/14, lacked evidence the missing parameters for PRN pain medications were identified. Review of the MAR dated 4/1/14 through 4/30/14, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (TID) as needed and Oxycodone 10 mg TID, both for pain, and lacked parameters for use. R36 had orders for multiple PRN pain medications which lacked parameters for use. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. Review of the MRR for R37 on 11/14/13, indicated R37 was taking Seroquel for psychosis, however lacked direction for target behavior monitoring. Review of the MRRs from 9/25/13-4/18/14, revealed the CP failed to identify the need for a gradual dose reduction or	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 283 documentation of the clinical contraindication. Physician and Nurse Practitioner (NP) Notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. R37 received Seroquel (an antipsychotic medication) daily without adequate indication for use, monitoring or an attempt at a gradual dose reduction. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist (CP) stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. When interviewed on 5/7/14, at 3:09 p.m. the CP stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received.	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 284 The consultant pharmacist did not identify the lack of monitoring for resident specific target behaviors and the lack of orthostatic hypotension side effect monitoring for R89's use of Zyprexa (an antipsychotic medication). R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 428}	Continued From page 285 dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily,	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 428}	Continued From page 286	{F 428}		

"Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.

A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident

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{F 428}	Continued From page 287	{F 428}		

continues to receive Zyprexa 7.5 mg daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective."

The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more."

The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia.

On 5/5/14, at approximately 1:40 p.m. R89 was observed to be lying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door.

Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target

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{F 428}	Continued From page 288 behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document	{F 428}		

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{F 428}	Continued From page 289 target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. The consultant pharmacist did not identify monitoring of R1's side effects for Trazodone and Venlafaxine (Effexor-both anti-depressants) and sleep monitoring was lacking. R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that	{F 428}		

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{F 428}	Continued From page 290 you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the Monthly Medication Regimen (MMR) from 3/18/14 forward, revealed the consultant pharmacist had reviewed R1's medications, both were undated and unsigned. The MMR's failed to identify side effects monitoring, and sleep monitoring were lacking, as indicated in the plan of correction dated 4/28/14. Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank	{F 428}		

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{F 428}	Continued From page 291 Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. registered nurse (RN)-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on	{F 428}		

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{F 428}	Continued From page 292 implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. R113 CP failed to identify lack of parameters for as needed pain medication. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15mg) by mouth every four PRN, Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider.	{F 428}		

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{F 428}	Continued From page 293 When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. The PharMerica Medication Regimen Review completed by the CP monthly dated 4/18/14, and two other times after which were signed but undated did not identify R113's physician orders lacked the parameters. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. On 5/7/14, at 1:56 p.m. CP stated he would expect parameters written by the physician to clarify when to give which medication.	{F 428}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		

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{F 431}	Continued From page 294 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5 medication and treatment carts had the internal	{F 431}		

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{F 431}	Continued From page 295 drawers kept clean; the facility failed to ensure medications were dated when opening; eye medications, suppositories, topical medications were observed to be stored together for 11 of 67 residents (R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88). In addition, the white refrigerator in the medication room (used to store refrigerated medications) was observed to have a heavy buildup of frost in the freezer compartment. These practices had the potential to affect all 67 residents residing in the facility. In addition, the facility failed to lock a medication cart which held biologicals and medications (anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication). This had the potential to affect 4 of 7 residents (R73, R37, R83, R115) who were near the medication cart. The four residents were able to access to the cart according to staff. Findings include: WEST MEDICATION CART On 5/7/14, at 7:52 a.m. first (top) drawer was observed to have the following: R13 had an open Advair Diskus inhaler (used for breathing) without an open date. R13's Minimum Data Set (MDS) dated 3/25/14, noted R134 had breathing problems and was cognitively intact. According to the package insert by GalxoKlineSmith dated 2008, staff were to "Take ADVAIR DISKUS out of the box and foil pouch. Write the 'Pouch opened' and 'Use by' dates on the label on top of the DISKUS. The 'Use by' date is 1 month from date of opening the pouch."	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 431}	Continued From page 296 R92 had an opened and expired bottle of Travatan Z 0.004% (reduce the elevated pressure inside your eye) eye drops for R92. The label indicated to "Order After 3/27/14." A sticker affixed to the bottle indicated the medication was opened on 3/3/14. The bottle was observed to be stored loosely with oral medications. A second bottle of the same eye drop with date opened of 4/19 (no year) written on the label, had no open date documented on the Date Opened sticker. A third bottle of the same eye drop was also observed to be stored loosely (no zip lock bag) in and with oral medications for various other residents and had no open date. All three Travatan Z bottles for R92 were opened and had remaining doses in each bottle. R92's MDS dated 1/15/14, indicated R92 had adequate vision and no vision problems. According to the package insert by Alcon Laboratories (SA) (Pty) Ltd, Revised 11/02, directed staff, "STORAGE INSTRUCTIONS: Store below 25°C., DO NOT USE MORE THAN 30 DAYS AFTER OPENING. KEEP OUT OF REACH OF CHILDREN." R9's Insulin Aspart pen (Novolog- used to control blood sugar) had no open date and had a sticker on the pen which indicated "EXP [expires]: 04/11/14." A second pen of the same medication for R9 lacked the protective cover for the end of the pen (where the needle affixes) and lacked an open date. Both pens were stored in and with eye drops for other residents. R9's MDS dated 3/24/14, indicated R9 was cognitively intact and had diabetes. According to the package insert by Novo Nordisk	{F 431}		

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{F 431}	Continued From page 297 INC, dated 2002 through 2008, staff were to store as follows: " Recommended Storage: Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated. Unpunctured vials can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused vials in the carton so they will stay clean and protected from light. R54 had a bottle latanoprost 0.005% (used to reduce the intraocular pressure) eye drops was observed to be stored loosely with other oral medications. R54's MDS dated 1/15/14, indicated R54 had adequate vision and no vision problems. - A 3 milliliter (ml) vial of 2.5 mg albuterol was observed to be stored loosely in the top drawer. The vial had no label to identify which resident the Albuterol was ordered for. - The first drawer was observed to have a light brown and crumb like consistency buildup of debris in the upper right corner of the drawer. A heavy buildup of sand colored debris was observed in the upper left corner of the first draw. The debris was observed to be with and under the stored inhalers. - The second drawer had a heavy buildup of brownish colored debris in the corners and bottom of the drawer. The debris appeared to be from pulverized/crushed medication tablets. On 5/7/14, at 8:15 a.m. the licensed practical nurse (LPN)-C verified the findings. SOUTH TREATMENT CART	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 298 On 5/7/14, at 8:39 a.m. the registered nurse (RN)-B verified he worked out of the cart and opened the cart. The following was observed: R29's Levemir insulin flexpen (used to control blood sugar) had no open date on the sticker. R29 's MDS dated 1/29/14, indicated R29 was cognitively intact and was a diabetic. According to the package insert by Novo Nordisk INC, dated 2005 through 20012, staff were to store as follows: "Recommended Storage: 3 mL LEVEMIR FlexPen: Not in-use (unopened) Room Temperature (below 30°C) for 42 days. In-use (opened) was to be stored for 42 days at room temperature." R25's Lantus insulin had an open date of 4/4 (no year) and expiration date of 5/3 (no year). The insulin was open, partially used and expired. R25's MDS dated 4/8/14, indicated R25 was a diabetic and was moderately cognitively impaired. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " R66's Lantus Solostar insulin had no open date.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 299 R66's MDS dated 3/25/14, indicated R66 was cognitively intact. The MDS did not indicate R66 was a diabetic. However, the MDS did indicate R66 received insulin injections in the past seven days. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " RN-B verified the findings at the time of the observation and stated the medications should have open dates. RN-B verified the expired medication was used "today." The second drawer of the south treatment cart was observed to have a buildup of potential pulverized medication debris in the corners of the drawer. The third drawer was observed to contain a plastic bin containing various tubes of topical medications for different residents. Some tubes were observed to be stored in zip lock bags with labels. All topical medication tubes in the bin had been used. Topical medications in the bin not in zip lock bags were observed to be in contact with each other. The topical medications not stored separately included a tube of unlabeled Dimethicone Skin no label (barrier ointment). R22's tube of Capsaicin 0.25% Cream (used to	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 300 control pain from arthritis) directed staff to apply the medication to the left hip and right rib. R22's MDS dated 1/9/14, indicated no musculoskeletal problems, no indications of pain, and also revealed R22 was moderately cognitively impaired. R95's Hydrocortisone 1% Cream (used to treat skin inflammation and itching) identified to apply the medication to R95's stomach and back; R95's MDS dated 2/28/14, indicated no rashes were present and revealed R95 was cognitively intact. - An unlabeled tube of Aquaphor healing ointment (barrier ointment) was approximately 90% used. R86 had a tube of Fluocinononide 0.05% solution (used to treat the itching, redness, dryness, crusting, scaling scalp) which directed to apply the medication to scalp; R86's tube of Desonide 0.05% (used to treat the redness, swelling, itching, and discomfort of various skin conditions) directed to apply the medication to axilla, groin and abdomen folds; a bottle of Deep Sea Premium Nasal Moisturizing Spray (moisturizes the nasal passages). The bottle of nasal spray was observed to be in contact with other topical medications in the bin. RN-B stated the spray, "Should be in other cart." R86's MDS dated 3/23/14, indicated no skin problems and was cognitively intact. R86's Treatment Administration Record (TARs) dated May 2014 indciated the R86 received topical cream to the face, skin folds, groin, and axilla once or twice a day for psoriasis bulgaris.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 301 R29's Nystatin - Triamcinolone Cream (used for yeast infections) directed to apply the medication to R29's labia. R29's MDS dated 1/29/14, indicated R29 was cognitively intact, received creams and ointment to other areas other than feet, and noted R29 was a diabetic. R29's Physician's Order sheet undated indicated Nystatin was to be applied to the labia three times daily for itching. - The drawer was observed to have a heavy buildup of crumbs, pulverized pill fragments and paper, foil and plastic pieces debris in all drawers. The corners and sides of the drawers had the highest build up. RN-B verified the findings at the time of the observation and confirmed the topical medications should be stored separate from nasal medications. RN-B verified the tubes of topical medications for different residents, should not be stored together. SOUTH MEDICATION CART At 9:06 a.m. the South Medication Cart second drawer was observed to have one white and one yellow medication tablet loose in the bottom of left section of the drawer, and one yellow tablet, one white tablet, one pink tablet and one beige tablet loose on the bottom of the right section of the drawer. A buildup of foil debris was observed in all corners. - The third drawer had one bright yellow tablet and a buildup of pulverized pills and foil debris in all corners. - Fourth drawer was observed to have a opened and partially used box of Bisac-Evac 10 mg Bisacodyl suppositories used for constipation) stored with nebulizer medications (breathing	{F 431}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 302 medications). - The first small left side drawer was observed to have one unlabeled vial of Albuterol neb solution (breathing medication) stored loosely in the drawer. - The third left side drawer was observed to have a sticky red colored substance spilled on the bottom of the drawer. The substance appeared to be smeared on the bottom of the drawer, was wet to the touch and easily removed with a finger. RN-B verified the above findings and was unclear on when the medication carts were cleaned. MEDICATION ROOM At 9:21 a.m. the white medication refrigerator was observed to have a heavy buildup of frost approximately two to three inches thick which completely encased an ice pack in the frost of the freezer. NORTH MEDICATION CART At 9:24 a.m. the following was observed: R88's Novolog insulin (used to control blood sugar) was observed to have an open dated of 3/22 (no year) and an expiration date of 4/20 (no year). R88's MDS dated 2/7/14, indicated the resident had expired. - The second drawer was observed to have a white half tablet, a red gel cap loose in the bottom of the drawer; foil, paper and pulverized medication debris was observed to have built up in edges and corners of the drawer. - The third drawer was observed to have built up foil, paper and pulverized medication debris in the corners, a red, sticky, circular shaped spill on the bottom of the drawer. LPN-F verified the findings at the time of the	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 431}	Continued From page 303	{F 431}		

observation. LPN-F was unclear on medication cart cleaning and stated she, does "not have time to get her medication pass done" due to it being "too heavy." LPN-F explained she had too many other responsibilities such as taking blood sugars, administering insulin verified she did not clean the medication cart. Although LPN-F stated she worked for the agency, LPN-F stated she usually worked on the North Medication cart and had worked in the facility for several weeks.

EAST MEDICATION CART
At 9:39 a.m. the second drawer was observed to have two white half tablets loose in the bottom of the drawer.

On 5/7/14, at 11:45 a.m. LPN-E verified she was in charge of the North Unit and stated the medication carts were "a mess" and stated she believed all the carts were newer and cleaned by "the pharmacy" last week. LPN-E was unclear on the cleaning schedule of the medication carts. LPN-E stated before there was trained medication aide (TMA) responsible for the cart and a nurse responsible for the treatment cart. Explained there were "fifteen different hands" in each cart and they were not being kept clean.
-At 12:00 p.m. LPN-E observed the medication carts with surveyor and verified the findings. LPN-E stated it was a new medication cart. LPN-C was present at the time of the observation and stated the medication cart was "not new." LPN-E verified eye drops, Advair Diskus inhalers, and insulin required open dates.

On 5/7/14, at 1:26 p.m. LPN-A verified she was in charge of the West and East units. LPN-A stated she had not completed any cleaning audits for the medication carts and did not know if audits were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 304	{F 431}		

completed. LPN-A stated she did not know the audit or cleaning schedules for the carts. LPN-A was unclear what the facility system was to ensure the medication carts were kept clean. LPN-A further stated she was unclear who was responsible for cleaning the medication carts and was unclear on the policy for medication cart cleaning.

On 5/8/14, at 4:21 p.m. the consulting administrator stated the facility did not have a policy or a procedure for medication cart cleaning and verified the carts should have been cleaned. The consulting administrator stated the facility was "not allowed to write policies," but could write a "procedure."

A PharMerica 3.7 Medications and Medication Labels policy dated 9/2010, directed multi-dose vials "shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)" The policy further identified all medications should have a pharmacy affixed label.

The PharMerica 4.1 Storage of Medication policy dated 9/2010, directed to store eye, internally administered, oral inhalation, nasal, oral and topical medications separately.

Medications carts were left unlock and un-supervised.
South Hallway Medication cart
On 5/5/14, at 1:39 p.m. observed the key lock to the nursing medication cart to be fully extended in the unlocked position on the South unit. Two residents were observed to wheel by the cart and no staff was in the hallway. RN-B, was observed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 305 to follow the surveyor from the nursing station onto the South unit and approach the medication cart and open the top drawer. East Hallway Medication Cart On 5/8/14, at 3:50 p.m. surveyor observed the unlocked medication cart across the nursing station in the East Hall Way. -At 3:53 p.m. observed the administrator walk past the unlocked cart. -At 3:55 p.m. observed the director of nursing walk past the cart then walk right past the cart back to the nursing station. -At 3:54 p.m. nursing assistant (NA)-F came stood approximately 6 feet beside the surveyor on the counter typing then walked away. -At 3:56 p.m. observed resident with a cane walk past the cart to his room. -At 3:57 p.m. observed NA-G standing on the opposite side of the hallway approximately 2 foot steps from the cart still unlocked. -At 3:58 p.m. director of nursing (DON) walked past the cart again and went down the hallway. -At 3:59 p.m. observed receptionist (O)-D walked past the medication cart approximately 1 step from the cart still unlocked. -At 4:00 p.m. DON walked past the medication cart still unlocked back to the nursing station. Went into the nursing station stood at the inside of the counter looking down the hallway where the unlocked cart was stationed. -At 4:01 p.m. observed NA-I walked past the medication cart to the South hallway. -At 4:02 p.m. O-D again went past the unlocked cart approximately one foot step went to the human resource office and came right out and returned to the front desk. -At 4:04 p.m. observed NA-I walked past the cart again and turned right and walked past the cart to	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 306 the South Hallway. When interviewed on 5/8/14, at 4:06 p.m. LPN-D if the medication cart was supposed to left open stated, "No." LPN-D walked over to unlocked medication cart and locked it. When interviewed on 5/9/14, at 10:05 a.m. LPN-E stated, "All the medication carts are not supposed to left open." When interviewed on 5/9/14, at 1:32 p.m. RN-B stated the medication cart should be locked when staff was not around and when nurses walked away from the carts. RN-B further stated the nurse that had left the cart unlocked had acknowledged she had left the cart unlocked on 5/8/14. The facility Storage of Medication dated 9/10, directed "In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.	{F 431}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 465}	Continued From page 307 by: Based on observation, interview and document review, the facility failed to ensure resident room carpets for 3 of 3 residents (R22, R56, R33) and an E-Z stand (a mechanical stand used for transfers) were kept in good repair, clean and in a sanitary manner. Findings include: A tour of the facility was conducted on 5/9/14, at 8:59 a.m. through 10:05 a.m. with the director of facility operations (DFO) and the following concerns were identified: Carpets: On 5/9/14, R22's portion of the room was observed. The carpet had large dark brown stain/spots from the bed to the dresser. DFO verified the carpet was not clean and stated, "I think it is filthy and trashed." R22's annual Minimum Data Set (MDS) dated 4/10/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs. R22 used both the walker and wheelchair (w/c) for mobility in his room. On 5/7/14, at 7:59 a.m. R22's carpet was observed to have dark brown spots/stain on the carpet around the bed area and to the entrance of the room. On 5/9/14, at 9:34 a.m. DFO verified R22's carpet was not clean stated "Again this is one of the rooms that I would like to have a deep cleaning and was hoping the cleaning of the carpet would have been done after pest control was here yesterday."	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 465}	Continued From page 308	{F 465}		

R56 was bedfast in the room. When R56's room was observed on 5/9/14, at 8:59 a.m. the carpet had several dark, black ground-in spots and stained red around the bed.

R56's annual MDS dated 2/25/14, indicated R56 required extensive to total assistance with activities of daily living (ADLs) including transfers, was bed bound, used a w/c for mobility and had intact cognition.

On 5/9/14, at 9:30 a.m. DFO verified the carpet in R56's room was not clean and stated, "It needs to be deep cleaned."

R33
On 5/6/14, at 9:00 a.m. surveyor noticed a strong malodorous urine smell coming out of R33's room and the carpet observed to have dark brown large stain/spots from the bed to the radiator and on the area between the foot of bed and dresser (walk area). During observation a housekeeping staff was observed standing outside R33's room but was cleaning the next room.

On 5/9/14, at 9:38 a.m. DFO verified the smell stated, "It's very strong and this is another room that needs to have the carpet cleaned or replaced." DFO stated, "We were supposed to get the air freshener's from Ameri-Pride today but they were supposed to be delivered on Friday." DFO further stated the carpet cleaning company had been to the facility recently and cleaned the common areas. The DFO knew the contract was expired and directed questions to the administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 465}	Continued From page 309 R33's quarterly MDS 2/20/14, indicated intact cognition, required limited assistance with ADLs, had impairment to both lower extremities and used a walker and w/c for mobility. R33's also received a diuretic. Mechanical lift: E-Z stand handle did not have a cleanable surface. On 5/9/14, at 9:05 a.m. the E-Z stand was observed stored on the alcove on the West Hall and the left bar was observed to have vinyl peeling off exposing the foam underneath. The cracked vinyl was covered with gray duct tape and at the end the tape was exposing the sticky side of the tape making it not a cleanable surface. When interviewed on 5/9/14, at 9:07 a.m. DFO verified stated, "I was told by the vice president to put the duct tape over for now and I have a bid for cushions and guard and am waiting." When interviewed on 5/9/14, at 8:38 a.m. the administrator stated there is a carpet cleaning plan with a contractor who would be coming in to clean a couple rooms at a time. Administrator further stated, "We are going to order replacement parts for the E-Z stand, we had been told that the duct tape was sufficient." Review of the w/c cleaning schedule for Maintenance dated May 2014 indicated R36's w/c had not been cleaned. The Wheelchairs To Pull For Night Washing sheets dated 5/1/14, through 5/9/14, also indicated R36's w/c had not been cleaned.	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 465}	Continued From page 310 The facility Maintenance Request Log Policy and Procedure revised April/2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs ..." The policy lacked information on how often residents carpets would be cleaned.	{F 465}		
{F 469} SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a pest control program effective in the control of ants in 1 of 1 resident room (R56). Findings include: During observation on 5/7/14, at 7:42 a.m. 12 winged insects were noted on R56's bed and on the wall at the head of the bed. During observation on 5/7/14, at 7:59 a.m. R56's room was noted to have open food items, The carpeting next to the bed was heavily soiled with brown and red material, and a foul odor was noted in the room. On 5/7/14, at 8:41 a.m. an ant mound and three ants were noted in the corner of R56's room by the window. Multiple ants were noted crawling on	{F 469}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 469}	Continued From page 311 and inside the heater under the window. When interviewed on 5/7/14, at 7:50 a.m. the director of facility operations stated the facility used Xtreme Pest Solutions for pest control. He stated staff identify any concerns with pests by documenting in the maintenance log kept behind the nursing station. When interviewed on 5/7/14, at 8:05 a.m. housekeeper-B verified there were bugs in R56's room and stated he had not seen them the prior Thursday when he'd cleaned the room. Housekeeper-B stated R56, "Has lots of sweets in her room and that may be why." On 5/7/14, at 8:09 a.m. the director of facility operations was asked to come to R56's room and stated, "We have to get her out of the room right away!" and call the pest company. He stated he was not sure what the bugs were but thought they were ants or wasps. The pest control contractor was interviewed on 5/7/14, at 12:52 p.m. and stated the bugs were a form of pavement ants and he had treated the room and the surrounding areas. He reported the ants were drawn into the room for food and the facility would need to maintain treatment to the affected areas. Review of the Service Report dated 2/13/14, included treatment for mice and rats. Review of the Service Report dated 4/3/14, included treatment for multiple targeted pests including ants. The Service Report dated 5/7/14, at 12:30 p.m. included treatment for multiple targeted	{F 469}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 469}	Continued From page 312 pests including ants and indicated four rooms on the south hall were treated as well as the exterior of the south wing. A policy regarding pest control was requested and the director of facility operations stated the facility did not have a policy.	{F 469}		
{F 490} SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: An immediate jeopardy related to administrative failures was identified during the revisit survey on 5/12/14. The immediate jeopardy began on 5/10/14 and was removed on 5/21/14. However, non-compliance remained at the lower severity level of F (wide spread with no actual harm). Based on observation, interview and document review, the administrator failed to provide adequate supervision and oversight for residents who had known drug and alcohol (ETOH) use for 2 of 11 residents (R37, R129). In addition, the administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues being identified at F490. In addition to the IJ issues, the facility was not administered in a manner to maintain compliance	{F 490}		

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{F 490}	Continued From page 313 with other regulations specific to meet the needs of residents for 15 of 40 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; 3 of 5 employees (E1, E2, E3) reviewed whose annual evaluations were not completed; 1 of 5 nursing assistants (NA-Z) did not meet the required inservice hours; 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) did not have current license verification. These administrative failures had the potential to affect all residents of the facility. The following deficiency was cited during a revisit conducted on 5/13/14, and was the basis for an IJ to resident's health and safety. The IJ began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by exit of the 5/13/14 survey. Findings include: On 5/9/14, the facility had been informed of serious and immediate safety and supervision issues related to a lack of adequate supervision for residents, specifically related to resident's with known drug and alcohol use issues, and elopements. The facility had been informed these issues constituted an immediate jeopardy situation. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect	{F 490}		

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{F 490}	Continued From page 314	{F 490}		

residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and/or alcohol intoxication. In addition, on 5/11/14, a vulnerable resident was able to elope from the facility on three separate occasions without staff present even though the facility had implemented a WanderGuard device.

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an IJ situation for R37, R129 and R116.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to

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{F 490}	Continued From page 315 screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, develop and implement interventions for medically-related social services, for residents known to provide and/or use illegal drugs and ETOH in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to ETOH abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, and supervise staff. An IJ was identified on 5/9/14, for lack of supervision related to drug and ETOH use for R37, R129, R41, R117, and for the lack of supervision for residents who were at risk for elopements, R13. On 5/9/14 the administrator, On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).	{F 490}		

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{F 490}	Continued From page 316 Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential	{F 490}		

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{F 490}	Continued From page 317 to affect all 67 residents in the facility. A letter was provided to surveyors on 5/19/14 by an employee who wished to remain anonymous. The letter indicated that as of that date, the President and CEO of Videll Healthcare was informing employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had also been posted at the employee time clock. The IJ that began on 5/10/14, was removed on 5/21/14, when the facility had implemented an IJ removal plan which included the development and/or revision of policies related to obtaining a drug and alcohol free facility and policies related to prevention of elopements. The facility initiated assessments for reisdents who had been identified at risk for drug/alcohol issues and elopements; The facility also developed a system for investigation of ongoing incidents; Staff were educated to their responsibilities for how to supervise, care for and protect residents; Direct care staff and licensed nursing staff were interviewed and were able to explain their responsibilities for identification of residents who were elopement risk. Administration convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate	{F 490}		

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{F 490}	Continued From page 318 concerns. However, non-compliance remained at the lower scope and severity (s/s) of an F (no actual harm with potential for more than minimal harm that is not immediate jeopardy) because of the number of deficient practices that remained uncorrected at the time of the revisit 5/21/14.	{F 490}		
{F 492} SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance to ensure freedome from tuberculosis (TB) before they were assigned to work. This had the potential to affect all 67 residents residing in the facility. Findings include: The facility did not comply with the Minnesota Statute 144A.72 REGISTRATION REQUIREMENTS; PENALTIES. Subdivision 1.Minimum criteria. The commissioner shall require that, as a condition of registration: (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel	{F 492}		

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{F 492}	Continued From page 319 employed in health care facilities. A review of the supplemental staff files revealed the following: NA-T had a negative tuberculin skin test (TST) administered on 8/26/11. There was no record to show a second TST was done. Licensed practical nurse (LPN)-C had a chest x-ray result dated 10/17/07. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-F's TB screening test result dated 4/10/14, read "Negative. M. tuberculosis infection not likely, but cannot be excluded in cases of immunosupression." There was no screening for symptoms of active TB and there was no examination done by a medical doctor after the TB screening test. LPN-I had a first TST administered on 3/29/11. There was no evidence of a second TST having been done. LPN-J had a negative CXR results done on 12/7/09. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-K CXR results done on 1/19/09, was read as "Unremarkable exam." There was no screening for symptoms of active tuberculosis and there was no examination done by a medical doctor. On 5/13/14, at 9:33 a.m. during a telephone interview, O-I from Soul Care staffing agency	{F 492}		

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{F 492}	Continued From page 320 verified the above-named supplemental staff are employed by Soul Care and that the same staff had been reporting for work at the facility. He further verified all of the findings pertaining to TB screening dates and procedures for the employees named. On 5/13/24, 10:27 a.m. LPN-A, nurse manager, stated the staffing agency would provide to the facility the TB screening records of staff coming to work. LPN-A stated that it was human resources (HR's) responsibility to keep track of the records and to keep the files for the facility. On 5/13/14, at 10:55 a.m., the consultant administrator verified the list of supplemental staff provided to surveyors was current, and the staff had been working at the facility. The consultant administrator stated that supplemental staff was not treated any differently from regular facility staff with regard to TB screening. She stated Soul Care provided the TB screening records of supplemental staff, and if staff were found positive for the TST results, they should have been required to undergo assessments for current TB symptoms, should have had CXR and physician's visit indicating employees were clear from tuberculosis. The consultant administrator stated HR was responsible to keep track of pool staff records and to report to the director of nursing and the administrator if issues were identified. The Clinical and Operations Manual dated 5/2012, directed the facility to administer a 2-step PPD (purified protein derivative used to do a TST) to all employees and that documented copies were to be kept in the employees' file records.	{F 492}		

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{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility for 15 of 44 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; facility failed to ensure 3 of 5 employees (E1, E2, E3) reviewed during the initial survey for annual evaluations were completed; In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed; the facility failed to ensure 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) had current license verification. In addition, the facility's governing body failed ensure vendors were paid in a timely manner. This had the potential to affect all 67 residents in the facility. Findings Include:	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 493}	Continued From page 322 Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse. Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 493}	Continued From page 323 (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 493}	Continued From page 324 Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13. Refer to F412: the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Refer to F490: the administrator failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 493}	Continued From page 325 in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F500: the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because they had not paid the bill to the agency. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging	{F 493}		

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{F 493}	Continued From page 326 Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice on Monday, May 5th, Tuesday, May 6th, and Wednesday, May 7th. The facility had social workers scheduled, but due to not paying their bill, the social workers were not provided." For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from	{F 493}		

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{F 493}	Continued From page 327 individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 493}		
{F 497} SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing	{F 497}		

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{F 497}	Continued From page 328 education for 1 of 5 NAs (NA-Z) reviewed. This had the ability to impact all 67 residents in the facility as the facility was a one story facility and the staff could work on all of the units. Findings include: Evaluations: On 5/12/14, at 10:00 a.m. employee performance evaluations for E1, E2 and E3 were requested of the administrator. He said he would get them; however, no evaluations were provided. On 5/13/14, at 12:41 p.m. performance evaluations for E1 through E3, from previous March 2014 survey and evaluations for all employees due for annual performance review in March 2014 and April 2014 was requested of the administrator. He said he would get the information. On 5/13/14, at 3:30 p.m. unable to interview the director of nursing (DON) as the DON had resigned. On 5/13/14, at 3:35 p.m. although the evaluations had been requested, no employee performance evaluations had been provided by facility as of that time. At the time of exit on 5/13/14, at 4:30 p.m. the evaluations still had not been provided. In-service: NA-Z was hired on 4/10/11. The employee file was reviewed for continuing education and noted NA-Z had only 3.5 hours of the 12.0 required hours from 1/1/13 through 5/12/14.	{F 497}		
{F 499} SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS	{F 499}		

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{F 499}	Continued From page 329 The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification of licensure for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C). These had the potential to affect all 67 residents residing in the facility. Findings include: Licensure verification: LPN-A's employee file folder lacked verification of the LPN license. The administrator verified on 5/12/14, at 12:45 p.m. there was no proof of nursing licensure obtained from the Minnesota Board of Nursing for LPN-A. RN-C was hired on 4/8/14, indicated no licensure verification (copy of license dated 10/4/13) had been completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge for doing license verifications for new employees. The administrator further stated the HR person was terminated two weeks ago. The administrator added the facility did not ensure tracking for new employees' license verification.	{F 499}		

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{F 499}	Continued From page 330 On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, then she started full time work on her own since 4/16/14. The facility's Clinical Manual, Operational Manual dated 5/2012, directed the facility to obtain verification of nursing licensure from the State licensing board upon employment and to keep a completed "License Verification Form" in the employee's personnel file.	{F 499}		
{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have contracted social services	{F 500}		

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{F 500}	Continued From page 331 available on 5/5/14, 5/6/14, and 5/7/14, because the facility had an outstanding debt to the agency. Findings include: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. At 2:30 p.m. the administrator stated the contracted social work agency was Circle of Life Aging Services. The owner of Circle of Life, Aging Services (contracted social service), interviewed On 5/12/14, 1:18 p.m.c stated, "The reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." Refer to F250: the facility failed to aggressively	{F 500}		

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{F 500}	Continued From page 332 identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) who needed social services interventions for alleged substance abuse and did not receive the services; and for 2 of 11 residents (R13, R103) who were alleged to have eloped and did not receive the medically needed social services.	{F 500}		
{F 502} SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Findings include: A Progress Notes dated 5/6/14, noted as a late entry for 5/5/14, indicated R37 was found outside of the facility and reported to staff he had gotten heroin and cocaine from another resident and had been injecting the drugs. R37 was noted to have several scattered purple bruises on his forearms.	{F 502}		

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{F 502}	Continued From page 333 A Physician's Orders dated 5/6/14, directed urine toxicology screen. A Progress Notes dated 5/6/14, indicated the nurse went to R37's room to obtain a urine specimen for toxicology screen. R37 refused to provide a urine sample to the nurse. The note indicated a urine sample cup and supplies were left in R37's room with instructions to obtain a sample when R37 had the urge to void even though a urine specimen for toxicology needed to be witnessed by staff. Review of the medical record lacked evidence of any further attempts made to obtain the urine toxicology screen or lab results. When interviewed on 5/12/14, at 11:53 a.m. the health unit coordinator stated there was not a urine toxicology screen completed as ordered and the only lab work completed for R37 in May 2014 was done in the hospital. A facility policy regarding lab work was requested and not provided.	{F 502}		
{F 514} SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	{F 514}		

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

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{F 514}	Continued From page 334 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete medical records, the charts lacked nursing notes, laboratory results, behavior monitoring. and assessment and plans for initial physician assessments for 20 of 40 residents (R103, R116, R86, R71, R9, R34, R51, R129, R13, R117, R41, R62, R37, R56, R36, R123, R1, R113, R29, R91). This had the potential to affect all 67 residents. Findings include: R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures of arm, leg, rib and pelvis related to a motor vehicle accident. Last progress note on 1/5/14, at 5:30 a.m., "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility, and currently uses Foley catheter." An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter. R103 was now	{F 514}		

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{F 514}	Continued From page 335	{F 514}		

assessed as independent in all functional activities of daily living. The chart lacked documentation of when the Foley catheter was removed.

The chart lacked a significant change MDS for improvement in more than two areas of functional status.

The care plan dated 8/9/13, and revised 3/29/14, and 4/26/14, indicated, "English as a second language, required short term placement for rehab and was expected to discharge to the community within the next 3 months. R103 had impaired mobility care plan related to MVA, multiple fractures and weakness, and was to use a cane. A potential for self-care performance deficit. A potential for alteration in bowel and bladder related to disease process, unsteady gait, and cultural differences."

The medical record was reviewed on 5/11/14, and lacked documentation of LOA (leave of absence) or discharge.

Orders dated 4/16/14 state may LOA unsupervised with medications.

On 4/20/14 at 9:48 p.m. Pt went on LOA. The chart lacked documentation of return to the facility.

On 5/10/14 at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on

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{F 514}	Continued From page 336 LOA. On 5/11/14, at 10:00 a.m. the facility was asked if the resident had been discharged, or was on LOA and had returned to the facility. HUC checked to see and resident was in room. He had signed in at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had notes for R103, but knew he had been working with a relocation worker. R71 was admitted to the facility on 5/17/10, with admission diagnosis of CVA (stoke) with hemiplegia (loss of all or part of one side of the body), chronic pain syndrome, depression, and diabetes. R71 was seen by the physician on 4/16/14, labs were ordered, and new medication orders dated 4/16/14, included: bendadryl 25 mg (milligrams) give 1-2, every 4-6 hours as needed for itching, and to increase gabapentin to 300 mg, give 2 every bedtime (for persistent left sided pain). On 4/18/14, a physician order to increase atorvastatin (a cholesterol-lowering medication) to 80 mg daily, and Metformin ER (used to treat type 2 diabetes) 1000 mg daily with supper. An initial primary care physician (PCP) to establish primary care on 4/16/14: noted a history of CVA (stroke), left hemiplegia (loss of use of part or all of the left side), hypertension, dyslipidemia, Major Depressive disorder, diabetes	{F 514}		

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{F 514}	Continued From page 337	{F 514}		

type II, tobacco abuse, and neuropathic pain. A review of medication list, and laboratory tests were ordered Hbg A1c (a indicator of diabetic compliance over a three month period), lipid panel (cholesterol testing) alt (liver test), lytes and BUN (kidney function tests).

On 5/6/14, a review of the medical record revealed no results for the lab tests that had been ordered on 4/16/14.

On 5/7/14, at 3:14 p.m. the health unit coordinator (HUC) verified the medical record lacked results of the 4/16/14, ordered labs, and also lacked the new PCP initial visit notes, assessment, or plan for patient treatment.

R9's medical record lacked laboratory results since 7/30/13.

On 5/13/14, at 9:30 a.m. during review of R9's medical reviewed it was revealed R9 had been to the primary physician's office several times for routine visit since 7/30/13, but lacked laboratory results for all the tests completed during the office visits.

When interviewed on 5/13/14, at 10:58 a.m. the HUC verified there were no labs in the resident chart since 7/30/13. The HUC stated the particular clinic the resident went to "always" had given her a hard time getting the notes and labs. The HUC indicated she had been told in the past that she had to call the day of the appointment to request for the information or write a note in the facility referral sheet but still nothing was being sent back with resident.

Copies of R34's care plan were requested from

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	245544	A. BUILDING _____ B. WING _____	R 05/21/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 514}	Continued From page 338	{F 514}		

the record. The vulnerable adult care plan for R51 was provided that had been in R34's chart. R34 and R51 have the same last name with different first names.

Refer to 223: the facility failed to ensure R34 was free from verbal abuse from R36 and review of the medical records for R34 and R36, lacked documentation regarding the incident which was reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, R9). That resulted in harm for R129, R117, R41, R37.

Refer to F274: the facility failed to complete a significant change assessment (SCSA) for 2 of 3 residents (R56, R116) with a decline in functional status.

Refer to F275: the facility did not comprehensively assess 1 of 1 resident (R36) who required a comprehensive assessment at 366 days.

Refer to F280: the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter for 1 of 3 residents (R36); and for 1 of 1 resident (R116) on Hospice who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who allegedly had

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{F 514}	Continued From page 339 substance abuse. Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F329: the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R36, R1, R89, R113, R29, R37, R91). Refer to F412: the facility failed to ensure residents were provided dental services for 1 of 3 residents (R36). In addition, the facility failed to ensure residents received recommended dental follow-ups for 1 of 3 residents (R9). Refer to F502: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Refer to F520: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.	{F 514}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS	{F 520}		

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{F 520}	Continued From page 340 A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 44 (R34, R37, R129, R116, R41,R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1, E2, E3) reviewed during the initial survey; the facility failed to ensure nursing assistants (NA) received the required continuing education for 1 of 5 (NA-Z); and 5 of 11 employees (registered nurse (RN)-C, RN-D,	{F 520}		

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{F 520}	Continued From page 341	{F 520}		

licensed practical nurse (LPN)-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility.

Findings include:

Refer to F223: the facility failed to ensure one of one resident (R34) was free of abuse.

Refer to F224: an Immediate Jeopardy (IJ) was identified at F224 for neglect of care for R37 and R129, when residents were able to access drugs and alcohol and required hospitalization after the Immediate Jeopardy at F323 had been identified on 5/9/14.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (RN-C, RN-D, LPN-A, NA-U, NA-Q).

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these

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{F 520}	Continued From page 342 services for residents known to provide and use illegal drugs and alcohol in the facility for 11 of 11 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323). Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14	{F 520}		

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{F 520}	Continued From page 343 through 4/5/14. Refer to F490: an IJ was issued at F490 for administration failure to fully implement the March POC, and to act upon the IJ identified at F323 on 5/9/14, to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C. These had the potential to affect all 67 residents residing in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. facility staff stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services.	{F 520}		

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{F 520}	Continued From page 344 On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. "For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." On 5/19/14, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the Limited Liability Company (LLC) would make an accounting of the monies deducted from individual checks and put	{F 520}		

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{F 520}	Continued From page 345 together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 520}		

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245544

April 11, 2014
By Overnight Mail

Ms. Catherine Scoville, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

Dear Ms. Scoville:

SUBJECT: NOTICE OF IMMEDIATE IMPOSITION OF REMEDIES
Cycle Start Date: March 18, 2014

SURVEY RESULTS
On March 11, 2014, a Life Safety Code survey and on March 18, 2014, a health survey were completed at Camden Care Center by the Minnesota Department of Health (MDH) to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. These surveys revealed that your facility was not in substantial compliance and found the most serious deficiencies to place the health and safety of your residents in immediate jeopardy. These deficiencies were cited as follows, including the level of scope and severity (S/S):

- F223 -- S/S: J -- 483.13(b), 483.13(c)(1)(i) -- Free From Abuse/involuntary Seclusion
- F323 -- S/S: K -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

In addition, the following cited deficiencies constitute substandard quality of care, and an extended survey was performed:

- F223 -- S/S: J -- 483.13(b), 483.13(c)(1)(i) -- Free From Abuse/involuntary Seclusion;
- F226 -- S/S: F -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies;
- F323 -- S/S: K -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

Surveyors found a situation of immediate jeopardy to resident health and safety that was removed on March 18, 2014. However, they also found that your facility continued to not be in substantial compliance with Federal requirements as a result of uncorrected deficiencies. These deficiencies are as follows:

- F155 -- S/S: D -- 483.10(b)(4) -- Right To Refuse; Formulate Advance Directives
- F157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
- F174 -- S/S: D -- 483.10(k),(l) -- Right To Telephone Access With Privacy
- F176 -- S/S: D -- 483.10(n) -- Resident Self-Administer Drugs If Deemed Safe
- F204 -- S/S: D -- 483.12(a)(7) -- Preparation For Safe/orderly Transfer/dischrg
- F221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
- F225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
- F226 -- S/S: F -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
- F241 -- S/S: D -- 483.15(a) -- Dignity And Respect Of Individuality
- F247 -- S/S: E -- 483.15(e)(2) -- Right To Notice Before Room/roommate Change
- F250 -- S/S: E -- 483.15(g)(1) -- Provision Of Medically Related Social Service
- F253 -- S/S: E -- 483.15(h)(2) -- Housekeeping & Maintenance Services
- F257 -- S/S: D -- 483.15(h)(6) -- Comfortable & Safe Temperature Levels

- F258 -- S/S: D -- 483.15(h)(7) -- Maintenance Of Comfortable Sound Levels
- F272 -- S/S: D -- 483.20(b)(1) -- Comprehensive Assessments
- F275 -- S/S: D -- 483.20(b)(2)(iii) -- Comprehensive Assess At Least Every 12 Months
- F279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
- F282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
- F283 -- S/S: E -- 483.20(l)(1)&(2) -- Anticipate Discharge: Recap Stay/final Status
- F309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
- F312 -- S/S: D -- 483.25(a)(3) -- Adl Care Provided For Dependent Residents
- F314 -- S/S: G -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
- F319 -- S/S: D -- 483.25(f)(1) -- Tx/svc For Mental/psychosocial Difficulties
- F328 -- S/S: D -- 483.25(k) -- Treatment/care For Special Needs
- F329 -- S/S: E -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
- F353 -- S/S: E -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
- F385 -- S/S: E -- 483.40(a) -- Residents' Care Supervised By A Physician
- F386 -- S/S: E -- 483.40(b) -- Physician Visits - Review Care/notes/orders
- F387 -- S/S: E -- 483.40(c)(1)-(2) -- Frequency & Timeliness Of Physician Visit
- F412 -- S/S: D -- 483.55(b) -- Routine/emergency Dental Services In Nfs
- F425 -- S/S: D -- 483.60(a),(b) -- Pharmaceutical Svc - Accurate Procedures, Rph
- F428 -- S/S: E -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
- F431 -- S/S: F -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals
- F441 -- S/S: D -- 483.65 -- Infection Control, Prevent Spread, Linens
- F465 -- S/S: E -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ
- F490 -- S/S: F -- 483.75 -- Effective Administration/resident Well-Being
- F493 -- S/S: F -- 483.75(d)(1)-(2) -- Governing Body-Facility Policies/appoint Admn
- F497 -- S/S: E -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
- F500 -- S/S: F -- 483.75(h) -- Outside Professional Resources-Arrange/agrmnt
- F501 -- S/S: F -- 483.75(i) -- Responsibilities Of Medical Director
- F514 -- S/S: F -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible
- F520 -- S/S: F -- 483.75(o)(1) -- QAA Committee-Members/meet Quarterly/plans

The State advised you of the deficiencies noted above and provided you with a copy of the survey reports (CMS-2567).

SUMMARY OF ENFORCEMENT REMEDIES
As a result of the survey findings, and as authorized by the Centers for Medicare & Medicaid Services (CMS), the MDH notified you on April 4, 2014, of the imposition of the following remedies, as well as your appeal rights:

- State Monitoring effective April 13, 2014

The State survey agency notified you they were recommending that the CMS impose additional remedies. We concur with the State's recommendation and are imposing the following remedies:

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective April 29, 2014
- See Civil Money Penalty below

The authority for the imposition of remedies is contained in subsections 1819(h) and 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

DENIAL OF PAYMENT FOR NEW ADMISSIONS
Denial of payment for all new Medicare admissions is imposed effective April 29, 2014. This action is taken pursuant to Section 1819(h)(2)(B) of the Social Security Act. We are notifying the National Government Services that the denial of payment for all new Medicare admissions is effective on April 29, 2014. We are further notifying the State Medicaid agency that they must also deny payment for all new Medicaid admissions effective April 29, 2014 pursuant to Section 1919(h)(2)(A) of the Social Security Act and Federal regulations at 42 CFR Section

488.417(a).

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

TERMINATION
If your facility has not attained substantial compliance by August 18, 2014, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR Section 489.57 will apply.

CIVIL MONEY PENALTY
The State Agency recommended the imposition of a CMP. We concur that a CMP is warranted. Thus, we are imposing the following CMP:

- Federal Civil Money Penalty of $6,300.00 per day for nine (9) days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00
- Federal Civil Money Penalty of $250.00 per day beginning March 18, 2014

The CMP continues to accrue at the amount of $250.00 until you have made the necessary corrections to achieve substantial compliance with the participation requirements, or your provider agreement is terminated. However, the amount of the CMP may be increased or decreased if we find that the noncompliance changes.

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm, including footnotes
- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider’s loan request for the amount of the CMP

The CMP is due and payable and may be placed in escrow account fifteen days after one of the following, whichever occurs first:
- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

CMP REDUCED IF HEARING WAIVED

If you waive your right to a hearing, in writing, within 60 calendar days from receipt of this notice, the amount of your CMP will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be sent to the Centers for Medicare & Medicaid Services, Division of Survey and Certification, 233 North Michigan Avenue, Suite 600, Chicago, Illinois 60601-5519. The failure to request a hearing within 60 calendar days from your receipt of this notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 245544.
- The start date for this cycle is March 18, 2014.

NURSE AIDE TRAINING PROHIBITION

Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Because the facility was subject to an extended survey, this provision is applicable to your facility. Therefore, Camden Care Center is prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from March 18, 2014. You will receive further information regarding this from the State agency. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

APPEAL RIGHTS

The State survey agency previously advised of your right to appeal the noncompliance that resulted in the finding of SQC which resulted in the loss of NATCEP approval. Please refer to that notice and note the deadline for that appeal. As of this date, we have not received a request for a hearing.

This formal notice imposed:

- Federal Civil Money Penalty effective March 9, 2014

If you disagree with the findings of noncompliance which resulted in this imposition, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132

Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

It is important that you send a copy of your request to our Chicago office to the attention of Jan Suzuki. Failure to do so could result in our office proceeding with collection of the CMP.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

INFORMAL DISPUTE RESOLUTION

The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)

In accordance with §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of SQC or immediate jeopardy. To be given such an opportunity, 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 (or why you are disputing the scope and severity assessments of deficiencies which have been found to constitute SQC or immediate jeopardy) to: www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm. This request must be sent within 10 calendar days of receipt of this offer. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

CONTACT INFORMATION

If you have any questions regarding this matter, please contact Jan Suzuki, Program Representative, at (312) 886-5209. Information may also be faxed to (443) 380-6602. All correspondence should be directed to Jan Suzuki in our Chicago office.

Sincerely,

Gregg Brandush
Branch Manager
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Long Term Care
Stratis Health

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRYI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**

2.STATE VENDOR OR MEDICAID NO.
(L2) **456190000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **12/01/2012**

6. DATE OF SURVEY **05/13/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 06/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 06/26/2014 (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
01/01/1991
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/08/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5544

On 05/13/14, a Post Certification Revisit (PCR) was completed by the Minnesota Department of Health and on 05/01/14, the Minnesota Department of Public Safety completed a PCR. Based on these PCRs, it has been determined that the facility has not achieved substantial compliance pursuant to the 03/18/14 extended survey. Refer to the CMS 2567 (for health), CMS 2567B for both health and life safety code. Post certification revisit to fallow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

FedEx Tracking Number 8047 7140 3710

June 2, 2014

Mr. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544023

Dear Ms. Smith:

On April 4, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective April 13, 2014. (42 CFR 488.422)

On April 11, 2014, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Civil money penalty for the deficiency cited at: F223 at a S/S level of J (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F226, at a S/S level of F (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F314, at a S/S level of G (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F323, at a S/S level of K (42 CFR 488.430 through 488.444)

- Optional Denial of Payment for New Medicare and Medicaid Admissions, effective April 24, 2014 (42 CFR 488.417 (b))

- Discretionary termination of your provider agreement, effective August 18, 2014 (42 CFR 488.412 and 488.456)

- Mandatory Denial of Payment for New Medicare and Medicaid admissions, effective June 18, 2014. (42 CFR 488.417 (b))

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Camden Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 18, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

This was based on the deficiencies cited by this Department for an extended survey completed on March 18, 2014. Conditions in the facility at the time of the extended survey constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health or safety. The extended survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections were required.

On May 13, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify if your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on March 18, 2014. During our PCR, a partial extended survey was conducted and determined conditions of both SQC and IJ to resident health or safety continue to exist in the facility. The most serious deficiencies at the time of the May 13, 2014 visit were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K), whereby corrections are required.

REMOVAL OF IMMEDIATE JEOPARDY

We verified, on May 21, 2014, that the conditions resulting in our notification of Immediate Jeopardy (IJ) pursuant to our PCR/Partial extended survey completed on May 13, 2014, for reissued deficiencies cited at F250, F323 and an additional deficiency cited at F224, have been removed.

The deficiencies not corrected at the time of the May 13, 2014 revisit are as follows:

F0157 -- S/S: D -- 483.10(b)(11) -- Notify Of Changes (injury/decline/room, Etc)
F0221 -- S/S: D -- 483.13(a) -- Right To Be Free From Physical Restraints
F0223 -- S/S: D -- 483.13(b), 483.13(c)(1)(i) -- Free From Abuse/involuntary Seclusion
F0225 -- S/S: E -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) -- Investigate/report Allegations/individuals
F0226 -- S/S: E -- 483.13(c) -- Develop/implment Abuse/neglect, Etc Policies
F0250 -- S/S: H -- 483.15(g)(1) -- Provision Of Medically Related Social Service
F0275 -- S/S: D -- 483.20(b)(2)(iii) -- Comprehensive Assess At Least Every 12 Months
F0280 -- S/S: D -- 483.20(d)(3), 483.10(k)(2) -- Right To Participate Planning Care-Revise Cp
F0282 -- S/S: D -- 483.20(k)(3)(ii) -- Services By Qualified Persons/per Care Plan
F0309 -- S/S: D -- 483.25 -- Provide Care/services For Highest Well Being
F0314 -- S/S: D -- 483.25(c) -- Treatment/svcs To Prevent/heal Pressure Sores
F0319 -- S/S: D -- 483.25(f)(1) -- Tx/svc For Mental/psychosocial Difficulties
F0323 -- S/S: K -- 483.25(h) -- Free Of Accident Hazards/supervision/devices

F0329 -- S/S: E -- 483.25(l) -- Drug Regimen Is Free From Unnecessary Drugs
F0353 -- S/S: F -- 483.30(a) -- Sufficient 24-Hr Nursing Staff Per Care Plans
F0412 -- S/S: D -- 483.55(b) -- Routine/emergency Dental Services In Nfs
F0428 -- S/S: E -- 483.60(c) -- Drug Regimen Review, Report Irregular, Act On
F0431 -- S/S: E -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals
F0465 -- S/S: E -- 483.70(h) -- Safe/functional/sanitary/comfortable Environ
F0490 -- S/S: J -- 483.75 -- Effective Administration/resident Well-Being
F0493 -- S/S: F -- 483.75(d)(1)-(2) -- Governing Body-Facility Policies/appoint Admn
F0497 -- S/S: C -- 483.75(e)(8) -- Nurse Aide Perform Review-12 Hr/yr Inservice
F0500 -- S/S: D -- 483.75(h) -- Outside Professional Resources-Arrange/agrmnt
F0514 -- S/S: E -- 483.75(l)(1) -- Res Records-Complete/accurate/accessible
F0520 -- S/S: F -- 483.75(o)(1) -- Qaa Committee-Members/meet Quarterly/plans

In addition, at the time of this revisit, we identified the following deficiencies:

F0224 -- S/S: J -- 483.13(c) -- Prohibit Mistreatment/neglect/misappropriatn
F0274 -- S/S: D -- 483.20(b)(2)(ii) -- Comprehensive Assess After Significant Change
F0469 -- S/S: D -- 483.70(h)(4) -- Maintains Effective Pest Control Program
F0492 -- S/S: E -- 483.75(b) -- Comply With Federal/state/local Laws/prof Std
F0499 -- S/S: D -- 483.75(g) -- Employ Qualified Ft/pt/consult Professionals
F0502 -- S/S: D -- 483.75(j)(1) -- Administration

The most serious deficiencies in your facility at the May 13, 2014 revisit were found to be a pattern of deficiencies that constituted immediate jeopardy (Level K) as evidenced by the attached CMS-2567, whereby corrections are required.

As a result that your facility has not obtained substantial compliance at the Post Certification Revisit (PCR) completed on May 13, 2014. The Category 1 remedy of State monitoring, effective April 13, 2014, will remain in effect.

In addition, this Department is recommending to the CMS Region V Office the following actions related to the remedies outlined in their letter of April 11, 2014:

- Civil money penalty for the deficiency cited at: F223, at a S/S level of D, remain in effect. (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F226, at a S/S level of E, remain in effect .(42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F314, at a S/S level of D, remain in effect .(42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F323, at a S/S level of K, remain in effect. (42 CFR 488.430 through 488.444)

- Optional Denial of Payment for New Medicare and Medicaid Admissions, effective April 24, 2014, remain in effect. (42 CFR 488.417 (b))

- Discretionary termination of your provider agreement, effective August 18, 2014, remain in effect. (42 CFR 488.412 and 488.456)

- Mandatory Denial of Payment for New Medicare and Medicaid admissions, effective June 18, 2014, remain in effect. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 11, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

Furthermore, we are recommending to CMS Region V office the following additional remedy for imposition:

- Civil money penalty for the deficiency cited at: F490, at a S/S level of J (at the time of the PCR) (42 CFR 488.430 through 488.444)

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

Remedies - the type of remedies that would remain in effect with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 5

months after the survey date; and

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

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **<u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Camden Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 18, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Enclosed is a copy of the CMS-2567 (Statement of Deficiencies) and Post Certification Revisit Form, (CMS-2567B) from this visit.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Telephone: (651) 201-3792
Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

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

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

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

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

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

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

- Include signature of provider and date.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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, if your PoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE FIFTH MONTH AFTER THE LAST DAY OF THE SURVEY

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 18, 2014 (five months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist

Licensing and Certification Program
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00166	A. Building B. Wing	5/13/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20330** Reg. # **MN Rule 4658.0125** LSC	Correction Completed **05/13/2014**	ID Prefix **20435** Reg. # **MN Rule 4658.0210 Subp. 1** LSC	Correction Completed **05/13/2014**	ID Prefix **20560** Reg. # **MN Rule 4658.0405 Subp. 1** LSC	Correction Completed **05/13/2014**
ID Prefix **20685** Reg. # **MN Rule 4658.0465 Subp. 1** LSC	Correction Completed **05/13/2014**	ID Prefix **20690** Reg. # **MN Rule 4658.0465 Subp. 3** LSC	Correction Completed **05/13/2014**	ID Prefix **20860** Reg. # **MN Rule 4658.0520 Subp. 1** LSC	Correction Completed **05/13/2014**
ID Prefix **21230** Reg. # **MN Rule 4658.0700 Subp. 1** LSC	Correction Completed **04/28/2014**	ID Prefix **21260** Reg. # **MN Rule 4658.0705 Subp. 1** LSC	Correction Completed **05/13/2014**	ID Prefix **21290** Reg. # **MN Rule 4658.0710 Subp. 1** LSC	Correction Completed **05/13/2014**
ID Prefix **21300** Reg. # **MN Rule 4658.0710 Subp. 4** LSC	Correction Completed **05/13/2014**	ID Prefix **21375** Reg. # **MN Rule 4658.0800 Subp. 1** LSC	Correction Completed **05/13/2014**	ID Prefix **21550** Reg. # **MN Rule 4658.1325 Subp. 1** LSC	Correction Completed **05/13/2014**
ID Prefix **21565** Reg. # **MN Rule 4658.1325 Subp. 4** LSC	Correction Completed **05/13/2014**	ID Prefix **21695** Reg. # **MN Rule 4658.1415 Subp. 4** LSC	Correction Completed **04/28/2014**	ID Prefix **21705** Reg. # **MN Rule 4658.1415 Subp. 6** LSC	Correction Completed **05/13/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	06/02/2014	30951	05/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00166	A. Building B. Wing	5/13/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date
ID Prefix **21805** Reg. # **MN St. Statute 144.651 Sul** LSC	**05/13/2014**	ID Prefix **21840** Reg. # **MN St. Statute 144.651 Sul** LSC	**04/28/2014**		

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GD/AK	06/02/2014	30951	05/13/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/18/2014			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing	5/13/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0167** Reg. # **483.10(g)(1)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0174** Reg. # **483.10(k),(l)** LSC	Correction Completed **04/28/2014**
ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0204** Reg. # **483.12(a)(7)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **04/28/2014**
ID Prefix **F0247** Reg. # **483.15(e)(2)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0257** Reg. # **483.15(h)(6)** LSC	Correction Completed **04/28/2014**
ID Prefix **F0258** Reg. # **483.15(h)(7)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0272** Reg. # **483.20(b)(1)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/28/2014**
ID Prefix **F0283** Reg. # **483.20(l)(1)&(2)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0328** Reg. # **483.25(k)** LSC	Correction Completed **04/28/2014**

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	06/02/2014	30951	05/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing	5/13/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0385** Reg. # **483.40(a)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0386** Reg. # **483.40(b)** LSC	Correction Completed **04/28/2014**
ID Prefix **F0387** Reg. # **483.40(c)(1)-(2)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **04/28/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/28/2014**
ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **04/28/2014**				

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/AK	06/02/2014	30951	05/13/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 3/18/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245544	A. Building B. Wing **01 - MAIN BUILDING 01**	5/1/2014

Name of Facility	Street Address, City, State, Zip Code
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix	Correction Completed **04/28/2014**	ID Prefix	Correction Completed **04/28/2014**	ID Prefix	Correction Completed **04/28/2014**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0038		LSC K0069	
ID Prefix	Correction Completed **04/28/2014**	ID Prefix	Correction Completed **04/28/2014**	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. #	
LSC K0072		LSC K0147		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	06/02/2014	28120	05/01/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?
3/11/2014	YES NO

June 13, 2014

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
PO Box 64900
St. Paul, MN 55164-0900

Re: Camden Care Center

Dear Ms. Derfus:

Attached please find Camden Care Center's credible allegation of compliance for the survey exit date of May 13, 2014. You can reach me with any questions or concerns at 612-529-7747 x201 or leah.smith@pathwayhealth.com . Thank you in advance for your consideration.

Respectfully submitted,

Leah Killian-Smith
Interim Executive Director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted on May 5, 6, 7, 8, 9, 10, 11, 12, and 13, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on March 18th, 2014. An IJ at F224 began on 5/10/14, when R37 was admitted to the hospital following the use of illicit drugs while in the facility and was identified on 5/12/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey. An IJ at F323 began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization and was identified on 5/9/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of additional components to the IJ related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey. An IJ at F490 began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by the exit date of the survey. An extended survey was conducted by the	{F 000}	Approved MK on 6/24/2014	

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

See attached Letter | 6/13/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 Minnesota Department of Health on May 12 and May 13, 2014. The post certification re-visit survey was exited without removal plans having been approved for any of the deficiencies identified at a scope/severity of IJ: F224, F323 and F490.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	{F 157}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 157}	Continued From page 2 the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and family member(s) was promptly notified for 1 of 1 resident (R13) observed to elope from the building during the survey on 5/6/14. Findings include: On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 exited the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 3	{F 157}		

smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to be smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to finish smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair using her feet to propel the wheelchair towards 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly (posted speed limit was 30 miles per hour). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor that R13 had been observed on the city sidewalks. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 4	{F 157}		

driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, assisted her to wheel back to the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, identified diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had a history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples' belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, the assessment indicated R13 was required to have supervised LOAs (Leave of Absences) only, and that R13 had a past history of drug abuse.

A LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and that the resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, included; "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 157}	Continued From page 5	{F 157}		

can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of daily living (ADLs).

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, indicated R13 had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "WanderGuard in place." An intervention dated as initiated 3/16/12, directed,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 6 "Resident has been assessed and may not leave this facility without supervision." An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. The receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident." Although the note indicated a message had been left for the NP, the NP and family member(s) were not called until three days after the incident.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 157}	Continued From page 7 On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, did O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. registered nurse (RN)-C stated she was in the room when O-C had reported R13 had eloped. RN-C stated the announcement was made and RN-C, licensed practical nurse (LPN)-E, LPN-A and dietary manager (DM) was present for the announcement. RN-C stated she had not reported the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; and would be responsible to notify the family and physician regarding the elopement.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) reviewed for restraint, was free of physical restraints while directly supervised by staff during meals. Findings include: On 5/7/14, at 8:28 a.m. R89 was observed to be at a meal in her wheelchair (W/C) with the right break locked. Anti-rollbacks (devices which engage and keep wheelchair from rolling back when a resident stands) were observed to be applied to the back of the W/C. A nursing assistant (NA)-V was observed to be sitting directly to R89's left and assisted R89 to eat. When asked why the W/C brake was locked, NA-V stated "we lock one brake," and verified the left brake was unlocked. NA-V explained "brakes" needed to be locked "to protect her [R89]." NA-V further explained R89 needed to protect from "falling." NA-V was unclear why the left brake was left unlocked. The right side of the W/C was observed to be flush to the table. During the observation, R89 was observed to stand repeatedly, had worried expression on her face and repeated in an anxious voice, "I gotta go!" On 5/8/14, at approximately 8:30 a.m. R89 was	{F 221}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 9	{F 221}		

observed to be at the dining room table in the same location. R89 was observed to have both W/C brakes locked; the anti-rollback device remained appropriately applied to the W/C. R89 attempted to stand multiple times, appeared worried when standing, then immediately sat back down.
- From 8:30 a.m. until 9:40 a.m. R89 remained at the breakfast meal. NA-V was observed to provide R89 her breakfast, set up the breakfast and sit directly next to R89 and assist her to eat. At no time were W/C brakes unlocked. R89 was observed to stand repeatedly throughout the meal, pushing back slightly with her legs as she stood. The W/C was flush to the top of the table, preventing R89 from leaving the table.

The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a W/C and had "N/A [non-applicable]" written by hand in the section. Review of the clinical record lacked evidence R89 was assessed for restraints.

R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 10	{F 221}		

use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint.

The Care Area Assessment (CAA) for activities of daily living (ADLs) Function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA.

The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease.

The clinical record lacked evidence R89 had been assessed for restraint use, including locked W/C brakes and having the W/C pushed flush to the table.

R89's care plan dated as last reviewed on 3/28/14, identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 221}	Continued From page 11	{F 221}		

did not include direction to place R89 against a desk or table. The care plan was updated on 4/30/14, to include, "Anti-roll back brakes installed onto wheelchair to prohibit wheelchair from rolling backwards when resident offloads independently. Least restrictive safety device while in wheelchair."

On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E stated R89 "was not restrained" and stated "anti-rollback brakes were placed on the wheelchair." LPN-E stated R89's W/C was "looked at by therapies" and therapies had assessed R89 for the use of the anti-rollbacks on the W/C. LPN-E was unclear whether the locking of R89's W/C brakes had been assessed as a form of restraint.
- At 9:28 a.m. LPN-E stated the therapy department had only made a "recommendation" and since R89 was not on the therapy case load, they "didn't document the evaluation." LPN stated direct care staff had been "educated" not to lock R89's brakes or restrain her against a desk or table. LPN-E verified if R89 was directly supervised by a staff person, the W/C brakes should not have been locked.

On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of anti-rollbacks and the use of potential restraints, such as having both brakes locked and the W/C pushed flush to a table. DON repeatedly stated he thought "physical therapy assessed the use of the anti-rollbacks" but was unclear if R89 was assessed for restraints. DON verified therapy assessments should have been documented in R89's clinical record.

On 5/12/14, at 12:28 p.m. the physical therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 12	{F 221}		

assistant and rehab manager (PTA), occupational therapist (OT), and physical therapist (PT) were interviewed together in the therapy gym. All denied having assessed R89 for the use of the anti-rollbacks, W/C brake locking, or restraints. PTA stated the anti-rollbacks had been an idea that had been "brought up" in the morning meeting as "a way to keep her [R89] safe without locking the brakes." The OT stated therapy staff had "helped maintenance order the device," and stated since maintenance had not seen the device before, therapy staff had assisted him to "apply it." The PT stated no therapy staff had actually assessed R89 because there was no "physician's order" and because R89 "was not on case load." All therapists verified they would not "assess" a resident without a physician's order and stated they were unclear when they should "get involved." All verified they were employees of Videll Healthcare Limited Liability Company (LLC), but then stated, "The facility doesn't have polices to let us know our responsibilities."

On 5/12/14, at 12:23 p.m. R89 was observed to be in her W/C at the lunch meal. NA-V was observed seated directly to the left of R89. NA-V was interacting with R89 before the meal. R89 was observed to have the W/C pushed up flush against the table and both W/C brakes were observed to be locked which caused R89 to be restrained. The left anti-rollback arm was observed to be twisted off R89's left W/C tire (rendering the anti-rollback ineffective). The surveyor alerted NA-V to the anti-rollback being ineffective.
- At 12:26 p.m. R89 was observed to be provided her meal. NA-V setup the meal and remained with R89. R89 was observed to remain in the dining room throughout the meal with the brakes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 221}	Continued From page 13 locked. NA-V sat next to R89 until approximately 1:20 p.m. NA-V then unlocked both brakes and wheeled R89 away from the table and into the activity room on the South unit. On 5/13/14, at 9:03 a.m. LPN-E verified R89 should not have been restrained at the table while supervised during the meal. The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lap buddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking a resident's W/C brakes, seating a resident up against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DON or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each shift and released according to physician's orders. The policy did not address the release of restraint devices, such as releasing the restraint every two hours, during supervised activities, or while the resident was supervised at a meal.	{F 221}		
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	{F 223}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 14 The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse from another resident (R36). Findings include: On 5/6/14, at 9:49 a.m., 5/6/14, at 11:32 a.m., 5/6/14, at 2:48 p.m., 5/7/14, at 1:40 p.m., 5/8/14, at 9:29 a.m., 5/8/14, at 2:08 p.m., 5/10/14, at 12:45 a.m. R34 and R36 were both observed on the smoking patio. The annual Minimum Data Set (MDS) dated 4/1/14, for R34 included a Brief Interview of Mental Status (BIMS) score of nine which indicated moderate cognitive impairment and a Patient Health Questionnaire (PHQ-9) score of five which indicated mild depression. The MDS indicated R34 did not have delusions or hallucinations. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/3/14, lacked a summary regarding R34's cognitive status. A Vulnerable Adult Assessment date 3/18/14, indicated R36 was verbally abusive and condescending towards others. A Vulnerable Adult Assessment dated 4/4/13, indicated R34 had behaviors which made her	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 15 susceptible to abuse by others. A Social Service Note dated 4/17/14, indicated R34 had reported on 4/15/14, R36 was verbally abusive towards her. The note indicated when R36 was interviewed on 4/16/14, he stated he calls R34 "a parasite every time I see her because that is what she is." The note indicated R36 was told calling other residents names was verbal abuse and verbal abuse was not tolerated. A Progress Notes dated 4/17/14, indicated the contracted licensed social worker (CLSW) met with R34 on 4/16/14, and R34 indicated R36 "calls her every name in the book, he is just mean." A Progress Notes dated 4/17/14, indicated social services met with R36 and R36 stated he was going to "do what he wants" and would continue to call R34 a parasite. R36 was informed calling R34 names was verbal abuse and R36 responded "I don't care." The Admission Record dated 4/28/14, indicated R34 was admitted to the facility on 3/28/13, with diagnoses which included dementia and depressive disorder. A copy of an Incident/Accident Report dated 5/5/14, was provided on 5/8/14. The Incident/Accident Report indicated R34 had reported R36 had pushed her into a patio chair and R34 had become stuck when the patio chair fell over. It was noted the incident had occurred on 5/4/14, at night with no exact time. R36 was noted to have denied the incident; the police were called and spoke with R34. On 5/7/14, at 3:10 p.m. a copy of the facility investigation was	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 16	{F 223}		

requested. The Incident/Accident Report lacked any additional investigation into the incident.

A Progress Note dated 5/9/14, indicated R34 reported she did not like R36 because "he is an old drunk." The note indicated R34 had agreed to stay away from R36 and that R34 had stated she was used to handling old drunks, and had showed staff an old scar she reported was from when her late husband broke her leg.

When interviewed on 5/7/14, at 2:41 p.m. R34 stated R36 called her names "all the time." When asked how being called names made her feel, R34 stated she had filed a police report because R36 had "assaulted her" two nights ago. When asked what she meant by assaulted, R34 stated R36 waited until nobody was around and then pushed her. R34 reported the director of operations helped her file a police report. Review of the medical records for R34 and R36, lacked documentation regarding the incident which was allegedly reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

When interviewed on 5/7/14, at 3:10 p.m. the director of operations reported he was aware of the incident which had occurred during the evening of 5/5/14, and confirmed he'd helped R34 call the police. During the interview, the administrator stated he was aware of the incident and that it had been reported to him on 5/6/14. The administrator reported R34 and R36 "spar all the time."

Upon interview on 5/8/14, at 11:36 a.m. the director of nursing (DON) reported he had received the Incident/Accident Report on 5/8/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 223}	Continued From page 17	{F 223}		

The DON stated he was not sure whether the incident was reportable because it had occurred on 5/5/14, and it was a "resident to resident altercation."

The director of operations was interviewed on 5/12/14, at 9:20 a.m. and stated R34 was very upset about the incident from 5/5/14, and had wanted the police called because it was not the first time, and that R34 had felt assaulted and wanted to press charges.

Upon interview on 5/12/14, at 9:24 a.m. the administrator stated the incident on 5/5/14, had been reported to the state agency and that he would provide documentation regarding the report made.

R34 was interviewed on 5/12/14, at 1:31 p.m., R34 stated R36 was abusive to her every day but that she'd heard he had gotten sent to another nursing home. R34 stated she felt what R36 was doing to her was both verbal and physical abuse.

When interviewed on 5/12/14, at 1:52 p.m. the administrator and consultant administrator reported R34 and R36 have had an ongoing fight going on. The administrator stated R34 and R36 allege physical things and then change their stories. The consultant administrator stated that although the police had been called regarding the incident on 5/5/14, R36 had denied it happened and R34 had no visible injuries noted. The administrator stated when allegations of abuse are made, an incident report was to be filled out and a supervisor consulted to determine whether a report was needed. The administrator said the residents would be separated, an assessment would be made, the incident would be reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 223}	Continued From page 18	{F 223}		

the Common Entry Point (CEP) if appropriate, would be presented at their stand-up meeting the next day, and an investigation would be started. The administrator stated incidents were reported to the administrator, DON or CLSW but verified, "that system has not always been working." The administrator stated the incident form 5/5/14, had not been reported to the State Agency (SA) or to the CEP and acknowledged things needed to be reported right away and then investigated.

Minneapolis Police Department officer (MPD)-E was interviewed on 5/12/14, at 3:38 p.m. and confirmed the police department had come to the facility regarding the incident between R34 and R36 on 5/5/14. MPD-E stated the facility was aware the residents called each other names and stated it was a facility problem.

The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated May 2012, indicated staff must not permit "anyone" to engage in verbal or physical abuse. The policy indicated the facility would implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. The definition of verbal abuse was described in the policy as, "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." The policy indicated the facility would protect residents from harm during the investigation and would "report allegations to the state survey and certification agency and any other state agencies pursuant to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 223}	Continued From page 19 state regulations."	{F 223}		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. The IJ began on 5/10/14, when R37 was admitted to the hospital following the use of illicit drugs while in the facility and was identified on 5/12/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ at 3:15 p.m. on 5/12/14. The immediate jeopardy was not removed by the exit date of the survey. Findings include:	F 224		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 20 On 5/9/14, the facility had been informed of serious and immediate safety of the residents related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. According to documented progress notes, R37 had been found with ETOH/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14 and 5/10/14. The record also indicated R37 had required hospitalizations related to the use of alcohol and or drugs on 2/22/14, 4/23/14, and 5/10/14. During observations of R37 the following was observed: -On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility. - On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was "crazy". - On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 224	Continued From page 21	F 224		

without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and speak to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left rear pant pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. Nursing assistant (NA)-L approached R37 and stated she was with him today. NA-L verified she was assigned to provide the 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken out of the facility to an ambulance.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 22	F 224		

for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, R37 removed the WanderGuard (departure alert system) and refused a new one to be placed.
- On 5/3/14, R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limousine and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a notation had been made indicating it was a late entry for 5/5/14, at 6:00 p.m., the note indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 23 scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. indicated R37 was placed on one to one (1:1) [to be within arm's length at all times] observation related to incidences of getting intoxicated. - On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time. - On 5/10/14, indicated R37 was observed giving	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 24	F 224		

his credit card to R117 on 5/9/14. A second note indicated R37 returned from leave of absence (LOA) accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's Orders and Nurse Practitioners (NP) Orders were reviewed and the following was noted:
- On 1/8/14, included a diagnosis of ETOH abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's ETOH, to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 25 encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain, and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 26 appointments without supervision but was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending Alcoholics Anonymous (AA) or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the WanderGuard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH use, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 27	F 224		

to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusal noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated the resident had received a first offense of the facility's smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 had obtained the ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money for ETOH, and stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 28	F 224		

has heard about exchanges but could not remember who he'd heard about it from.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. The HUC said R37 had told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14, or 5/6/14, she had observed R37 in the parking lot, and had been told there was nothing they could do about it by the facility administrator. She said she'd requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested that the safety monitor put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of ETOH withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 29	F 224		

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 had refused to go to the bank with R37 and that friend-A had signed R37 out. The DON said the consultant administrator had been going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH and three plastic containers with the labels removed, which nursing indicated were methadone containers, had been found in R37's room.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on LOA and that R37 had returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 30	F 224		

stated the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 having left on LOA, she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and that she'd told friend-A that R37 could not go there. CLSW-A said friend-A had reassured her he had been sober for ten years and would never take R37 to a liquor store. The CLSW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and had informed her that friend-A was R1's drug dealer. CLSW-A stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing did not find the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 31	F 224		

R129 was identified by the facility to have a history of drug seeking and ETOH dependency. Although the facility had determined R129 required a 1:1 staff member since at least 3/18/14, according to a Vulnerable Adult (VA) assessment, the appropriate supervision was not implemented and/or effective.

According to review of the progress notes in R129's record, on 5/3/14, R129 had reported to the facility that she had obtained and consumed cocaine. The documentation indicated R129 had a staff assigned as a 1:1 at the time of the incident.
An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she had taken and indicated R129 then "confessed" to having taken cocaine. The report documentation indicated R129 had been sent to the emergency room (ER) and included, "She said, 'I knowingly took cocaine'.. Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1...remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others."

A North Memorial Medical Center (NMMC) Emergency Department (ER/ED) note dated 5/3/14, identified R129 had reported she'd taken cocaine at the nursing home. The ER note indicated R129 had taken the cocaine to "help with the pain" in her abdomen. "Patient [R129] is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 32	F 224		

triaged directly back to ED." The Clinician History of Present Illness section of the form identified R129 had reported to hospital staff she had snorted cocaine "5 hours ago."
On 5/11/14, at 4:00 a.m. the progress notes indicated R129 had obtained and consumed a life threatening amount of ETOH, causing her to require hospitalization in an intensive care unit (ICU) with subsequent intubation (mechanical ventilator assisted breathing) as a result of a blood ETOH level of 0.323. (According to Minnesota Statute 169A.20, 0.08 is considered impaired for driving). A 1:1 staff was supposed to have been in place at the time of the incident.

The resident's record included a note documented by the facility's HUC on 5/11/14, at 10:09 a.m. which indicated NMMC had called the facility "requesting" R129's medication administration records (MARs). The note indicated the registered nurse (RN) from the hospital had notified the HUC that R129 had been admitted to the ICU, and had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of 0.323."

The record also included a note documented by the director of nursing (DON) on 5/11/14, at 10:55 a.m. The DON's note recapitulated R129 had been sent to the hospital, identified the time of transport as "around 4 a.m." on the night shift, and identified R129 had been sent in "for intoxication." The DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the nursing assistant (NA) staff assigned to the 1:1 was called. The note indicated the NA assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 33	F 224		

R129 "reported that resident has been in and out of [R14's room number] but that she had not noticed any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident [R129] is visiting." In addition, the DON's documentation indicated R14 had denied giving or knowing how R129 had obtained the ETOH, and documented R14 had "mentioned that resident had alcohol overnight."

An additional progress note, dated 5/11/14, at 2:49 p.m. had been written by the DON indicating NMMC had been contacted to request updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."

Additional record review revealed an admission MDS dated 2/1/14, that indicated R129 had a BIMS score of 15, indicating R129 was cognitively intact. The MDS identified R129 was independent with all ADLs. The MDS identified R129 rejected cares and wandered one to three days during the assessment period. R129's comprehensive assessment analysis (CAA) for mood state dated 2/7/14, identified R129 as having intact cognition, with poor decision making and as having diagnoses of "substance induced psychotic disorder, opiate dependence, and ETOH dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug ETOH use" and depression. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAA lacked documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 34 interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment. A Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had behaviors including a history of rummaging through others' belongings and "drug use." The assessment indicated R129 had been placed on 1:1 due to rummaging in other resident rooms. R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and required a "1:1" which was spelled out in large	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 35 bold print. On 5/12/14, at 10:26 a.m. DON was interviewed about R129 having obtained ETOH and/or drugs while on a 1:1. The DON verified the 1:1 should have been within arm's length of R129 at all times. The DON denied having any knowledge of how R129 had obtained ETOH. On 5/13/14, at 2:21 p.m. the administrator stated during interview that the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and ETOH use. On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 36	F 224		

Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.

The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed:

"If staff have reasonable suspicion that a resident has used, has in their possession, or has distributed to other residents in the facility ETOH, street drugs, or other pharmacological substances not prescribed by treating physician the facility staff, under the direction of administration, shall:

· Search the residents room and remove such substances
· Notify the physician and obtain an order for blood and urine drug testing
· Notify the family and/or responsible party of the event

If the tests return positive the resident with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 37 positive results will be immediately discharged for placing the resident population at risk for abuse. If ETOH, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified." The facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The policy also included "Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision." Appendix A of the policy included examples of neglect including: "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision) which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety." According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 38	F 224		

which had been implemented to prevent the resident's elopement.

Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance."

A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 39	F 224		

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 224	Continued From page 40	F 224		

the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 41 On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 224	Continued From page 42 designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA). On 5/7/14, at 10:02 a.m. the ombudsman was interviewed. The ombudsman stated she wanted to be sure the state agency surveyors were aware that resident's of the facility were purchasing ETOH and drugs. The ombudsman reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff were finding ETOH bottles. In addition the ombudsman reported R37 had been found intoxicated several times and she was involved in discussing abuse prevention planning and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. The ombudsman stated the police had been notified and had been to the facility "quite often". She also stated she was aware R129 was on a 1:1 and had somehow obtained and consumed an "illegal drug [cocaine]" in the facility.	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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F 224	Continued From page 43 On 5/7/14, at 10:05 a.m. the administrator verified during interview that the ombudsman had been called 5/6/14, to speak with the facility regarding R37 having given his credit card to R117 to purchase ETOH because R37 had been "drunk for days." The IJ that began on 5/10/14, was not removed at the time of the exit from the survey because the facility failed to have developed and/or revised policies related to obtaining a drug and alcohol free facility; residents with a WanderGuard system or who had been identifed as at risk for elopement had not been re-assessed; facility elopement policies had not been reviewed or revised; no efforts had been established to ensure all staff were aware of how to supervise, care for or protect the residents. In addition, adminsitration had not yet convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate concerns.	F 224		
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	{F 225}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 225}	Continued From page 44 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Findings include:	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 45 R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated. R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form	{F 225}		

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{F 225}	Continued From page 46 also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for	{F 225}		

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{F 225}	Continued From page 47 R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility.	{F 225}		

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{F 225}	Continued From page 48 Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility	{F 225}		

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{F 225}	Continued From page 49 Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m. R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated. R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been	{F 225}		

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{F 225}	Continued From page 50	{F 225}		

obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the

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{F 225}	Continued From page 51 receptionist on the sidewalk." The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident. R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked	{F 225}		

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{F 225}	Continued From page 52 R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified. On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified. On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified. The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to	{F 225}		

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{F 225}	Continued From page 53 ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."	{F 225}		
{F 226}	483.13(c) DEVELOP/IMPLMENT	{F 226}		7/6/14

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{F 226} SS=E	Continued From page 54 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their Prohibiliton of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Propery policies for immediate reporting and thorough investigation were implemented for 8 of 9 residents (R37, R66, R70, R14, R41, R13, R129, R116) reviewed with allegations of such; the facility also failed to screen new employees for reference checks, back ground studies and license/certification verification for 6 of 6 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q, NA-W). Findings include: The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment,	{F 226}		

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{F 226}	Continued From page 55	{F 226}		

or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency (SA) and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."

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{F 226}	Continued From page 56 R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R129: An Incident/Accident Report dated 5/3/14,	{F 226}		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 226}	Continued From page 57	{F 226}		

at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 58	{F 226}		

interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk."

The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

On 5/9/14, at 1:43 p.m. LPN-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the form did not identify when the administrator or SA was notified.

On 5/12/14, at 10:26 a.m. director of nursing (DON) stated he was not in the facility at the time of R13's elopement and had not been informed until 5/8/14. The DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 59	{F 226}		

unescorted and stated residents with a WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. The DON also verified the incident had not been thoroughly investigated.

R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago."' "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated.

R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 60	{F 226}		

indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 61 R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified. On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified. R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 226}	Continued From page 62	{F 226}		

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 63 notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 226}	Continued From page 64 On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified. EMPLOYEE SCREENING: On 5/12/14, at 10:00 a.m. the employee files were reviewed and the following was observed: Licensure verification: Licensed practical nurse (LPN)-A's employee file folder lacked verification of the LPN's license. The administrator verified at 12:45 p.m. there had been no proof of nursing licensure obtained for LPN-A from the Minnesota Board of Nursing. Registered nurse (RN)-C's employee personnel file indicated RN-c had been hired on 4/8/14, and that a back ground study request had been submitted on 4/8/14, however there were no results yet. In addition, no licensure verification completed, only a copy of a license with expiration of 10/4/13. Background study: RN-D's file indicated RN-D had been hired 4/16/14, and that a background Study Request had been submitted on 4/14/14. However, the background study incorrectly indicated NA-U's background study information. Nursing assistant (NA)-U's file was reviewed and was found to include a statement that NA-U had a Minnesota Department of Human Services Background Study (MN DHS BS) form dated 5/25/14, which indicated NA-U "cannot provide	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 226}	Continued From page 65	{F 226}		

Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The administrator verified that NA-U could not provide care but had been providing care unsupervised, from 4/23/14, through 5/12/14.

NA-U had RN-D's BS in NA-U's employee file. Also, RN-D's BS was in NA-U's employee folder. RN-D's BS indicated that RN-D could not perform cares unsupervised. However, during the survey the administrator obtained the blue BS form which indicated RN-D could perform cares unsupervised.

NA-Q was hired on 3/6/14. The facility received a yellow MN DHS BS on 3/10/14, which indicated NA-Q "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The white BS computer genreated copy request indicated the form was submitted on 3/6/14, and passed as of 3/10/14, however the employee file lacked the information as the facility provided the information during survey. The facility did not have system in place to ensure BS were being monitored for the employees ability to work unsupervised.

Reference checks:
RN-C was hired on 4/8/14, and no reference checks had been completed.

RN-D was hired 4/16/14, and no reference checks, could be located in the employee file.

LPN-A's file lacked a hire date and no reference checks were completed as the facility policy had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 226}	Continued From page 66 directed staff to complete. NA-W hired 4/23/14, had no reference check completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge of doing license verifications and background checks for new employees. The administrator further stated the HR person had been terminated two weeks ago and no one else had been designated to follow-up on background checks that had been flagged. The administrator acknowledged the facility had not ensured tracking for new employees' license verification and background checks. On 5/13/14, at 8:10 a.m. NA-U verified during interview that she was a NA and had started orientation on 4/23/14. When asked if she worked under supervision, NA-U stated she had received "a couple of days training" and had started working on her own on 4/28/14. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, but stated she had been working full time on her own since 4/16/14.	{F 226}		
{F 250} SS=H	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 250}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) for alleged substance abuse, and for 2 of 11 residents (R13, R103) who allegedly eloped from the facility. Findings include: Alleged substance abuse: On 5/8/14, at 8:02 a.m. a list of residents allegedly bringing drugs and alcohol (ETOH) into the facility, as well as a list of residents known to use drugs or alcohol in the facility was requested. A list provided by the administrator at 11:00 a.m. included R129, R86, R41, R37, R14, R56, R117, R62 and R9 as alleged substance users. R129 was not provided consistent medically related social services to address ongoing drug seeking behaviors and sustained harm. Although R129 was assigned a one to one (1:1) as of 3/14, the clinical record lacked evidence of social service assessment and interventions. On 5/3/14, R129 reported to facility staff, that she had obtained and consumed cocaine while under 1:1 supervision. On 5/11/14, at 4:00 a.m. R129 had obtained and consumed ETOH while supervised 1:1 by facility staff. This resulted in harm when R129 required hospitalization in an intensive care	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 250}	Continued From page 68 unit (ICU) where she was intubated (mechanical ventilator assisted breathing) for a blood ETOH level of 0.323. R129's admission Minimum Data Set (MDS) dated 2/1/14, revealed a Brief Interview of Mental Status (BIMS--a tool to determine cognitive status) score of 15, indicating the resident was cognitively intact. In addition, it was noted R129 was independent with all activities of daily living (ADLs), rejected cares, and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R129 displayed poor judgment, and had impaired cognition and poor decision making skills. The CAA identified diagnoses including "substance induced psychotic disorder, opiate dependence, and alcohol dependence," as well as hepatitis C, "Hx [history] of drug alcohol use" and depression. Although the history of drug and ETOH dependence was identified, the CAAs lacked documentation of interventions to promote sobriety, such as but not limited to offering chemical dependency (CD) treatment. The Vulnerable Adult Assessment (VAA) dated 3/18/14, identified R129 had a history of ETOH abuse and "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse related to substance use and required supervision with leaves of absence (LOAs) from the facility. It was noted R129 had a history of rummaging through others belongings and "drug use," and 1:1 staffing was initiated due to rummaging in other resident rooms. R129's Smoking Evaluation dated 3/18/14, directed staff to "monitor for ETOH use or over	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 69 sedation." A Pain Evaluation and Management Plan dated 5/1/14, identified R129 had daily chronic pain, and a history of pain and seeking drugs. "Resident is on a restricted recipient program [where only one pharmacy may fill narcotic prescriptions to deter drug seeking behavior] due to drug seeking...MD [medical doctor] is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking." An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." R129 was described as "very sweaty, weak and tired...she looked very sleepy," and pupils were "large and nonreactive to light." When the nurse asked the resident what she'd taken, she "confessed" to taking cocaine. The report noted, "She said, 'I knowingly took cocaine'...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The resident's history of drug use and receipt of drugs from others was noted, as well as the fact that the resident had current 1:1 staffing. Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14. An Emergency Department Chart [from the hospital ER] dated 5/3/14, identified R129 reported to have taken cocaine while residing at the facility to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 70	{F 250}		

Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine '"5 hours ago."' Although R129 was identified as requiring the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use, only pain. The laboratory (lab) reports indicated various pertinent lab values were checked, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of Dilaudid (narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the designated State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug had been obtained while the resident had 1:1 staff supervision.

A unlabeled typed page insert in the front of R129's paper chart dated 4/15/14, read "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program...All scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their on call MD."

On 5/7/14, at 10:24 a.m. the a return call was made to the ombudsman who had requested contact. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she visited the facility on 5/6/14, and spoke with various residents as well

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 250}	Continued From page 71 as management staff regarding drug, alcohol and discharge planning concerns. The ombudsman, facility staff, and residents were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [cigarettes, alcohol and drugs] for them." The ombudsman stated the police had been notified and responded "quite often." Allegedly residents who were chemically dependent were drinking in their rooms and facility staff were conducting room checks each shift and "finding empty alcohol [vodka] bottles" in resident rooms, and residents had been found "intoxicated." The ombudsman specifically reported R129 had 1:1 staffing, yet had "somehow" obtained and consumed an illegal drug (cocaine). Although the facility had employed "three temporary social workers, social services is overwhelmed" due to "no policies and procedures in place." R129's care plan for safety/vulnerability dated 3/25/14, identified the resident was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated 4/11/14, directed staff to provide "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru [sic] their personal belongings." Review of the undated Group 7 nursing assistant	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 72 (NA) assignment sheet (for quick reference guide providing care-related direction) indicated R129 was independent with ADLs and "1:1" was noted in larger bold print. Pertinent Nursing Progress Notes read as follows: 1) On 3/14/14, at 6:18 p.m. R129 "had an appointment yesterday and was immediately transferred to the hospital...while on the way home [unclear on prior destination] stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams (mg) (a narcotic and Tylenol pain medication)...failed to alert staff and stated that there were no new orders." The hospital, on call MD and triage nurse were updated on R129's "history of narcotic use." 2) On 3/16/14, at 6:34 a.m. R129 was "caught going through another resident's belonging...opening her purse." The note indicated R129 admitted going in the room but denied taking "any money." 3) On 3/17/14, at 3:34 p.m. "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the record lacked documentation when the 1:1 staffing was initiated. At 10:17 p.m. "called on call [physician]," reported two incontinent episodes, "lower extremities [sic] hurts" and edema (abnormal build up of fluid in the tissues). Was encouraged to "sit and rest the leg" but refused and reported the pain was "unbearable." R129 wanted to be evaluated at the hospital, and "called 911 herself." Although a previous note indicated R129 required 1:1 staffing, it was noted R129 planned to "take care of her own transportation to ER...left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 73 4) On 3/18/14, at 3:56 a.m. R129 returned from the ER at 3:30 a.m. with a "New order. No new concern at this time." At 2:31 a.m. R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty. 5) On 3/20/14, at 10:08 a.m. the physician R129 identified as her new primary care physician (PCP) was contacted to inform the provider R129 lived in a health care facility, and orders needed to be coordinated with the facility. The PCP was provided an update regarding R129 changing her PCP, trips to the ER and drug seeking behavior. The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "Went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (hypnotic used to promote sleep). "Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. Patient will be monitored for increased sedation." Although the previous note indicated the transportation company was directed not to make any stops during transport, R129 had been brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription had been written and a report the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 74	{F 250}		

script was lost had been reported by R129. The physician denied taking R129 on as a patient, however, and referred the facility to R129's current PCP.
6) On 3/28/14, at 11:52 a.m. R129 met with social services and "Also spoke with resident regarding her drug seeking. [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
7) On 4/4/14, at 7:11 p.m. R129 met with psychologist, as well as the DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's...informed her she was on 1:1's because of her frequent drug seeking...admits that she has urges to seek medications to manager her pain...denies addiction." Inpatient treatment was discussed such as drug and emotional counseling, which R129 rejected. The note indicated the psychologist agreed with the need for treatment, "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
8) On 4/7/14, at 10:47 a.m. R129 remained, but requested she be removed from 1:1 supervision, which was noted as required "for going into other resident rooms."
9) On 5/4/14 12:03 a.m. R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [R1's room number]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 75	{F 250}		

to to the ER for evaluation. "The nurse requested for toxicology screen and a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129's involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified,and toxicology screening was obtained. Although R129 had an assigned 1:1, the record lacked evidence as to how the resident obtained and ingested the drugs, the incident was not immediately reported to the administrator and SA, nor was it investigated. In addition, the record lacked evidence R129 had received a CD evaluation or were immediate changes made in the monitoring and supervision provided for the resident's safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice...remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.

10) On 5/4/13, at 12:12 p.m. an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they were only accepting on-call emergencies. Staff would notify doctor the morning of 5/5/14. The resident returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, she immediately requested pain medication upon return to the facility (the note was not closed or signed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 76 writer). On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room. The door was open and R129 was dressed and was lying in bed with her eyes closed. NA-K reported she was assigned as a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms." The following day at 8:30 a.m. NA-M (1:1 staff) followed R129 down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length and looking in the opposite direction from R129 and talked with another staff person in the smoking area. R129 stood with other residents and smoked out of direct sight of NA-M. At 8:33 a.m. R129 sat on a bench with another resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same staff person. NA-M was not near enough to R129 to intervene should there have been a concern. At 8:37 a.m. staff spoke to each other and then NA-M turned his back on all smokers (including R129) and spoke to a male who was in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the staff directly. NA-M was not within arm's length or direct eye sight of R129. At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 77	{F 250}		

directly behind her into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway. At 9:34 a.m. R129 pushed R62 in her wheelchair out of the facility and onto the smoking patio. R62 held out a cigarette for R129 ask she pushed the chair, and R129 concealed the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. At 9:35 a.m. a staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents who were unsupervised. At 9:37 a.m. R117 came out of the facility, lit a cigarette at the front entrance, jumped up onto the cinder landscape block planter with ease, and walked across the top of the planters with a skipping gait. Neither the smoking monitor nor another female staff in the area intervened. R117 was observed to speak briefly with the female smoking monitor, approached R36, pulled out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter. NA-M was not within arms reach nor eyesight of R129, and was not supervising the resident. NA-M remained with the other female staff, with his back to R129. At 9:40 a.m. R129 stood and pushed R62's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 78	{F 250}		

wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 pushed the wheelchair down the hallway with NA-M walking beside R129. At 10:19 a.m. R120 walked out to the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retrieved a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make eye contact with R129 and was not in arms reach as he spoke with the smoking monitor. At 10:25 a.m. NA-M and R129 went inside with NA-M walking within arms reach of the resident.

On 5/8/14, at 11:22 a.m. R129 was observed lying in bed, NA-E was making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, which she had reported to facility staff. When asked when this occurred, R129 stated it was "on Saturday" (5/3/14)." When asked where she snorted the the cocaine, R129 replied, "not in the facility...down the block." When asked if she received the cocaine from another resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 79	{F 250}		

the person's name, description, or gender. R129 said she snorted "about $20 worth." When asked what happened then R129 stated, "They sent me to the hospital...They accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day by the 1:1 assigned to her that day. R129 stated the 1:1's name (NA-G) who was to be with her at all times. She said the reason for the 1:1 was because she was accused of "rummaging" in other residents rooms. R129 reported she had a 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 said she was "a recovering addict," but denied social services had been provided by facility staff, including assistance to obtain CD treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the ER, but was given two shots of Dilaudid. R129 explained she "thought" that was going to happen, yet admitted she was "surprised" to have received the narcotic pain medication. Although R129 was relaxed during the interview, she was hesitant to answer some questions and did not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified the responsibility of the 1:1 staff was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated was unaware of alcohol or drugs were being exchanged on "my shift," but stated was aware of situation "weeks ago" when she came to work and noticed R14 was not in his room. NA stated she asked where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 80	{F 250}		

he was and a NA "who was [R129's] 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated had not witnessed any exchanges and stated if she had she would have reported it to the nurse.

On 5/8/14, at 11:40 a.m. NA-S reported seeing alcohol bottles in residents' rooms and smelled alcohol on a resident and reported it to a nurse, but was unclear when it had occurred. NA-S "heard rumor" of a resident dealing drugs in the facility, and recalled seeing a resident with marijuana in January or February, and "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she overheard residents talk about it. NA-S believed R117 was a drug dealer, as the resident left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was from an "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. housekeeper (H)-A when asked, reported she had seen "empty pint bottles" of vodka in the trash by the front doors. The last time had been, "a few months ago," and she had reported any bottles she found. " H-A was unsure which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew how the bottles had been obtained, she was unsure, but thought they may have been brought in by family members.

On 5/8/14, at 12:03 p.m. LPN-H stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 81 confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, as well, but it was unclear how it was being provided. LPN-H verified R129 was on 1:1 which meant within arms reach. LPN-H was unaware R129 had obtained cocaine in the facility. On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. The HUC stated there was "always hearsay between residents...their selling [drugs and alcohol] to each other...it's always stories," including hearsay stories regarding heroin and cocaine. The HUC had put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program, and R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." R129 "refuses to tell" about the prescriptions, and the HUC went to the social worker to report these concerns. R129 denied having pills, "but I know she did get them...every week" R129 was finding a new doctor, and not providing the correct paperwork, or altering paperwork. The HUC was aware residents consumed alcohol in the facility, and some became intoxicated, however, it was unclear how they had obtained it. "I feel like we're supposed to do something, 'cuz no one will take charge." The HUC was aware R129 obtained cocaine and was sent to the ER, but was unsure if a toxicology screen had been done, although she had asked for them in the past. The HUC said she and other staff believed R129's (making quotation gestures) "son" was R129's dealer, and described him as a man she referred to as her son, who was at the facility at the time the resident snorted the cocaine.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 82 Further review of the nursing progress notes also revealed indicated the following: 1) On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (narcotic pain medication) refills and determined 110 Percocet tablets had been delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information. 2) On 5/11/14, at 10:09 a.m. a note written by the HUC indicated North Memorial Medical Center (NMMC) called "requesting" R129's Medication Administration Records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 had been able to obtain and ingest a life threatening amount of alcohol. Although the administrator was updated, the clinical record lacked evidence the SA was also immediately notified of the incident. The record lacked documentation at the time of the incident, as well as pertinent assessment information such as vital signs and symptom descriptions. In addition, the record lacked evidence of an immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time. 2) On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." R129 had "become weak" and needed to be lowered to the floor." Two LPNs were contacted and the NA staff	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 83	{F 250}		

assigned to the 1:1 was called. The NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting...." R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained the alcohol.
3) On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."
4) On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait." R129 was identified at risk for falling, was verbally aggressive to staff and stated, "'I'm drunk.'" The room was checked and no evidence of alcohol was found. R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening that was "reducing her hours to once a week." Both verified they had not specifically

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 84	{F 250}		

worked with R129 regarding CD treatment and verified was last offered to R129 on 4/4/14 and had not revisited CD treatment options after R129 reported cocaine use on 5/3/14. Neither was aware R129 had been hospitalized for alcohol toxicity and said they "should have been notified." CLSW-A and B had not worked the previous few days, as facility had not paid the contracted company's bill. CLSW-B expressed concern for the residents, and said R129 should have been reassessed after she had obtained and used cocaine, and both SWs felt R129 had been harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R86 was committed as mentally ill and chemically dependent per Hennepin County Commitment papers dated 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. R86 was placed at harm as R86 was hospitalized due to alleged substance abuse. On 3/16/13, R86 was admitted to the facility per the Admission Record. Diagnoses include hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage,

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 85 thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness. A care conference dated 1/2/13 [sic -2014], lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable. A progress note dated 2/22/14, at 11:00 p.m. "Pt was found smoking 'pot' in his room. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out." A progress note dated 2/23/14, at 10:33 a.m., "Resident left with family member in a VAN for unknown destination at this time, hoping to return today. We will follow up with resident safe returned." A progress note dated 2/23/14, at 10:23 p.m., "Resident returned from visiting with a family. The nurse checked resident. No injury observed." A progress note dated 2/24/14, at 4:38 a.m., "Resident had been very confused and having difficulty to settled [sic] down in bed. judgment [sic] has been non-intact [sic] and appeared restless with a lot of tremor. He attested to this writer that when he goes LOA he smokes marijuana but never drink alcohol at all. He state [sic] "If I drink I will die". His platelet has been dangerously lower [sic] thus posing him at a risk for bleeding. Update on call doctor about resident change in condition, who then mandate this writer to send resident to the emergency room for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. " The resident was admitted to the hospital.	{F 250}		

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{F 250}	Continued From page 86 A progress note dated on 2/24/14, at 3:32 p.m., " Writer called PCP and updated on his current use of marijuana, as well as updating that he is in the hospital." A progress note on 2/27/14, at 3:59 p.m."Nurse from U OF M,updated writer about resident current status, stating that, resident is alert and oriented x 3, appear to be quiet stable, but a little restless" and that R86 will "arrive at 1445 at facility, will pass this info to p.m. nurse." A progress note dated 3/4/14, at 6:11 a.m., "While executing initial nursing rounds this shift, this writer smell [sic] and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staffs [sic] that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinue. He had flexeral [sic- Flexeril (cyclobenzaprine) is a muscle relaxant used to treat skeletal muscle conditions] with some benefit noted. He want [sic] another sleeping pills [sic] at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg [milligrams] of Trazodone [an antidepressant], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment." A progress note dated 3/15/14, at 09:48 a.m., "[R86] having behaviors which are not in line his norms. Behaviors like going into other resident's room and sitting on their bed, coming in the hallway half naked. Patient at time have uncontrolled coughing as well." A progress note dated 3/15/14, at 10:22 a.m., "Resident left the facility this morning around 10:20 am for the Fairview ER [emergency room].	{F 250}		

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{F 250}	Continued From page 87	{F 250}		

He was escorted by two paramedics and admitted to the hospital."
A progress note dated 3/17/14; at 8:21 p.m. R86 came back from hospital at 3:45 p.m.., "Resident is alert and oriented. A progress note dated 5/10/14 at 10:04 p.m. R86 did not sign out when leaving facility. Writer called resident. Resident states he will be back by 11 p.m.."
A progress note on 5/11/14, at 6:30 p.m., "Writer not able to assess and talk to resident in relation to his h/o [sic history of] chemical dependency due to resident being LOA at this time. Writer will approach at a later time."
A progress note dated 5/19/14, at 1:37 a.m. indicated: at about 11:00 p.m. " Res noted with increased confusion, coughing constantly, and emesis X 2 [two times]. Cough meds admin per HSO [house standing orders] with no relief. Refused VS [vital signs]. Call placed to on-call MD at 12:10 a.m. Returned call from [MD ' s name] with an order to send resident to UMFH for eval [evaluation]. MPD [Minneapolis Police Department] non-emergency called at 12: 30 a.m. to request for transportation. "
A progress note dated 5/21/14, at 5:05 p.m., "Resident readmitted to facility from Fairview Medical Center. LOA safety assessment completed. Resident assessed to be appropriate to leave the facility unsupervised without medications and supervised with medications except narcotics due to history of chemical abuse. MD faxed for LOA orders and clarification of all other admitting orders. Resident is able to make needs known and removed himself from unsafe situations. Able to verbalize steps to take should a situation arise while out in the community. Able to verbalize LOA policy. Risk of drug/alcohol assessment/re-assessment completed. Resident is at risk for drug/alcohol

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 250}	Continued From page 88	{F 250}		

abuse. Has a dx of depression and ETOH abuse. Was recently discharged from the hospital. Has had no room or other significant changes in routine since return to the facility. Medication side effects remain on MAR. Offered and resident refused social service visits, spiritual counseling, in house psych, outside psych, and AA/NA. Bio-psychosocial assessment of drug and alcohol use in the facility completed. Resident denies any drug/alcohol use and reports using only his prescribed medications. Declined all resources offered. Repeatedly said throughout interview, 'If I drink it will kill me.' Smoking assessment completed, resident denies any tobacco use. Risk of elopement/wandering assessment completed. Resident is not at risk for elopement/wandering. Has no history of elopement/wandering. Is alert and oriented x 3. Able to make needs known. Uses call light appropriately. Katherine Leslie, responsible party, called and updated on assessments and residents readmission to facility at 1635. Care plan updated to reflect assessments."
A vulnerable adult assessment dated 3/18/14, noted "past and recent chemical abuse. Fluctuating cognitive deficits related to liver damage, chemical use. Needs supervised LOA due to fluctuating cognition and chemical use."
A smoking assessment dated 3/18/14, indicated "reports of smoking marijuana outside, and recent drug use reported by resident."
A LOA safety assessment dated 3/18/14, indicated "mental illness, fluctuating cognition related to liver disease. Needs supervised LOA due to fluctuating cognition and chemical use. (Lacked mention of committed to the facility related to substance abuse and mental illness."
An annual MDS dated 3/22/14, had a "BIMS score of 15/15. R86 required setup for dressing

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 89 and meals and was independent with all other cares." On 4/13/14, a care conference indicated: "long term placement waiting for liver transplant. Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past." The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. Per CLSW-B, "tried to build report with him. He had been given 30 day notice for Marijuana in his room, but it was not a proper notice and he had not been given another." R86 planned to stay in the facility until he received a liver transplant. CLSW-A stated, "I thought people would not be eligible for a liver transplant if they were actively doing drugs." R86's The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. R86 was committed to prevent exposure to alcohol and chemical substances of abuse. The facility lacked coordination of care between departments and	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 90	{F 250}		

lacked review of facilities own progress notes, which verified substance abuse, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided.

R41:
The facility failed to provide supervision to prevent ingestion of alcoholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m., 5/9 at 3:00 p.m., 5/10 at 2:30 p.m., 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m. On 5/11/14, at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 91	{F 250}		

Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 92	{F 250}		

was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 93	{F 250}		

resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as alcoholics anonymous (AA) or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.

The medical record lacked evidence that social service intervention had been put into place since his last MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression was identified at 7 out 15. The Care Area Assessments indicated he would be seeing the house psychologist and R41 had not been seen by the house psychologist. The medical record also lacks any staff intervention for providing information for his drinking such as like AA and referral to any place for help. Therefore, he was still drinking for depression and left the facility unsupervised. R41 remains at harm.

The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 94 Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. #. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required. R37's Progress Notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. Observations of R37 revealed the following: -On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility. - On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the HUC and in a loud voice stated he was crazy. - On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 95	{F 250}		

gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 was intoxicated, when he was friendly and chatting.

The Nutritional Status CAAs dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 96 following was noted: - On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed. - On 5/3/14, indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas. - On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait. - On 5/5/14, at 10:25 p.m. indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, which indicated it was a late entry for 5/5/14, at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 97	{F 250}		

found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to alcohol withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 98 positive for methadone at the hospital. R37 did not have a prescription for methadone. The Physician's Orders and NP Orders were reviewed and the following was noted: - On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility. - On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol. - On 2/28/14, directed to discharge R37 to another facility (that allowed drinking). - On 3/5/14, directed "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 mg orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 99 - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week. The interventions included; encourage attending AA or	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 100 other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37's alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA. The quarterly MDS dated 3/18/14, indicated	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 101 R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions. A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 102	{F 250}		

the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. LPN-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN-B stated she did not know where R37 got alcohol from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:19 p.m. the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 103	{F 250}		

administrator was approached after several staff reported they had not been informed of the immediate jeopardy (IJ) that was called on 5/9/14, at 2:02 p.m. The consultant administrator stated she wanted the administrator to indicate why staff was not informed of the IJ and asked "are we in trouble?" The administrator approached and stated, yesterday when the IJ was called, by the time we were done with a meeting with our boss, the nurse managers had gone for the day. The administrator stated he thought they would come up with a plan and would have an all staff meeting 5/10/14, to inform staff of the IJ. The administrator further stated a meeting was scheduled at 1:45 p.m. and verified staff had not been informed of the IJ.

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. RN-B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and friend-A signed R37 out. The consultant administrator was going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 104	{F 250}		

reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. CLSW-A stated during a room search a quart bottle of alcohol had been found in R37's room and three plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A and had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and R37 could not go there. Friend-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 105	{F 250}		

reassured her he had been sober for ten years and would never take R37 to a liquor store. The SW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and friend-A was R1's drug dealer. She stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping alcohol under the edge of his mattress and she could not understand why nursing did not find the alcohol when they made the bed. R37 remained at harm as he did not receive the requested services to assist him with the self-reported drug/ETOH abuse.

R14 was not provided medically-related social services to address known illegal drug use in the facility as recently as 5/3/14.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knee amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others one to three days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA was all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. The CAAs did not identify any history of drug use.

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 106 R14's Vulnerable Adult care plan dated as revised on 4/26/14, defied R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility. A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a NA reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician was notified and R14 was sent to the ER for evaluation. A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified R14 had the lab for "drug ingestion." Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, but not limited to: immediate notification of the administrator and SA, thorough investigation of the incident to determine potential source(s) R14 may obtained the illegal drug from, notification of law enforcement, follow up assessment of R14's	{F 250}		

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{F 250}	Continued From page 107	{F 250}		

safety, evaluation of R14's access to leave the facility, such as to smoke; documentation of how they would prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically-related social services.

On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "epileptic." R14 denied awareness of illegal drug and alcohol activity in the facility. When asked what R14 would do if she observed illegal drug or alcohol activity in the facility, R14 stated he would "tell the resident not to do it," but would not notify staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!"
On 5/12/14, at 10:26 a.m. the DON was interviewed, verified had not read the plan of correction and did not know what the plan was. DON verified he was not aware of changes made and reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. Stated he read the survey results from 2013 and stated he was not given an accurate picture of the facility problems. Verified there was no system for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 108 screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R56 had conflicting advanced directives dated 4/21/14 and 4/26/14, in her record. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband. A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of intravenous (IV)/intramuscularly (IM) antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56. The annual MDS dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 109 (cognitively intact). Review of the facility care plan dated 4/23/14, indicated R56 was DNR/do not intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Physician's Order dated 4/18/14, directed ok for hospice to evaluate and treat and ok for in-house psych to see. A nurse practitioner progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56 about her POLST. R56 reported to CLSW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. CLSW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares.	{F 250}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 110 On 5/13/14, at 8:41 a.m. a review of the Physician's Orders signed 4/9/14 continued to direct "Full Code." On 5/7/14, at 9:31 a.m. RN-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. LPN-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. CLSW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care.	{F 250}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 111 On 5/7/14, at 12:14 p.m. the HUC verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. NA-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14 with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14 and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. CLSW-B stated she had followed up with hospice and the intent is for R56 to be DNR and CLSW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the Physician's Orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. The facility Social Services/Social Work policy	{F 250}		

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{F 250}	Continued From page 112 (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided. R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents. R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression. The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility. R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be	{F 250}		

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{F 250}	Continued From page 113	{F 250}		

aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called."

The progress notes were reviewed and noted:
- On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator."
- On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the

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{F 250}	Continued From page 114 facility." - On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware." - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours."	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 115 - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident." - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding." - On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning." - On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 116 materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks." - On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen." - On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated. - On 5/2/14, at 2:00 p.m. a progress note	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 117 indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 118	{F 250}		

meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "
- On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a DM did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.
- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 119 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker. - On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14). - On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on." - On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility." - On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only. - On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility. - On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 120	{F 250}		

unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic."
- On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office."
- On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital."
- On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 121 a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating." - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and CHF condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 122 knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" resident stated "yes." Police and EMT then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50	{F 250}		

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{F 250}	Continued From page 123 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time." - On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified." - On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information." - On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering	{F 250}		

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{F 250}	Continued From page 124 substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present." - On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road. - On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called." On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed. When interviewed on 5/12/14, at 2:43 p.m.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 125 CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency. R62 had documented drug use on the facility grounds without any social service interventions developed to address substance abuse. R62 was admitted on 8/31/13, with diagnoses that included memory loss, dementia and	{F 250}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 126	{F 250}		

cerebrovascular accident (CVA). Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident.

Review of the most recent Social Services Quarterly review dated 2/25/14, indicated no changes to the LOA Safety, Vulnerable Adult and Smoking Assessment.

Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport.

R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes.

Review of R62's Progress Notes revealed the following:
-On 1/24/14, at 5:03 p.m. indicated "a resident approached writer alerting us that another resident is sitting out front smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 250}	Continued From page 127 consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any." - On 1/24/14, at 5:17 p.m. indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor." During an interview on 5/13/14, at 10:18 a.m. the DM stated, "I did what the 1/24/14, progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were un-aware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14, identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month." CLSW-B stated she has been at the facility since 3/19/14, a day after the Vulnerable Adult Assessment had been completed. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 verified she was smoking 'weed' and told them she did not have anymore. RN-B stated they did not search R62's	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 128	{F 250}		

room for drugs and "I would assume that administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 was offered chemical dependency assistance.

No social service interventions had been developed for R62 for assistance for services associated with substance abuse even though it had been identified and verified by the facility.

R9 had been identified as "Known pot smoker" but was not provided medically-related social services to address known illegal drug use at the facility.

On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke.
-At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area.
At 10:14 a.m. R9 lit another cigarette leaned very

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 129	{F 250}		

far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.
-At 10:19 a.m. R9 returned back to the building.

R9's significant MDS dated 3/24/14, identified R9's diagnoses included Schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease (COPD). The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with ADL's. The nutritional status CAA dated 3/25/14, had identified R9 had history of tobacco abuse. R9's Vulnerable Adult care plan revised 10/20/11, identified R9 was a vulnerable adult related to cognitive limitations and physical limitations. The care plan goal indicated R9 would "remain safe within Camden Care Center at all times." The care plan identified R9 required supervision for LOA's from the facility. The care plan lacked to indicate R9 was a "Known pot smoker"

A Vulnerable Adult assessment dated 3/18/14, indicated R9 had history of aggression to others, had mental illness/poor judgment, had no history of chemical abuse and "Cannot leave the facility unsupervised." The assessment did not indicate R9 was a "Known pot smoker."

When asked on 5/13/14, at 8:36 a.m. regarding smoking "Pot" R9 stated "It's a deem lie that am using any pot" and kept repeating same statement to the surveyor.
Social Service Notes were reviewed which revealed:
-Social Service Note dated 4/23/14, indicated R9 had gone to social worker (SW) requesting to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 130 her tobacco materials that had been taken from her roommate side back and had indicated they were hers. SW's reported to R9 the materials taken from the room were not on her side of the room and was informed her family was encouraged to come and get the plastic bag of smoking things as well as the cigarette roller "since her roommate would no longer be able to do this for her." Note indicated social service would follow as deemed necessary. -Social service Note dated 4/30/14, per request of director of maintenance both social workers accompanied him to R9's room. Neither R9 nor her roommate was in the room. "Per regulations, the bottle of "Shout" was removed from the room." R9 was outside the room and the director of maintenance had reported to R9 the bottle of "Shout" was taken. R9 was upset and turned her w/c away from staff and the bottle of "Shout" along with R9's raw tobacco & other materials (for the tobacco to be rolled) were placed in the Administrators office so it was more convenient for the family to pick up when they visit. Note indicated social service would follow as deemed necessary. When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 131 issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up. When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up. Elopements: R13 eloped from the facility on 5/6/14, after staff allowed the resident to transport to and from the designated smoking area without staff. R13 was not provided with medically-related social services to address her elopement risk and smoking. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 132	{F 250}		

wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly 30+ miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 133	{F 250}		

notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, R13 was identified to require supervised LOAs only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 134 from the facility and thus wears a wanderguard [sic-departure alert system] to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection." The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs. A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13. The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 135	{F 250}		

goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard [sic] in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/9/14, at 11:00 a.m. R13 was observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 136 wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and dietary manager (DM) were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or State agency (SA) would be notified. When asked if and when	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 137	{F 250}		

the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if this occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement. RN-C provided a copy of a corresponding nursing progress note dated 5/8/14

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

R103 was admitted to the facility on 7/29/13, per the Admission Record with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

A progress note on 1/5/14, at 5:30 a.m. "Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 138 is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility." An MDS quarterly assessment dated 1/31/14, indicated R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. Physician's Orders dated 4/16/14, indicated R103 may have a LOA unsupervised with medications. A progress Note dated 4/20/14, at 9:48 p.m. read, "Pt went on LOA." The chart lacked documentation of return to the facility. The medical record was reviewed on 5/11/14, and lacked documentation of LOA or discharge. The facility could not locate the Patient Sign In/Sign Out log sheet for that date. On 5/10/14, at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA. On 5/11/14, at 10:00 a.m. facility staff were asked whether the resident had been discharged, was on LOA, or had returned to the facility. The HUC checked to see and resident was in room. He had signed out on the Resident Sign Out sheet on 5/10/14, and R103 had signed in on the Resident Sign Out sheet on 5//11/14, at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 250}	Continued From page 139 On 5/11/14, at 10:10 a.m. RN-A was interviewed and was unaware R103 had left the building for ten and a half hours. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had any documented notes for R103, but knew he had been working with a relocation worker. They verified R103 had not received any social service interventions for planning for discharge. The Videll Healthcare Limited Liability Company (LLC) Elopement policy dated as effective 5/2012, identified, "Videll Healthcare LLC facilities shall provide a safe environment for resident who are assessed at risk for elopement." The policy defined elopement as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure directed if exit seeking behavior was identified to immediately implement interventions to "manage exit seeking behaviors" such as applying "personal security devices such as WanderGuard..." The procedure to directed staff to complete a "thorough" investigation of the event, document a factual account of the occurrence in the medical record and to update/complete an elopement risk evaluation. Although the policy included pertinent direction for searching if a resident eloped, the policy did not address risks such as smoking and access to the designated smoking area.	{F 250}		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive	F 274		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 274	Continued From page 140 assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 residents (R56, R116) who had sustained a decline in functional status; and for 1 of 3 residents (R103) who had experienced a significant improvement in activities of daily living (ADLs). Findings include: R56's record was reviewed. A SCSA minimum data set (MDS) assessment was initiated with an assessment reference date (ARD) of 4/26/14, and when reviewed on 5/7/14, at 9:00 a.m. the MDS was noted as in progress with an expected completion date of 5/12/14, twenty-two days after the change in status had been identified. When interviewed on 5/7/14, at 10:40 a.m. registered nurse (RN)-C stated the SCSA MDS	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 274	Continued From page 141	F 274		

was scheduled to be completed on 5/12/14, and the care plan would be completed seven days later on 5/19/14.

When interviewed on 5/13/14, at 9:53 a.m. RN-C stated she had never done MDSs before and had only received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident.

A MDS policy was requested and was not received.
R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression.

The admission MDS dated 1/26/14, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which showed no cognitive deficit, and a Patient Health Questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. According to the admission MDS, R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene.

On 4/15/14, at 10:49 p.m. a nursing Progress Note indicated, "Pt is declining. He is very weak and needs a lot of assistance." The quarterly MDS dated 4/24/14, depicted R116 as needing assist of one person for bed mobility, ambulation in and out of room, dressing toilet use and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 274	Continued From page 142	F 274		

hygiene. R116 had also deteriorated and required supervision for eating and transfers.

On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that "a significant change MDS should have been done when it had been determined his condition declined in two areas of functional status." Although the resident had declined in bed mobility, transfers, toileting, dressing, ambulation and personal hygiene, no significant change MDS had been conducted. The quarterly MDS (ready to export, but not exported) did show the extensive assist that R116 now required but interim MDS coordinator verified "it should have been a significant change MDS."

R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

The progress note dated 1/5/14, at 5:30 a.m. indicated R103 was oriented X 3, able to communicate needs and wants. In addition, the notes indicated R103 was independent with movement and bed mobility, and currently utilized a Foley catheter.

An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter was in use. R103 was assessed as independent in all functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 274	Continued From page 143 activities of daily living. Although R103 had improved in more than two functional areas, no significant change MDS had been completed as a result of the improved status. According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident 's condition is not expected to return to baseline within two weeks."	F 274		
{F 275} SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 3 residents (R36) who required an annual comprehensive assessment. Findings include: The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12.	{F 275}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 275}	Continued From page 144 On 5/13/14, at 9:52 a.m. the electronic record (Point Click Care) was reviewed and revealed R36 had an admission Minimum Data Set (MDS) completed on 5/29/13. The Quarterly MDS's were completed on 8/29/13, 11/21/13, and 2/18/14. A fourth quarterly MDS had been initiated with an assessment reference date of 5/14/14. An annual comprehensive MDS was not initiated as required. When interviewed on 5/13/14, at 9:53 a.m. registered nurse (RN)-C verified she had initiated a quarterly MDS instead of the required annual MDS and confirmed that an annual MDS should have been implemented. RN-C stated she had never done MDSs before and received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS scheduling and completion policy was requested and was not received.	{F 275}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	{F 280}		7/6/14

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{F 280}	Continued From page 145 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter use for 1 of 3 residents (R36); for 1 of 1 resident (R116) who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who had substance abuse issues. Findings include: Review of R36 ' s quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 did not have a Foley catheter in use. Review of the care plan for R36 dated 3/18/14, identified a focus topic; " alteration in elimination". The care plan further indicated R36 had a temporary indwelling Foley catheter in place due to diuretic use. Interventions listed; change R36 catheter as needed per Physician ' s Orders and to irrigate the catheter as needed. When interviewing R36 on 5/7/14, at 7:41 a.m. he stated he did not have a catheter and used the toilet independently. During interview on 5/7/14, at 1:45 p.m. with	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 146	{F 280}		

registered nurse (RN)-A, she confirmed R36 did not have an indwelling Foley catheter.

During interview on 5/13/14, at 11:41 a.m. with RN-B, she indicated R36 previously had an indwelling Foley catheter but no longer used one. RN-B confirmed the care plan should have been updated to reflect R36's current status.

A care plan policy was requested and was not provided.

R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression.

R116 was receiving hospice care since 1/21/14, the resident was independent in self-cares, transfers, and mobility.

The admission MDS dated 1/26/14, identified a brief interview for mental status (BIMS) score of 15/15, which showed no cognitive deficit, and a patient health questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. The MDS further indicated R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene.

Review of the quarterly MDS dated 4/24/14, indicated R116 as requiring 1assistance with bed

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 280}	Continued From page 147 mobility, ambulation in and out of room, dressing, toileting and hygiene. The MDS further indicated R116 required supervision for eating and transfers. Review of the progress notes for R116 on 4/15/14, at 10:49 p.m. indicated R116 condition was declining and requiring more assistance with ADL's. Review of R116 ' s care plan with a revision date of 5/2/14, indicated, "Cognition intact and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis." The care plan had not been revised to depict the changes in ADLs. On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that R116 care plan was not current to reflect R116 decline in health status that required assistance with ADL's updated with the needed assistance with ADLs. R62 was admitted to the facility on 8/31/13, with diagnoses that included; memory loss, dementia and cerebrovascular accident (CVA) per the Admission Record. Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, verified that she had smoked marijuana, denied having more marijuana and verbalized understanding regarding discharge if she continued this behavior. Review of the most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the residents health status	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 280}	Continued From page 148 Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 as having "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 required supervised LOA (leave of absence) except for appointments with scheduled transport. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, R62 denied she was smoking marijuana Review of R62's care plan with a revision date of 4/26/14, identified R62 having a history of being in an abusive relationship, and as having impaired cognitive function/dementia. Interventions included "approach resident in a calm manner, assess and report any change in mood/behavior and provide the resident with resources as needed. R62 has been assessed and may not leave the facility without supervision." The care plan had never been revised to include R62's known alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment dated 3/18/14, and documented in the nursing progress notes on 1/24/14. During an interview with the facility contracted licensed social worker (CLSW)-A and CLSW-B confirmed the plan of care had not been revised to reflect R62's substance abuse.	{F 280}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	{F 282}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 149 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the care plan was followed and target behaviors were monitored for the use of Zyprexa (olanzapine-an antipsychotic medication) for 1 of 1 resident (R89), and failed to ensure smoking interventions were followed in accordance with the care plan for 4 of 4 residents who smoked (R36, R1, R9, R22), and failed to ensure the care plan was followed for 1 of 3 residents (R9) who required dental services. Findings include: R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 as having a physician order for Zyprexa (an antidepressant) related to "potential injury to self or others, dementia, agitation and pick [sic] disease." The care plan directed the staff to administer the medication as ordered, monitor/document for side effects and effectiveness of the medication. The care plan further directed the staff to "discuss with MD [physician], family regarding ongoing use of the medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of target behaviors such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 150 the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. Review of the clinical record indicated R89 was not monitored for target behaviors. Review of the Consultant Pharmacist Recommendations dated 4/17/14, identified olanzapine (Zyprexa) 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist (CP) review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. Observations of R36 on 5/6/14, at 11:32 a.m. the resident was observed retrieving a cigarette from the inside of his coat and lit it with a lighter from his right pocket. The smoking monitor personal was directed away from the resident and approximately 20 feet away. Observations of R36 on 5/7/14, at 7:07 a.m. the resident was observed smoking a cigarette without a smoking apron on. The smoking monitor personal was approximately ten feet away from the resident.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 151 Observations of R36 on 5/7/14, at 7:41 a.m. the resident was observed to have multiple burn holes in his gloves. Observation of R36 on 5/7/14, at 8:18 a.m. the resident obtained a cigarette from inside his coat and a lighter from his right pocket and lit the cigarette. R36 did not have a smoking apron on. The smoking monitor personal did not offer R36 a smoking apron. Observations of R36 on 5/7/14, at 9:21 a.m. the resident was observed smoking without a smoking apron on and the smoking monitor personal was approximately 20 feet from R36 and was focused on the street and not the resident. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed in his room with a pack of eight cigarettes in his shirt. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed smoking without a smoking apron. The smoking monitor personal was approximately 15 feet from R36. Observations of R36 on 5/7/14, at 3:15 p.m. the resident was observed smoking without a smoking apron and the smoking monitor personal was not within arm's reach. Observations of R36 on 5/8/14, at 9:29 a.m. the resident was observed smoking a cigarette; the smoking monitor personal offered a smoking apron to R36 but the resident refused. The staff did not encourage the resident to wear. Observations of R36 on 5/8/14, at 2:08 p.m. the resident was observed smoking without a	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 152	{F 282}		

smoking apron on. The smoking monitor personal was approximately 15 feet away and was looking in the opposite direction.

Observations of R36 on 5/9/14, at 7:15 a.m. the resident was approached by facility staff to wear a smoking apron. R36 stated he wouldn't wear one after what happened yesterday. R36 stated when staff put a "bib" on R34, R34 took it off and threw it on the ground. R36 stated if she (R34) did not have to wear one, he did not either. R36 wheeled to the smoking patio and smoked a cigarette without an apron on.

Observations of R36 on 5/12/14, at 11:38 a.m. the resident wheeled by the smoking monitor personal and lit a cigarette and smoked without an apron on. The smoking monitor personal did not offer R36 a smoking apron.

Review of R36 ' s care plan dated 6/14/13, identified R36 as having impaired cognitive function/dementia, alteration in decision making, and/or impaired thought processes. The care plan further indicated R36 required supervision when smoking, and that the resident was to smoke only in designated areas utilizing adaptive equipment apron for safety.

An undated list of facility smokers indicated R36 was a supervised smoker and indicated staff keeps smoking material with directions to wear a smoking apron and stay within arm's reach.

When interviewed on 5/7/14, at 7:33 a.m. nursing assistant (NA)-B stated she offers to lock the cigarettes in the facility locked box for residents who are unsafe to keep them on their person. NA-B stated if a resident refuses to follow the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 153 smoking rules, such as refusing to turn in their smoking materials, refusing to wear aprons, or smoking in non-smoking areas, she makes a note in the smoking monitor log. R1 was observed on 5/5/14, and consecutive days 5/6/14, 5/7/14 and 5/8/14, smoking without wearing an apron, keeping her smoking material's on her and not smoking in the facility designated areas. When interviewed on 5/8/14, at 10:03 a.m. NA-E stated R1 had a pack of cigarettes and a lighter when she got off the transportation van. NA-E stated "She is very stubborn". When interviewed on 5/8/14, at 11:32 a.m. R1 indicated she had left to the appointment with five cigarettes and her lighter because it was going to be a long time without smoking and when she returned to the facility she had handed the cigarettes back to the smoking monitor. Review of R1's smoking evaluation dated 3/17/14, identified R1 as having a history of unsafe smoking practices when heavily medicated and or tired and falls asleep while smoking. R1 cannot safely utilize lighter/matches and cannot safely handle lit smoking materials and was a supervised smoker. The smoking care plan dated 3/12/14, identified R1 was a smoker. The goals were "Will follow all guidelines regarding smoking at Camden Care Center and will remain safe while smoking." The care plan directed R1 will smoke only in designated smoking areas, was a supervised smoker and had refused Cigarettes and lighter to be kept at nursing station for safety.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 282}	Continued From page 154 When interviewed on 5/9/14, at 1:59 p.m. the director of nursing (DON) stated R1 had been educated about leaving her smoking materials in the cart and had been asked to take the cigarettes one at a time. The DON confirmed the plan of care had not been followed. On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to a covered ash tray. During observation NA-B noticed R9 smoking and covered her with a smoking apron at that time. Observation at 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked. On 5/6/14, at 2:45 p.m. when interviewing R9, surveyor observed a cigarette box in each of her socks. When R9 was asked why she was storing the cigarettes in her socks she stated "You can leave now, go now". The smoking care plan dated 10/20/11, identified R9 as a smoker. Goal "R9 will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker. When interviewed on 5/6/14, at 3:06 p.m. the	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 282}	Continued From page 155 DON verified R9 was a supervised smoker which meant she should relinquish her cigarette and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. . When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified R9 did not have cigarettes in the facility locked box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box. Observation on 5/6/14 at 8:05 a.m., staff was observed assisting R22 to the smoking area, applied a smoking apron and placed a blanket around his shoulders. Staff remained near but not within an arms-length as R22 held a handful of Kleenex while smoking. Observation on 5/7/14, at 9:27 a.m. R22 was observed outside in the designated smoking area sitting in his w/c next to the building pillar. R22 was holding a cigarette on the right hand and the other hand holding a the self-extinguishing ash tray. R22 was not wearing a smoking apron and had a blanket across his lap. R22 dropped his cigarette on to his shirt/blanket, was able to pick it up himself. The smoke monitor personal was not at arms-length and did not observe this happen. NA-B was standing approximately six feet away from the resident. At 9:31 a.m. R22 continued to smoke with no smoking apron, he dropped his cigarette for the second time on to his lap and was able to pick it up himself. NA-B was observed standing by the smoking cart approximately 5 feet away from the resident and was not at arms-length to quickly assist the resident.	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 282}	Continued From page 156 Review of R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "(R22) will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was wear smoking apron while smoking. Staff to intervene is resident displays unsafe smoking behaviors or refuses safety interventions, and R22 was a supervised smoker. Review of R22's Smoking Evaluation dated 4/22/14, indicated R22 had a history of smoking in inappropriate places, burn holes in his clothing , was a supervised smoker and smoking materials were secured by staff. When interviewed on 5/7/14, at 9:33 a.m. NA-B stated she had not witnessed R22 drop his cigarette at 9:27 a.m. and again at 9:31 a.m. even though she was standing near the smoking cart and designated to monitor resident during smoking. When interviewed on 5/9/14, at 1:59 p.m. the DON confirmed the plan of care had not been implemented related to R22 smoking privileges and safety. Review of the annual Minimum Data Set (MDS) dated 10/11/13, did not identify R9 dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene. R9's care plan reviewed 4/9/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing	{F 282}		

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{F 282}	Continued From page 157 teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." R9 had diagnoses which included Schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and 12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful." On 5/6/14, at 2:45 p.m. R9 was observed to have missing teeth during an interview in her room. On 5/7/14, at 3:28 p.m. LPN-A was interviewed and stated "I went thru the progress notes and I don't see anything that addresses the dental exam. " During an interview on 5/7/14, at 3:30 p.m. household unit coordinator (HUC) stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this."	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	{F 309}		7/6/14

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{F 309}	Continued From page 158 accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Findings include: R56's annual Minimum Data Set (MDS) dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact). A physician's order dated 4/18/14, gave approval for hospice to evaluate and treat and for in-house psychiatry services to be provided. A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband. Review of the facility care plan dated 4/23/14, indicated R56 was DNR/Do Not Intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice. A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible	{F 309}		

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{F 309}	Continued From page 159 Conditions and included interventions and treatments of IV/IM antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56. A nurse practitioner (NP) progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Note dated 5/12/14, indicated contracted licensed social worker (CLSW)-B spoke with R56 about her POLST. R56 reported to SW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. SW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares.	{F 309}		

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{F 309}	Continued From page 160 On 5/13/14, at 8:41 a.m. a review of the physician's orders signed 4/9/14, continued to direct "Full Code." On 5/7/14, at 9:31 a.m. registered nurse (RN)-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. licensed practical nurse (LPN)-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, at 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. SW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care.	{F 309}		

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{F 309}	Continued From page 161 On 5/7/14, at 12:14 p.m. the health unit coordinator (HUC) verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. nursing assistant (NA)-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14, with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14, and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. SW-B stated she had followed up with hospice and the intent is for R56 to be DNR and SW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the physician's orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency.	{F 309}		

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{F 309}	Continued From page 162 On 5/13/14, at 1:50 p.m. RN-B provided a copy of the POLST signed by the hospice physician and stated the NP was aware of the code status because she had given orders for hospice. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided.	{F 309}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers at the time of admission to the facility. Findings include: R123's Hospital Nursing Progress Note dated 4/11/14, indicated R123 had three pressure ulcers which were connected to continuous wound vacuum (vac) suction and the dressings	{F 314}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 314}	Continued From page 163 were intact. The pressure ulcers locations and stages were not identified. R123 was admitted to the facility on 4/18/14, and deceased on 4/21/14. R123's diagnoses included: spastic paralysis due to multiple sclerosis (MS), pressure ulcers, physical deconditioning, generalized weakness, abnormal pain, diabetes, cerebral palsy, and weakness of both legs obtained from the Discharge Orders and Plan dated 4/18/14. Admission Nursing Assessment dated 4/18/14, indicated a full skin assessment had been completed and a right hip pressure ulcer area with measurements 6.5 centimeters (cm) length (L) x 3 cm width (W) x 2.2 cm depth (D) and 2.5 cm tunnel at 6 o'clock position, right buttock with measurements 4.6 cm (L) x 2.0 cm (W) X 0.0 cm (D) cm and right heel area measured 1.2 cm (L) x 1.0 cm (W) x 2.0 cm (D) had all been identified. The form did not indicate if the areas were pressure related nor were the areas staged. Progress Notes dated 4/18/14, indicated a full skin assessment had been completed with measurements as noted on the Admission Nursing Assessment dated 4/18/14. On the right hip area a wet to dry dressing had been removed and wound bed consisted of moist yellow, pink, red tissue with moderate amount of yellow, red odorless drainage were observed and the surrounding wound tissue had no redness, warmth, or tenderness noted and wound vac dressing had been applied. On the right buttock foam dressing had been removed from with wound bed consisting of dry pink and red tissue, no drainage, no redness, warmth, or tenderness noted to the tissue surrounding the wound and	{F 314}		

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{F 314}	Continued From page 164	{F 314}		

non-adherent dressing applied. On right heel foam dressing had been removed ulcer observed with wound bed consisting of moist red and yellow tissue with scabbing, large amount of odorless drainage noted, no redness or warmth noted to the tissue surrounding the wound and non-adherent dressing was applied. The Progress Note did not also indicate if the areas neither were pressure related nor were the areas staged.

A Physician's Order dated 4/18/14, directed staff to "Apply non-adherent dressings to right ischial tuberosity wound and right heel until needed supplies are received."

The facility Initial/Temporary Care Plan dated 4/18/14, identified R123 had pressure areas marked and indicated with wound vac. However, the medical record lacked evidence of any other interventions being put into place to prevent and/or minimize potential further skin breakdown such as turning and repositioning, wound care, and pressure relieving mattress.

During document review it was revealed a Braden Scale-For Predicting Pressure Sore Risk dated 4/21/14, indicated R123 had a score of 11 which indicated R123 was at high risk and the Comprehensive Evaluation of Skin Risk Factors dated 4/21/14, identified the risk factors but lacked immediate interventions to minimize further potential skin breakdown.

R123's admission Minimum Data Set (MDS) dated 4/21/14, indicated R123 required limited to extensive assist of one to two with activities of daily living (ADL's) including bed mobility and transfers; had impairment on one side on the

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{F 314}	Continued From page 165	{F 314}		

lower extremity with limited range of motion (ROM) and had one Stage 1 (a Stage I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching) and two Stage 2 pressure ulcers (a Stage 2 is partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS noted R123 was not on a turning and repositioning schedule and did not have wound care treatments that were completed in the last seven days.

When interviewed on 5/12/14, at 9:58 a.m. registered nurse (RN)-C MDS coordinator verified the temporary care plan had been developed but there without interventions to minimize further potential skin breakdown. RN-C further indicated "I believe there should have been more interventions listed than just the wound vac as resident had already pressure ulcers."

On 5/13/14, director of nursing was unavailable for interview.

The facility policy entitled Skin Integrity Management, dated 5/12, directed director of nursing services (DNS) or designee and the interdisciplinary team (IDT) were responsible to ensure the development and implementation of a comprehensive plan of care including prevention and wound treatments as indicated. The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin

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{F 314}	Continued From page 166 issues, maintain function and improve quality of life.	{F 314}		
{F 319} SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate treatment/services were offered for 1 of 1 newly admitted resident (R41) who had expressed difficulty with adjustment related to chemical dependency. Findings include: R41 was admitted to the facility on 2/4/14, according to the Admission Record from another long term care facility. The Admission Record indicated R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which	{F 319}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 319}	Continued From page 167	{F 319}		

indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

A LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 319}	Continued From page 168 use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 had become intoxicated while off the facility property on a LOA. Upon his return to the facility, R41 had driven his electric w/c off the curb of the driveway to the facility. R41 had been found lying on the pavement on his right side and his speech was slurred, but R41 remained alert and oriented. The notes indicated, "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, documentation in the record indicated R41 had been readmitted to the facility from the hospital at 1:43 p.m. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. progress note documentation indicated facility staff had met with	{F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 319}	Continued From page 169 the resident to discuss the incident that occurred on 5/1/14, the facility had obtained an order for a supervised LOA. According to the progress note, R41 had stated he was drinking because he was depressed. The only new intervention was that the facility placed a WanderGuard on R41's wheelchair (w/c). Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk as the facility staff continued to silence the alarm at the front desk and let him out of the facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention to help with adjustment at the facility had been offered, even though staff were aware the resident had depression and had acknowledged he continued to drink related to depression. No referrals had been made to meet the resident's needs such as referral to alcoholics anonymous (AA), or referral to any other counseling services to help or support R41. The medical record lacked evidence that interventions had been developed or initiated since R41's MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression, scoring a 7 out 15 on the depression scale. The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. 3. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate	{F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 319}	Continued From page 170 admissions if required.	{F 319}		
{F 323} SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in an Immediate Jeopardy (IJ) for these four residents. A second IJ component was identified for 2 of 3 vulnerable residents at risk for elopement (R13, R116), due to the facility's failure to ensure adequate supervision and protection to prevent elopement from the facility. In addition to the resident(s) identified in the IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113) and failed to ensure 3 of 3 residents (R1, R36, R22) who smoked cigarettes did so in a safe manner as determined by their plans of care. The IJ began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization. The administrator, consulting	{F 323}		7/6/14

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{F 323}	Continued From page 171	{F 323}		

administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of the additional IJ concerns related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey.

Findings include:

Alleged substance abuse:
R37's progress notes indicated the resident had required hospitalizations 2/22/14, 4/23/14 and 5/10/14, related to ETOH/drug use. The Admission Record dated 1/14/14, indicated R37 had been admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and a history of alcoholism. Progress note documentation indicated R37 had been found with ETOH/vodka while in the facility on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14.

Observations of R37 revealed the following:
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. This surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to

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{F 323}	Continued From page 172 push another resident's wheelchair down the West hallway and was observed outside R9's room. There was no staff with R37 when during the observation. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and the HUC asked him where his partner was. Nursing assistant (NA)-L approached at that time and told the HUC she was the 1:1 for R37 today. - On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. Additional review of R37's record revealed these Progress Notes: - On 11/26/13, the notes indicated chemical dependency (CD) treatment/Alcoholics Anonymous (AA) was discussed. R37 had stated he'd participated in AA services in the past and he'd had success including three years of sobriety before a recent relapse. The note indicated nursing had reported two episodes of ETOH intoxication while in the nursing home since the last visit and R37 had acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no ETOH use with nursing to monitor. The NP indicated there were "clear dependency concerns." - On 1/8/14, the notes indicated the resident had a history of ETOH abuse which had also occurred since living at the facility. - On 2/21/14, the notes indicated R37 had been drinking vodka and that an empty bottle had been found. The notes also indicated R37 had been observed to be distributing money to staff and residents. When R37 had noticed he had no money to buy vodka, he had gone to the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 173	{F 323}		

automatic teller machine (ATM) machine to get money. The notes indicated staff were concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. a note had been documented which indicated R37 was handing out his money to "anyone who would listen" and staff had taken $116.00 dollars from him to lock up.
- On 2/22/14, at 10:14 p.m. the notes indicated R37 had called 911 to send himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift had taken a bottle of vodka from him. The notes indicated R37 had asked the p.m. shift to return the vodka or pay him $25.00.
- On 2/27/14, at 1:13 p.m. the notes indicated R37 wanted to leave on a leave of absence (LOA), was advised he could not go on an unsupervised LOA, but had left the facility.
- On 2/27/14, at 10:07 p.m. indicated R37 was "drunk" and had a blood pressure of 147/105.
- On 3/2/14, indicated R37 was "drunk" and was noted to have a blood pressure of 176/98 and a pulse of 99.
- On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital.
- On 4/13/14, the notes indicated R37"seemed intoxicated" and one full bottle of vodka and one quarter full bottle were removed from the room.
- On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37's room. At 12:04 p.m. staff checked R37's room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink ETOH at the facility. R37 was offered a transfer to a facility that

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{F 323}	Continued From page 174 allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of ETOH. R37 stated he would like to get help to have ETOH removed from his body. Staff called 911 and police escorted R37 to detox. - On 4/24/14, at 9:30 a.m. the notes indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of ETOH. At 12:01 p.m. on that day, the notes indicated R37 approached staff and "again was clearly intoxicated." The notes indicated the contracted licensed social worker (CLSW)-A and a police officer had entered R37's room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assaultive in any way. A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 had been observed earlier walking into and out of R117's room and "seemed to be like an exchange of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for ETOH consumption. Further the note indicated, "A few hours later" R37 was shouting and appeared "intoxicated" and a 75% emptied bottle of vodka was found in R37's room. - On 4/25/14, at 9:58 a.m. notes indicated R37 was "clearly inebriated", had slurred speech and could barely wake up. R37 refused to provide the source where he continued to get ETOH. - On 4/25/14, at 3:24 p.m. notes indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and still smelled like he had ETOH on his breath.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 175 - On 5/2/14, notes indicated R37 had removed a wander guard and refused a new one to be placed. - On 5/3/14, notes indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. the notes indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of ETOH and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and had said he was going to Las Vegas. - On 5/5/14, at 4:56 p.m. the notes indicated R37 had slurred speech, smelled of ETOH and had a staggering gait. - On 5/5/14, at 10:25 p.m. the notes indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, a note, which indicated it was a late entry for 5/5/14 at 6:00 p.m., indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 had stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 176	{F 323}		

bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. the progress notes indicated R37 had been placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, notes indicated R37 "was clearly intoxicated" and that an empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, notes indicated R37 had been observed giving his credit card to R117 on 5/9/14. A second note indicated R37 had returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood

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{F 323}	Continued From page 177 pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, the progress notes indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for Methadone. The Physician (MD) and Nurse Practitioner (NP) orders indicated they were aware of R37's alcohol use. Notes included: - On 1/8/14, included a diagnosis of ETOH abuse and a note the resident continued to have problems while living in the facility. - On 2/5/14, indicated R37 had recently been found with a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH. - On 2/28/14, an order directed staff to discharge R37 to another facility (that allowed drinking). - On 3/5/14, an order directed; "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, notes indicated R37 had been hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement. the notes indicated R37 had been treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's use of alcohol, to encourage R37 not to use, and that even if R37 appeared intoxicated it was ok to administer all medications as ordered.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 178 - On 5/6/14, an order directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, an order directed "no LOA-supervised or other". In addition, the NP included an order for a WanderGuard, and to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and ETOH counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs. - The Depression care plan dated 3/11/14,	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 179 included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 180	{F 323}		

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had a history of significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of ETOH intoxication and ETOH withdrawal noted 9/23/13, and substance abuse noted 2/23/14.

A Care Conference Summary dated 4/1/14, indicated a discharge plan of "discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37 had a history of drinking and bringing ETOH in the building or going on unsupervised LOA and R37 had stayed in the building with no ETOH use since 3/3/14.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 323}	Continued From page 181 On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing ETOH and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding ETOH bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase ETOH and R37 had been "drunk for days." On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 got ETOH from. The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or ETOH and stated he has heard about exchanges but could not remember who he had heard it about.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 182 The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever." On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for Delirium tremens (DTs-significant withdrawal symptoms). During interview on 5/12/14, at 8:59 a.m., registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check. The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy (stated name) a friend of R1" went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware of who R1's friend was. The DON stated the 1:1 had refused to go to the bank with R37 and that the friend of R1 had signed R37 out. The DON stated the consultant	{F 323}		

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{F 323}	Continued From page 183	{F 323}		

administrator was going to go with R37 and R1's friend to the bank until it was decided the facility was not comfortable with her (the consultant administrator) going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA, but stated the administrator, consultant administrator and the social worker had decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH had been found in R37's room and 3 plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on a LOA, and stated R37 had returned with a card from Walgreens so they knew he hadn't followed his agreement to only go to the bank. The administrator stated the friend of R1 would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOA and that he had believed CLSW-A and had not checked the chart himself. The administrator stated he was also not aware of R1's relationship with the friend and that the DON had not told him about the order for no LOA or the relationship between R1 and the friend.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she had been informed by nursing (she could not remember who) that R37 could leave the facility

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{F 323}	Continued From page 184	{F 323}		

with supervision. CLSW-A reported she'd made it clear to the person taking R37 out, R1's friend, that R37 could only go to the bank and nowhere else. She stated she'd told R1's friend that R37 would try and talk him into going to the liquor store but that R37 could not go there. CLSW-A said R1's friend had reassured her he had been sober for ten years and would never take R37 to a liquor store. CLSW-A stated it was not until after R37 had left, that nursing (did not remember who) told her R37 had orders for "no LOA" and that R1's friend was a drug dealer. CLSW-A said it would have been nice to have known that information before she'd allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she'd trusted nursing to know the correct information. She also stated she was aware R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing hadn't been finding the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs or aware that R1's friend was her drug dealer prior to having allowed R37 to leave with R1's friend on an LOA.

R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times). R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed ETOH on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation

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{F 323}	Continued From page 185 (mechanical ventilator assisted breathing) for a blood ETOH level of .323. The admission MDS dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's CAA for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with ADLs. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering CD treatment. The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms. R129's Smoking Evaluation dated 3/18/14,	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 186 identified to "monitor for ETOH use or oversedation." The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking." A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the DON on 5/5/14. An Emergency Department Chart [a form from	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 187 the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or ETOH use. R129 was given two doses of Dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1. A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD." On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request	{F 323}		

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{F 323}	Continued From page 188 to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, ETOH and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and procedures in place." R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and	{F 323}		

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{F 323}	Continued From page 189	{F 323}		

prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings."

Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print.

Nursing Progress Notes:
- On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 mg [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."
- On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money."
- On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a

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{F 323}	Continued From page 190 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. - On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty. - On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was	{F 323}		

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{F 323}	Continued From page 191 notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP. - On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction." - On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 192	{F 323}		

continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
- On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms."
- On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal drugs was identified, reported to the administrator immediately, reported to the SA or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety.
At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 193	{F 323}		

resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.
- On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer].

On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 194 R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M. - At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern. - At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129. - At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway. - At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. - At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 195	{F 323}		

behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking beside (to the left) of R129.
- At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 196	{F 323}		

watch R129. R129 sat on planter side and spoke with R14.
- At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor.
- At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk.

On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 197	{F 323}		

stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and ETOH treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of ETOH or drugs being exchanged on "my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 198	{F 323}		

shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse.

On 5/8/14, at 11:40 a.m. NA-S stated they had seen ETOH bottles in residents rooms and smelled ETOH on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January 2104 or February 2014. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. a housekeeper (H)-A was asked if they were aware of any residents drinking ETOH in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any ETOH bottles found in the facility "and has." H-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 199	{F 323}		

was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the ETOH bottles came from, H-A stated she was unclear, but thought they may have been provided by family.

On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated ETOH from R37. LPN-H verified ETOH was provided to R37 and suspected to other residents of the facility, but was unclear how the ETOH was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility.

On 5/8/14, at 12:10 p.m. the HUC stated she was aware of resident drug and ETOH use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming ETOH in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the ETOH was coming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 200	{F 323}		

from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and ETOH use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
- On 5/11/14, at 10:09 a.m. a note written by the HUC indicated NMMC called the facility "requesting" R129's medication administration records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 201 R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough ETOH to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the ETOH and/or if the assigned 1:1 was interviewed at the time. - On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two LPNs were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of ETOH. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving R129 ETOH, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her ETOH. - On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 202	{F 323}		

chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."
- On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of ETOH was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."
- Was asked regarding R129 obtaining ETOH or drugs while on a 1:1, DON verified the information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 203	{F 323}		

observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and ETOH while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained ETOH, but verified R129 was harmed by the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for CD treatment and verified was last noted to be offered to R129 on 4/4/14. Both verified they should have revisited CD treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for ETOH toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. CLSW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 204	{F 323}		

obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much ETOH in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R41:
The facility failed to provide supervision to prevent ingestion of alocholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m. , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 205 legs that can create sensory, motor and bodily function problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detected depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist. An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff. A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for	{F 323}		

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{F 323}	Continued From page 206 unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 9-1-1 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication. On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14,	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 207	{F 323}		

included, "No longer okay to leave unsupervised LOA's." A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as AA or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.

R117:
R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents.

R117 was admitted to the facility 1/21/14, with

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 208 admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression. The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility. R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA. The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 209 R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called." The progress notes were reviewed and noted: - On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator." - On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility." - On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware." - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 210 environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours." - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident." - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 211	{F 323}		

means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding."
- On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning."
- On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks."
- On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 212 that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen." - On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated. - On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 323}	Continued From page 213 facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes." - On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. " - On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 214	{F 323}		

and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.
- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 215 survey exit) and today (5/7/14). - On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on." - On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility." - On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only. - On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility. - On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic." - On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 216 Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office." - On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital." - On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating." - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 217 the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and congestive heart failure (CHF) condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen. - On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 218	{F 323}		

him "you are leaving the facility against medical advice?" Resident stated "yes." Police and emergecnt medical technician (EMT) then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had

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{F 323}	Continued From page 219	{F 323}		

stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time."
- On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified."
- On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information."
- On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 220	{F 323}		

the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present."
- On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road.
- On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called."

On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed.

When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 221 the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency. ELOPEMENT: On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 323}	Continued From page 222 On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly The speed limit was 30 miles per hour (MPH). The smoking monitor was observed to be behind a pillar with	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 223	{F 323}		

his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 224 independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection." The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs. A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13. The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 323}	Continued From page 225 R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision. An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 226	{F 323}		

would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then.

The SA form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk."

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 227 time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and DM were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or SA would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if that occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview. On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 228 On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a WanderGuard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident. According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 229	{F 323}		

permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance."

A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 230	{F 323}		

unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 231	{F 323}		

updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 232 investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 233	{F 323}		

the care plan would be reviewed and revised.
The administrator of designee reports the event to the appropriate state agency (SA).
R9 was not supervised during smoking, was keeping smoking materials and was an alleged "Pot smoker."

On 5/6/14, at 7:40 a.m. R9 was observed smoking cigarettes out front on the designated smoking patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area, she retrieved cigarettes and a lighter from her right sock and placed them on the table next to a covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. During observation, NA-B went over to the smoking cart to get a smoking apron, applied the apron on R9, and sat directly across from R9.
-At 9:05 a.m. NA-B continued to watch R9 as she smoked.
-At 9:08 a.m. R9 was observed wheeling herself into the building. No burn holes noted on the front of her shirt or clothing.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke.
-At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area.
At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 234	{F 323}		

her socks and continued to lean forward multiple times as she smoked.
-At 10:19 a.m. R9 returned back to the building.

On 5/6/14, at 2:45 p.m. when interviewing R9 surveyor observed a cigarette box in each white sock on each inner leg. When R9 was asked why she was storing the cigarettes in the socks she stated "You can leave now, go now". Surveyor left the room as requested.

When interviewed on 5/6/14, at 3:06 p.m., the DON stated he was not sure if R9 was supposed to be supervised during smoking, and indicated he had been given a list of smokers who required supervision just that day. Upon review of the list, the DON stated R9 was a supervised smoker which meant she should relinquish her cigarettes and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. Following the interview, the DON was observed to approach R9 at the smoking area and speak to her, and to return to tell the surveyor R9 had refused to give him the cigarettes she had in her socks.

When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified after looking through the locked cigarette box on the cart R9 did not have cigarettes in box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box.

When interviewed on 5/6/14, at 3:20 p.m. the administrator, DON and LPN-A (the resident care manager for R9) all stated if a resident was a supervised smoker they were supposed to relinquish all smoking materials but many refused. They said they couldn't force them to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 235	{F 323}		

it as the residents were part of the supervised program. LPN-A further stated "They have been told that they have to do this and we had a meeting with all smokers last week. They were given a copy of the smoking policy by social services and were supposed to sign it, but some refused. We have told them the rules and when they are or aren't allowed to keep them [their cigarettes], but they don't care. [R9] should be in there, but she won't give them to us."

When interviewed on 5/6/14, at 3:25 p.m. the DON stated, "We have a smoking policy updated and it does include that they should relinquish, are still supervised, the smoking monitor makes sure they are safe with their usage, that is why they are out there and we are still keeping them safe, we have tried to get her lighter and cigarettes on repeated effort but have not been able to do so."

When interviewed on 5/6/14, at 3:43 p.m. LPN-A stated "Problem is if I took her cigarette and lighter, she would just get the cigarettes from somewhere else probably gives someone money to go buy a pack of cigarettes. We tried this morning to take them from her and she stated "I'm not giving them to you because you will sell them to another resident". LPN-A stated the policy had been explained and R9 had asked what would happen if they did not abide and LPN-A had stated they were consequences. LPN-A further stated the NA who was monitoring the smoking had a book on the cart and documented when a resident refused or when they are not safe. When asked by surveyor if the smoking monitor had reported off to her LPN-A stated she was not sure maybe the social worker had been reported to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 236	{F 323}		

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found on the roommate's side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family had been very upset about staff removing the roller from the room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not received the list of all the residents who had been thought to have substance abuse issues.

When R9 was interviewed on 5/13/14, at 8:36 a.m., and asked whether she smoked "pot', R9 stated "It's a lie that I am using any pot" and kept repeating same statement to the surveyor.

R9's MDS dated 3/24/14, identified R9's diagnoses included schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease. The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with transfers, dressing, hygiene, and R9 was did not use any mobility devices yet R9 used a w/c during the course of the survey around and off the unit for mobility. The nutritional status Care Area Assessment dated 3/25/14,, had identified R9 had history of tobacco abuse.

The smoking care plan dated 10/20/11, identified R9 was a smoker. Goal "[R9] will follow all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 237 guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker. Smoking Evaluation dated 10/7/13, indicated R9 was independent with smoking and smoking materials. After concern was brought to the facility attention on 5/6/14, another Smoking Safety Assessment was completed which indicated R9 was to remain as a supervised smoker, facility was to store tobacco products but may choose to wear apron or not. Progress Note dated 4/30/14, indicated the director of facility operations and two social workers had been to R9's room and a bottle of "Shout", raw tobacco and other materials (for the tobacco to be rolled) had been removed from the room and placed in the Administrator's office for the family to pick up when they visited. The undated and untitled list of Unsupervised and Supervised Smokers, revealed R9 was identified as a supervised smoker,did not need to wear a smoking apron, but was supposed to be within an arms distance from the smoking monitor. R14 was observed to ingest an unknown substance, was sent to the hospital and tested positive for THC (the active substance in marijuana) on 5/3/14, R14 was not evaluated for substance abuse, assessed for safety or provided supervision to prevent potential future access to illegal drugs. R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knew amputation. R14's	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 238 significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others 1-3 days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA were all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. CAAs did not identify any history of drug use. R14's Vulnerable Adult care plan dated as revised on 4/26/14, indicated R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility. A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a nursing assistant (NA) had reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician had been notified and R14 had been sent to the ER for evaluation.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 239 A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified the laboratory report had been obtained for R14 due to "drug ingestion." Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, investigation of the incident to determine potential source(s) R14 may have obtained the illegal drug from, notification of law enforcement, any follow up assessment of R14's safety, an evaluation of R14's access to leave the facility, such as to smoke; documentation of how to prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically related social services. On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "eplileptic." R14 denied awareness of illegal drug and ETOH activity in the facility. When asked what R14 would do if she observed illegal drug or ETOH activity in the facility, R14 stated he would "tell the resident not to do it," but would not notifiy staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, and verified there was no current system in place for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 240 On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R62 was identified by the facility to have past/recent substance abuse. R62 had diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the quarterly MDS, dated 2/25/14, indicated R62 had moderate cognitive impairment. Review of facility progress note dated 1/24/14, at 17:03, indicated "a resident approached writer alerting us that another resident (res) is sitting outfront smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any".	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 241 Review of facility progress note dated 1/24/14, at 17:17, indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor". Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address ETOH and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes. Review of a facility provided list of residents with questionable or known ETOH and drug use dated 5/8/14, at 8:02 a.m. identified R62 for drugs. During an interview on 5/13/14, at 10:18 a.m., the DM stated "I did what the 1/24/14 progress note says and reported it to the social worker, director	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 242 of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were unaware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14 identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month". SW-B stated she has been at the facility since 3/19/14. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 had verified she'd been smoking 'weed' but had told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume the administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 had ever been offered any chemical dependency assistance. R86 had been committed as mentally ill and chemically dependent on 10/31/12, which was amended on 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. According to the Admission Record dated 3/16/13, R86 had been admitted to the facility with diagnoses including: hepatic encephalopathy (confusion related to liver failure) and cirrhosis of	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 243	{F 323}		

the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness.

A care conference dated 1/2/13[sic] (2014), lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.

A progress note dated 2/24/14, at 4:38 a.m. " Resident had been very confused and having difficulty to settled down in bed. judgement [sic] has been non intact and appearing restless with a lot of tremor. He did attested [sic] to this writer that when he goes LOA he smokes marijuana but never drink ETOH at all. He state "If I drink I will die. " His platelet has been dangerously lower thus posing him at a risk for bleeding. Update DR smiley about resident change in condition, which then mandate this writer to send resident to the emergency for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. "

A progress note dated 2/24/14, indicated at 11:00 p.m. "Pt was found smoking 'pot' in his room. His roommate was in the room at that time. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."

A progress note dated 3/4/14, at 6:11 a.m. noted, " While executing an initial nursing rounds this shift, this writer smell and noted a medicine bottle fill up with marijuana. Upon conversation, this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 244 resident did urge this staff that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinued. He had flexeral [sic]with some benefit noted. He want [sic] another sleeping pills at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg of Trazodone [sic], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment. " An annual MDS dated 3/22/14, had a BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares. A vulnerable adult assessment dated 3/18/14, noted past and recent chemical abuse. R86 had fluctuating cognitive deficits related to liver damage, chemical use and needed supervised LOA due to fluctuating cognition and chemical use. A smoking assessment dated 3/18/14, indicated reports of smoking marijuana outside, and recent drug use reported by resident. A LOA safety assessment dated 3/18/14 indicated mental illness, fluctuating cognition related to liver disease. R86 needed supervised LOA due to fluctuating cognition and chemical use (no mention of committed to the facility related to substance abuse and mental illness. On 4/13/14, a care conference indicated: long term placement waiting for liver transplant. " Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 245 Discussed AA (alcoholics anonymous), stated he has tried in the past. " The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. R86 was committed to prevent exposure to ETOH and chemical substances of abuse. The facility lacked coordination of care between departments, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided. R113 was a known alleged narcotic seller by the facility staff. On 5/12/14, at 12:36 a.m. R113 was observed ambulating across the nursing station with his walker as he conversed to both residents and staff as he ambulated to his room down the hallway. On 5/12/14, at 1:53 p.m. R113 was observed sitting on his bed back facing the door and was observed rolling cigarettes using a cigarette roller. R113 asked if it was okay to continue to roll the cigarettes as surveyor talked to him. -At 1:54 p.m. R113 stated he knew exactly who	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 246	{F 323}		

started the rumor about the narcotics. R113 indicated he is currently trying to resolve his marriage and his wife who would not allow him to come out to her house for visits if she found out he had ETOH and drugs issues. R113 stated he remembered the incident when the therapy staff had intervened when he had been approached by another resident for cigarettes and he remembered being talked to by the administrator and social worker about the policy. R113 further stated he also took his medications in front of the nurses as he knew this was going to be a concern/issue and also indicated he knew of ETOH being used at the facility by other residents but because he was a recovered alcoholic he kept his nose out of all trouble to get back with his wife.

When interviewed on 5/12/14, at 1:57 p.m. RN-A stated he always watched R113 take all his medications and made sure he swallowed them then took the medication cup out of the room.

When interviewed on 5/12/14, at 2:18 p.m. both CLSW-A and CLSW-B stated they were not aware of R113 using any illicit drugs at the facility. CLSW-A stated she remembered talking to R113 for less than ten seconds when he had asked if he would continue to roll the cigarettes and had told him not to until he was told otherwise.

R113's significant MDS dated 2/14/14, indicated R113's diagnoses included acute ETOH hepatitis, ETOH withdrawal, ETOH dependence and insomnia. The ADL Functional/ Rehabilitation Potential CAA dated 2/14/14, indicated R113 had history of ETOH abuse.

The mood/Behavior care plan dated 4/28/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 323}	Continued From page 247 identified R113 had history of ETOH abuse, had history of depression and had recent amputation of toes due to frost bite. Resident List Report dated 5/8/2014, provided by the administrator indicated R113 was selling narcotics. Smoking Evaluation dated 3/17/14, indicated R113 had no history of unsafe smoking practices and was independent with smoking and smoking materials. Vulnerable Adult Assessment dated 3/17/14, indicated R113 had history of chemical abuse but no recent history. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. Progress Notes review revealed the following: -Progress note dated 4/24/14, indicated R113 was in therapy when another resident approached him and asked to buy rolled cigarettes from him. Therapist stopped transaction to check facility policy. R113 and therapist approached social services to ask about policy and were directed to the administrator but the administrator was unavailable and a note was left for administrator to please visit with R113 regarding policy. R113 was instructed not to sell any rolled cigarettes until cleared by administrator.	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 248 -Social Services Progress Note dated 5/2/14, indicated R113 had declined to attend the smokers meeting to be updated on the facility policy and procedure regarding smoking. The administrator and social worker had met with R113 and was given a copy of the facility policy and discussed the rules regarding smoking. R113 was also educated on rolling cigarettes for other residents and informed until further notice he could not be not allow to give, sell, trade, or buy cigarettes with other residents which R113 acknowledged. R1 was not smoking at the designated area, was not wearing an apron, had known alleged drug involvement at the facility and was keeping her smoking materials. On 5/5/14, at 1:50 p.m. during the initial tour R1 was observed to be assisted to light a cigarette while outside on the smoking patio. At 1:52 p.m. staff provided R1 with a smoking apron and attempted to apply but R1 was observed to shake head no. At 1:54 p.m. R1 still had no smoking apron applied but continue to smoke in the front designated smoking area and staff was within arms-length reach of R1. On 5/7/14, at 7:34 a.m. R1 was observed with a lit cigarette right outside the front door with no smoking apron on. NA-E got into the front seat of the transport van and R1 was observed throwing her cigarette over her shoulder prior to getting into the van. On 5/7/14, at 8:47 a.m. R1 was asked to look at her clothing for burn holes, since she was observed smoking without an apron that morning in front of the building prior to getting in the van. R1 agreed, and a review of her closet verified no new holes were observed in the clothing. R1	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 323}	Continued From page 249 stated "I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing. Now because I have a 1:1 R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." On 5/8/14, at 9:45 a.m. R1 was observed getting out	{F 323}		
{F 329} SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	{F 329}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 329}	Continued From page 250 Based on observation, interview and document review, the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R91, R36, R37, R89, R1, R113, R29). Findings include: R91 had physician orders for PRN Tylenol, Ibuprofen and Oxycodone (pain medications) without identified parameters for when to use which medication. Review of the Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13 with a diagnosis of osteoporosis. The significant change in status Minimum Data Set (MDS) dated 4/1/14, indicated R91 had frequent pain rated at a six. Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain and lacked parameters for use. Review of the Medication Administration Record (MAR) dated 4/1/2014-4/30/2014, revealed R91 did not receive any PRN Tylenol and Ibuprofen and received multiple doses of PRN Oxycodone. R36 had physician orders for PRN Tylenol and Oxycodone without identified parameters for when to use which medication.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 329}	Continued From page 251	{F 329}		

The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12 with diagnoses of femur fracture and alcoholic cirrhosis of the liver.

The quarterly MDS dated 2/18/14, indicated R36 had occasional pain rated at a four.

The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (tid) as needed and Oxycodone 10 mg tid both for pain and lacked parameters for use.

Review of the MAR dated 4/1/2014-4/30/2014, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight.

When interviewed on 5/7/14, at 1:51 p.m. registered nurse (RN)-A reported he would usually do a pain assessment for PRN pain medications and for a pain level below three he would not give Oxycodone.

When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist stated he would expect parameters written by the physician to clarify when to give which PRN pain medication.

On 5/9/14, at 8:46 a.m. licensed practical nurse (LPN)-B was interviewed and stated when there is multiple PRN pain medications ordered, she would assess pain level and start with the lowest pain medication unless the resident's pain was "really bad" or something else worked for the resident.

Upon interview on 5/12/14, at 9:40 a.m. RN-B stated she would start with Tylenol first and see if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 329}	Continued From page 252 it works, then would document if it was ineffective and then try Oxycodone unless there was a specific physician order. The facility Pain Management policy revised May 2013, lacked direction regarding parameters for PRN pain medication. R37 had physician orders for Seroquel (an antipsychotic medication) without adequate indications for use, without side effect and symptom monitoring and lacked evidence of a gradual dose reduction (GDR) or documentation of a clinical contraindication. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/7/13, indicated R37 was receiving antidepressant and antipsychotic medications; however, lacked a comprehensive assessment summary regarding the medications in use. A Psychotropic Medications care plan revised on 3/16/14, included Seroquel was used for psychoses and directed to monitor for side effects and consult with pharmacy and physician to consider dosage reduction when clinically appropriate. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 253 Review of the Physician's Order Sheet dated 5/1/14, lacked a diagnosis for the medication. The Information and Consent for Psychotropic Medications dated 9/19/13 and 2/26/14, indicated the diagnosis to support use were "agitation/sleep." A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. Physician and nurse practitioner notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist (CP) stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident. Upon interview on 5/12/14, at 3:57 p.m. the nurse practitioner (NP) stated R37 received Seroquel for psychosis, verbal outbursts and generalized anxiety which were mainly problematic when R37 was drinking. The NP stated she believed a different medication was used when R37 was in the hospital prior to admit and was unsuccessful because of liver disease. The NP stated she had not reviewed R37's medications because he had been in the hospital frequently and she tries to do dose reductions quarterly.	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 254 When interviewed on 5/13/14, at 8:46 a.m. LPN-A stated the indication for use for Seroquel was not listed and she would have to check with the physician. LPN-A stated she was not sure what target behaviors were being monitored for Seroquel. LPN-A stated orthostatic blood pressures were recorded in the electronic record. After review of the Weights and Vitals Summary, LPN-A verified there were no orthostatic blood pressures recorded for R37 since December 2013. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received. The facility Psychoactive Medication Management policy revised May 2013, directed the DNS [director of nursing services] or designee was responsible to ensure timely medical consultation when a psychoactive medication requires a medical review. R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic medication). In addition, R89 was not monitored for potential side effect of orthostatic hypotension (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position). R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The	{F 329}		

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{F 329}	Continued From page 255 MDS identified R89 had hallucinations, delusions, and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate	{F 329}		

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{F 329}	Continued From page 256 response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.	{F 329}		

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{F 329}	Continued From page 257 Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg [milligrams] daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in	{F 329}		

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{F 329}	Continued From page 258 meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective." The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more." The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia. On 5/5/14, at approximately 1:40 p.m. R89 was observed to be laying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Observations of R89 on 5/7/14, at 8:28 a.m.; 5/8/14, at 8:30 a.m.; and 5/12/14, at 12:23 p.m. Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the LPN-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no	{F 329}		

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{F 329}	Continued From page 259 orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of antirollbacks and restraints. DON verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The	{F 329}		

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{F 329}	Continued From page 260 Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the consultant pharmacist was called and a message left. The consultant pharmacist did not return the call. R1 was not monitored for potential side effects related to use of Trazodone and Venlafaxine (an anti-depressants) and Zolpidem (a hypnotic). Findings include: R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1	{F 329}		

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{F 329}	Continued From page 261 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 Milligrams (mg) by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. RN-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 329}	Continued From page 262	{F 329}		

just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently.

When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others.

When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently.

The Psychoactive Medication Management policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 329}	Continued From page 263 dated as reviewed 5/2013, indicated the care plan would identify side effects of the use of any psychoactive medications but lacked monitoring of side effects of anti-depressants and sleep study/logs for resident who were taking medication to aide sleep. R113 lacked parameters for as needed pain medication Oxycodone. R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. Physician's Order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. Pain Assessment dated 4/25/14, indicated R113	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 264 had pain daily and was predictable and the pain did not prevent resident from doing or results in mood or behavior. The assessment indicated the pain was worse and/or breakthrough pain with therapy and dressing change. Summary indicated the pain was from the amputation sites to his both feet toes and was aggravated by therapy and wound care but was relieved by treating with PRN medications prior to treatment and resident reported current pain regime was effective. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider. When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." DON was not unavailable to interview on 5/13/14, regarding pain medication parameters. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided. R29 had physician orders for PRN morphine (pain medication) with no parameters for use, in addition no pain monitoring was completed.	{F 329}		

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{F 329}	Continued From page 265 Review of the Admission Record dated 4/28/14, indicated R29 was admitted on 1/15/14, with diagnoses that included chronic pain, diabetic polyneuropathy (nerve damage) and adult failure to thrive. The quarterly MDS dated 4/17/14, indicated R29 had frequent pain rated at a pain level of six. The CAA dated 1/28/14, indicated R29 "has chronic back pain, she gets Neurontin, OxyContin and oxycodone PRN, it has been effective at time". The CAA did not indicate diseases or conditions that may cause the pain, characteristics or frequency of the pain, but indicated it adversely affects mood. During observation on 5/12/14, at 9:10 a.m. R29 was observed to be very thin, awake in a darkened room, in bed and when surveyor asked to enter room, resident stated "no". During observation on 5/12/14, at 2:01 p.m. R29 was in darkened room, in bed sleeping. During observation on 5/13/14, at 850 a.m. R29 was observed lying in bed, dressed in a hospital gown in a darkened room. R29 stated "I am not doing well today, the pain is constant, the meds help for a while, then it starts again". R29 stated she does go to a pain clinic. Review of the physician's order sheet dated 5/9/14 included an order for morphine 30 mg four times daily as needed. Review of the MAR dated 4/1/14 to 5/31/14, revealed R29 received multiple doses of PRN morphine. Review of the pain evaluation and management	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 329}	Continued From page 266 plan dated 4/17/14, indicated R29 had occasional pain in back and feet, current pain regimen was effective and nursing would continue to monitor and update MD/NP as needed. R29's care plan with revision date of 4/12/2014, identified R29 was on pain medication therapy due to foot surgery and chronic back pain. Interventions included: pain assessment per facility policy, administer medication as ordered and to frequently review for pain medication efficacy. During an interview on 5/12/14 at 3:29 a.m., LPN-E stated that for R29, "some days are good, some days are bad, she is on quite a bit of meds for pain" and that on 5/9/14 R29's primary physician increased some meds, "that may be why she is sleepy". LPN-E stated R29 was not on her caseload, but she would have put short term implementations of pain monitoring in place when there is a change in meds. LPN-E verified that it looks like every three to four hours the morphine is given and that the order should be more specific "like every 4 or 6 hours [hrs]". LPN-E verified there was no pain monitoring being completed, "it must have fallen thru the cracks when we went from paper to the computer". During an interview on 5/13/14, at 10:58 a.m. LPN-G stated he had not given any morphine yet today and would ask the resident if she has any pain. LPN-G further stated he would expect the order to be more specific such as "every 4 or 6 hrs" in addition to PRN, but would ask the nurse manager for more clarification. Review of Medication Administration General Guidelines, section 7.1, page 3 of the facility	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 329}	Continued From page 267 Nursing Care Center Pharmacy Policy & Procedure Manual date 2007, indicated that medications are administered in accordance with written orders of the prescriber. If a dose seems excessive....or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. The DON was not available to interview on 5/13/14, regarding pain medication parameters and monitoring. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.	{F 329}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	{F 353}		7/6/14

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{F 353}	Continued From page 268 Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate staff to meet the individual needs for safety, supervision and care for 13 of 44 residents reviewed during the revisit (R22, R129, R1, R41, R37, R13, R86, R116, R36, R117, R9, R14, R62). In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect each of the 67 residents who resided at the facility. Findings include: The facility has started using agency staff, licensed nursing and nursing assistants (NA) from Soul Care LLC 1521 Como Ave Southeast Minneapolis, 55414. On 5/6/14, orientation was requested for any agency staff that has worked since the last survey. A review of the orientation files verified that the facility did not ensure staff had background checks, and had received the required tuberculin skin testing (TST). A review of the facility schedules dated from 4/5/14 through 5/17/14, indicated the facility staffing plan called for on the day shift: two licensed nurses with 13 nursing assistant (NA's); on the evening shift: two licensed nurses with 13 NA's and on the night shift: two licensed nurses	{F 353}		

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{F 353}	Continued From page 269 with 6 NA's. Open nursing and NA shifts in the two week block of time from 5/4/14 through 5/17/14, included nine nursing day shifts and 53 NA's open day shifts, 17 open evening shifts, and 30 open night shifts. Two additional staff was being used for 1:1's for R1 who was alleged by the facility to both ingest and provide illicit substances to residents within the facility and R129 after she had obtained and ingested cocaine within the facility and required hospitalization. An undated facility typed document titled 1:1 Observation Staff Responsibilities indicated: only one staff person performs the 1:1 observation with only one resident during the assigned time, and follows the resident wherever he/she goes and maintains a distance no further than arm's length at tall times. When the resident is in the room, staff will be either sitting outside or inside his/her room and make sure that they maintain residents visual at all times. Notify nurse/supervisor with any suspicious activity observed on resident. Will accompany resident if he desires to go out and smoke and make sure that appropriate clothing is worn, and oxygen is removed 5 minutes before going out to smoke. Nursing was to oversee the 1:1 observations and respond to concerns reported. One additional staff per shift was used as a smoke monitor. The Smoking Monitor Responsibilities (undated document) directed the monitor to ensure the smoking areas are monitored at all times, carry a list of smokers, and the smoking assessment results at all times. The monitors were to use the list to determine which	{F 353}		

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{F 353}	Continued From page 270 residents require close supervision or other interventions and ensure the interventions are in place. "Supervised smokers must be within direct line of sight at all times. Those requiring assistance with smoking materials must be within reach of the smoking monitor.... Direct all smokers to the designated smoking areas only... No smoking will be allowed in front of the building. Notify supervisor immediately if: a resident not on the list is smoking. A resident refused indicated interventions, such as wearing a smoking apron or staying within the designated smoking area." On 5/7/14, at 9:27 a.m. and again at 9:31 a.m. R22 (a resident identified by the facility as a supervised smoker required to wear a smoking apron) was observed by surveyors to drop a lit cigarette onto his shirt, both times the resident was able to pick it back up. When interviewed at 9:32 a.m. the smoke monitor NA-B stated she had not observed R22 dropping the cigarette at 9:27 a.m. or 9:31 a.m. and verified that she had been more than an arm ' s length away from the smoker. R22's clothing was checked and no burn holes were noted in his shirt, or in the blanket that had been covering his lap. NA-B stated that R22 was supposed to be a supervised smoker with a smoking apron, but the resident had refused to wear the smoking apron. NA-B verified she had given R22 a cigarette to smoke, even though she knew he was assessed to require a smoking apron. NA-B stated when R22 or any resident refused to wear the smoking apron, or follow the rules; they would record it in the smoke monitor notes. The smoke monitor notes were reviewed and revealed that notes started on 3/15/14, and were present for March 16th through 21st, 24th through 27th, 28th was blank, 29th and 30th, and	{F 353}		

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{F 353}	Continued From page 271 the 31st was blank. On April 28th and 30th and May 2nd-3rd, and 4th were left blank. On all of the days listed residents had refused to wear smoking aprons, and/or relinquish the smoking materials. The administrator stated he thought the other logs had been collected, but stated he had not reviewed them for compliance with the smoking policy. Residents within the facility were able to obtain, ingest and allegedly sell alcohol and drug substances within the facility while the smoking monitor, safety monitor and 1:1 staff were in place for R129 and R1. Immediate Jeopardy (IJ) was identified at F323 for lack of supervision to prevent alcohol and drug use that lead to hospitalization for (R41, R129, and R37) and elopement by R13, a resident with a WanderGuard (an alert system that lets the facility know a resident has left the building) who was let outside to smoke and went from there to the public sidewalk, the facility had to be notified by surveyors of the elopement) Refer to F323 on 5/9/14. After the IJ was identified on 5/9/14, two Residents (R129 and R37) who both had one to one (1:1) staff (defined by the facility administrator as being within arm's length of the resident to prevent incidents from occurring) were able to obtain and ingest alcohol and drug substances on 5/10/14. On 5/10/14 at 1:07 p.m. R37 was taken to North Memorial Medical Center for intoxication. R37 was animated and chatting with the medics as he was taken, and the health unit coordinator (HUC) stated that is how you know he is intoxicated, he was friendly and chatting, when not intoxicated he	{F 353}		

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{F 353}	Continued From page 272	{F 353}		

was usually very quiet. It was reported from the hospital that the resident had alcohol and methadone (a drug he had not been prescribed) in his system. The administrator stated the 1:1 staff assigned to R37 should have been able to prevent him from obtaining and consuming alcohol and methadone.

On 5/11/14, at 10:55 a.m. the administrator notified surveyors he had not been notified that R129 was sent to emergency room, at 4:00 a.m., after she had reported to a staff member that she was intoxicated. A blood alcohol level was determined to be .323 (more than three times the legal limit) and R129 was in the intensive care unit, intubated and assisted to breath by a mechanical ventilator. The administrator stated the 1:1 staff assigned to R129 should have been able to prevent her from obtaining and consuming alcohol. After investigation it was noted by contracted licensed social work (CLSW)-A that R1 accelerated away from her 1:1 staff at a high rate of speed in her electric w/c and was able to make an exchange with R117 (a former resident), R1 and R129 were noted to make an exchange later in R129's room, both had 1:1 staff who did not report the exchange, and failed to protect the residents on 1:1 observation.

A special Staffing - One to One Assignment policy dated May 2012 and revised May 2013 included: one to one staffing assignments are in place based on an assessed need until appropriate permanent alternative arrangements can be made reasons may include, but are not limited to: treat of suicide by a resident, altered mentation that may dislodge treatment lines or devices, escalating exit seeking behavior, altered cognition in an agitated state that is not easily

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{F 353}	Continued From page 273 redirected., or not respected the boundaries of other residents. The procedure stated "to keep the one to one within arm's reach at all times. (if not suicidal may have visual privacy for toileting). Alternatives to one to one assignment are investigated as timely as possible. (alternative care setting, medical evaluation), family or responsible party are notified to see if they are available to provide this heightened level of supervision. Documentation of the one to one assignment is made in the clinical record; appropriate care plan/review/revision is made during the one to one assignment. IDT [interdisciplinary team] will meet to determine the appropriateness of removing a one to one and under what circumstances it may be reinitiated." The one to one staff, and safety monitor were not effective in preventing residents from obtaining and consuming drugs and alcohol within the facility, the facility lacked an analysis of that staffing failure and lacked additional interventions to safe guard residents. Refer to F224: the facility failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, the facility failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents (R13). These facility failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. This had the potential to affect all 67 residents in the facility.	{F 353}		

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{F 353}	Continued From page 274 F323: the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in Immediate Jeopardy (IJ) on 5/9/14, at 2:03 p.m. Also a second IJ was identified for 2 of 3 residents (R37, R129) on 5/12/14, at 2:51 p.m. In addition, the facility failed to ensure residents with WanderGuard were supervised when leaving the facility for 2 of 3 residents (R13, R116) observed to elope from the facility. R13 was observed on 5/6/14, to leave the facility with a WanderGuard attached. This resulted in IJ on 5/9/14, at 2:03 p.m. R116 was observed to leave the facility on 5/11/14, at 9:30 a.m. This resulted in IJ on 5/12/14, at 2:51 p.m. In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113). Also, the facility failed to ensure residents were smoking safely according to the plan of care for 3 of 3 residents (R1, R36, R22).	{F 353}		
{F 412} SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	{F 412}		7/6/14

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{F 412}	Continued From page 275 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed without dentures during the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m. When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s) (edentulous); maintained oral care independently and R36 had reported he had dentures at home	{F 412}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 412}	Continued From page 276 not at the facility. Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him. Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums. The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..." The Camden Care Center Quarterly Care Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet. R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns. The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or dentures and is able to chew adequately without	{F 412}		

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{F 412}	Continued From page 277 his teeth and noted weight as stable. Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested. When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care. When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms. When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him. When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..." On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 412}	Continued From page 278 while ago and would like new ones if his old ones could not be found. On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones. The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided. The facility plan of correction indicated by 4/28/14, social service and nursing would coordinate getting R36 fitted with dentures and these activities would be clearly documented in the clinical record to include any and all communication with the guardian. Review of R36's record on 5/7/14, at 1:50 p.m. lacked evidence of a dental visit. When interviewed on 5/7/14, at 2:10 p.m. the health unit coordinator (HUC) stated reported she had spoken to R36 and he stated his dentures were in a storage locker and he did not want new ones and stated the information was in the progress notes. The HUC was again interviewed on 5/8/14, at 8:17 a.m. and she stated she was unable to locate any documentation regarding her conversation with R36 regarding his dentures and she verified she had not offered R36 a routine dental exam. At 2:32 p.m. the HUC reported R36 had agreed to a dental visit and would be scheduled for one. When interviewed on 5/13/14, at 2:29 p.m. licensed practical nurse (LPN)-E stated the facility did not have a dental policy and the corporate consultant stated it was on a case by case basis.	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 412}	Continued From page 279	{F 412}		

The facility Medical Services policy dated May 2012, indicated the social services director or designee was responsible to arrange dental services to meet the needs of the residents.

R9 had a dental exam on 2/27/14, which indicated that more dental treatment was needed, however had not received dental follow up as recommended.

The annual MDS dated 10/11/13, did not identify R9 had any dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene.

Review of R9's care plan dated 4/10/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." The careplan indicated R9 had diagnoses that included schizophrenia, diabetes mellitus, and orofacial dyskinesia.

Review of In House Senior Services, LLC (limited liability company) Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and #12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful. Res was cooperative, though has difficult time holding her mouth still, and her

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{F 412}	Continued From page 280 tongue is very active." During an interview on 5/6/14, at 2:45 p.m. R9 stated "I can chew. I saw a dentist here. I'm missing some teeth but he said they have to fall out before I can get dentures." During an interview on 5/7/14, at 3:28 p.m. LPN-A stated "I went through the progress notes and I don't see anything that addresses the dental exam." During an interview on 5/7/14, at 3:30 p.m. HUC stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this." Review of the facility Medical Services policy with revision date of May 2013, indicated the facility will ensure each resident has access to dental/vision/hearing/podiatric services to meet their individualized needs, resident needs are identified at the time of admission and additionally through the RAI [resident assessment indicator] process and daily assessment/monitoring of resident condition and change in condition also alerts staff to the need for medical services.	{F 412}		
{F 428} SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	{F 428}		7/6/14

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{F 428}	Continued From page 281	{F 428}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the consultant pharmacist failed to identify lack of medication parameters for as needed (PRN) pain medications for 2 of 7 residents (R91, R36), failed to identify a lack of adequate indication for use, resident specific target behaviors and monitoring for antipsychotic medication for 2 of 7 residents (R37, R89) and failed to identify a lack of side effect monitoring and sleep monitoring for antidepressant medications for 1 of 7 residents (R1) reviewed for unnecessary medications.

Findings include:

R91's Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13, with a diagnosis of osteoporosis.

Review of the Medication Regimen Reviews (MRR) for R91 from 10/17/13 through 5/7/14, lacked evidence the missing parameters for PRN pain medications were identified.

Review of the Medication Administration Record (MAR) dated 4/1/14 through 4/30/14, revealed R91 did not receive any PRN Tylenol (a mild amalgesic) and Ibuprofen (an anti-inflammatory medication) and received multiple doses of PRN Oxycodone (a narcotic).

Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650

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{F 428}	Continued From page 282 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain. R91 had orders for multiple PRN pain medications which lacked parameters for use. R36's Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12, with diagnoses of femur fracture and alcoholic cirrhosis of the liver. Review of the MRR for R36 from 4/22/13 through 5/6/14, lacked evidence the missing parameters for PRN pain medications were identified. Review of the MAR dated 4/1/14 through 4/30/14, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (TID) as needed and Oxycodone 10 mg TID, both for pain, and lacked parameters for use. R36 had orders for multiple PRN pain medications which lacked parameters for use. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. Review of the MRR for R37 on 11/14/13, indicated R37 was taking Seroquel for psychosis, however lacked direction for target behavior monitoring. Review of the MRRs from 9/25/13-4/18/14, revealed the CP failed to identify	{F 428}		

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{F 428}	Continued From page 283 the need for a gradual dose reduction or documentation of the clinical contraindication. Physician and Nurse Practitioner (NP) Notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. R37 received Seroquel (an antipsychotic medication) daily without adequate indication for use, monitoring or an attempt at a gradual dose reduction. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist (CP) stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. When interviewed on 5/7/14, at 3:09 p.m. the CP stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received.	{F 428}		

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{F 428}	Continued From page 284 The consultant pharmacist did not identify the lack of monitoring for resident specific target behaviors and the lack of orthostatic hypotension side effect monitoring for R89's use of Zyprexa (an antipsychotic medication). R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects."	{F 428}		

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{F 428}	Continued From page 285 R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note	{F 428}		

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{F 428}	Continued From page 286 indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia. Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no	{F 428}		

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{F 428}	Continued From page 287 s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective." The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more." The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia. On 5/5/14, at approximately 1:40 p.m. R89 was observed to be lying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical	{F 428}		

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{F 428}	Continued From page 288 record lacked evidence resident specific target behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors,	{F 428}		

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{F 428}	Continued From page 289	{F 428}		

and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data.

Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call.

The consultant pharmacist did not identify monitoring of R1's side effects for Trazodone and Venlafaxine (Effexor-both anti-depressants) and sleep monitoring was lacking.

R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let

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{F 428}	Continued From page 290 yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the Monthly Medication Regimen (MMR) from 3/18/14 forward, revealed the consultant pharmacist had reviewed R1's medications, both were undated and unsigned. The MMR's failed to identify side effects monitoring, and sleep monitoring were lacking, as indicated in the plan of correction dated 4/28/14. Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was	{F 428}		

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{F 428}	Continued From page 291 not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. registered nurse (RN)-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 292 further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. R113 CP failed to identify lack of parameters for as needed pain medication. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15mg) by mouth every four PRN, Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider.	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 428}	Continued From page 293 When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. The PharMerica Medication Regimen Review completed by the CP monthly dated 4/18/14, and two other times after which were signed but undated did not identify R113's physician orders lacked the parameters. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. On 5/7/14, at 1:56 p.m. CP stated he would expect parameters written by the physician to clarify when to give which medication.	{F 428}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 431}	Continued From page 294 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5	{F 431}		

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{F 431}	Continued From page 295 medication and treatment carts had the internal drawers kept clean; the facility failed to ensure medications were dated when opening; eye medications, suppositories, topical medications were observed to be stored together for 11 of 67 residents (R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88). In addition, the white refrigerator in the medication room (used to store refrigerated medications) was observed to have a heavy buildup of frost in the freezer compartment. These practices had the potential to affect all 67 residents residing in the facility. In addition, the facility failed to lock a medication cart which held biologicals and medications (anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication). This had the potential to affect 4 of 7 residents (R73, R37, R83, R115) who were near the medication cart. The four residents were able to access to the cart according to staff. Findings include: WEST MEDICATION CART On 5/7/14, at 7:52 a.m. first (top) drawer was observed to have the following: R13 had an open Advair Diskus inhaler (used for breathing) without an open date. R13's Minimum Data Set (MDS) dated 3/25/14, noted R134 had breathing problems and was cognitively intact. According to the package insert by GalxoKlineSmith dated 2008, staff were to "Take ADVAIR DISKUS out of the box and foil pouch. Write the 'Pouch opened' and 'Use by' dates on the label on top of the DISKUS. The 'Use by' date is 1 month from date of opening the pouch."	{F 431}		

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{F 431}	Continued From page 296 R92 had an opened and expired bottle of Travatan Z 0.004% (reduce the elevated pressure inside your eye) eye drops for R92. The label indicated to "Order After 3/27/14." A sticker affixed to the bottle indicated the medication was opened on 3/3/14. The bottle was observed to be stored loosely with oral medications. A second bottle of the same eye drop with date opened of 4/19 (no year) written on the label, had no open date documented on the Date Opened sticker. A third bottle of the same eye drop was also observed to be stored loosely (no zip lock bag) in and with oral medications for various other residents and had no open date. All three Travatan Z bottles for R92 were opened and had remaining doses in each bottle. R92's MDS dated 1/15/14, indicated R92 had adequate vision and no vision problems. According to the package insert by Alcon Laboratories (SA) (Pty) Ltd, Revised 11/02, directed staff, "STORAGE INSTRUCTIONS: Store below 25°C., DO NOT USE MORE THAN 30 DAYS AFTER OPENING. KEEP OUT OF REACH OF CHILDREN." R9's Insulin Aspart pen (Novolog- used to control blood sugar) had no open date and had a sticker on the pen which indicated "EXP [expires]: 04/11/14." A second pen of the same medication for R9 lacked the protective cover for the end of the pen (where the needle affixes) and lacked an open date. Both pens were stored in and with eye drops for other residents. R9's MDS dated 3/24/14, indicated R9 was cognitively intact and had diabetes.	{F 431}		

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{F 431}	Continued From page 297 According to the package insert by Novo Nordisk INC, dated 2002 through 2008, staff were to store as follows: " Recommended Storage: Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated. Unpunctured vials can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused vials in the carton so they will stay clean and protected from light. R54 had a bottle latanoprost 0.005% (used to reduce the intraocular pressure) eye drops was observed to be stored loosely with other oral medications. R54's MDS dated 1/15/14, indicated R54 had adequate vision and no vision problems. - A 3 milliliter (ml) vial of 2.5 mg albuterol was observed to be stored loosely in the top drawer. The vial had no label to identify which resident the Albuterol was ordered for. - The first drawer was observed to have a light brown and crumb like consistency buildup of debris in the upper right corner of the drawer. A heavy buildup of sand colored debris was observed in the upper left corner of the first draw. The debris was observed to be with and under the stored inhalers. - The second drawer had a heavy buildup of brownish colored debris in the corners and bottom of the drawer. The debris appeared to be from pulverized/crushed medication tablets. On 5/7/14, at 8:15 a.m. the licensed practical nurse (LPN)-C verified the findings.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 298 SOUTH TREATMENT CART On 5/7/14, at 8:39 a.m. the registered nurse (RN)-B verified he worked out of the cart and opened the cart. The following was observed: R29's Levemir insulin flexpen (used to control blood sugar) had no open date on the sticker. R29 's MDS dated 1/29/14, indicated R29 was cognitively intact and was a diabetic. According to the package insert by Novo Nordisk INC, dated 2005 through 20012, staff were to store as follows: "Recommended Storage: 3 mL LEVEMIR FlexPen: Not in-use (unopened) Room Temperature (below 30°C) for 42 days. In-use (opened) was to be stored for 42 days at room temperature." R25's Lantus insulin had an open date of 4/4 (no year) and expiration date of 5/3 (no year). The insulin was open, partially used and expired. R25's MDS dated 4/8/14, indicated R25 was a diabetic and was moderately cognitively impaired. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " R66's Lantus Solostar insulin had no open date.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 299 R66's MDS dated 3/25/14, indicated R66 was cognitively intact. The MDS did not indicate R66 was a diabetic. However, the MDS did indicate R66 received insulin injections in the past seven days. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " RN-B verified the findings at the time of the observation and stated the medications should have open dates. RN-B verified the expired medication was used "today." The second drawer of the south treatment cart was observed to have a buildup of potential pulverized medication debris in the corners of the drawer. The third drawer was observed to contain a plastic bin containing various tubes of topical medications for different residents. Some tubes were observed to be stored in zip lock bags with labels. All topical medication tubes in the bin had been used. Topical medications in the bin not in zip lock bags were observed to be in contact with each other. The topical medications not stored separately included a tube of unlabeled Dimethicone Skin no label (barrier ointment).	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 300 R22's tube of Capsaicin 0.25% Cream (used to control pain from arthritis) directed staff to apply the medication to the left hip and right rib. R22's MDS dated 1/9/14, indicated no musculoskeletal problems, no indications of pain, and also revealed R22 was moderately cognitively impaired. R95's Hydrocortisone 1% Cream (used to treat skin inflammation and itching) identified to apply the medication to R95's stomach and back; R95's MDS dated 2/28/14, indicated no rashes were present and revealed R95 was cognitively intact. - An unlabeled tube of Aquaphor healing ointment (barrier ointment) was approximately 90% used. R86 had a tube of Fluocinononide 0.05% solution (used to treat the itching, redness, dryness, crusting, scaling scalp) which directed to apply the medication to scalp; R86's tube of Desonide 0.05% (used to treat the redness, swelling, itching, and discomfort of various skin conditions) directed to apply the medication to axilla, groin and abdomen folds; a bottle of Deep Sea Premium Nasal Moisturizing Spray (moisturizes the nasal passages). The bottle of nasal spray was observed to be in contact with other topical medications in the bin. RN-B stated the spray, "Should be in other cart." R86's MDS dated 3/23/14, indicated no skin problems and was cognitively intact. R86's Treatment Administration Record (TARs) dated May 2014 indciated the R86 received topical cream to the face, skin folds, groin, and axilla	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 301 once or twice a day for psoriasis bulgaris. R29's Nystatin - Triamcinolone Cream (used for yeast infections) directed to apply the medication to R29's labia. R29's MDS dated 1/29/14, indicated R29 was cognitively intact, received creams and ointment to other areas other than feet, and noted R29 was a diabetic. R29's Physician's Order sheet undated indicated Nystatin was to be applied to the labia three times daily for itching. - The drawer was observed to have a heavy buildup of crumbs, pulverized pill fragments and paper, foil and plastic pieces debris in all drawers. The corners and sides of the drawers had the highest build up. RN-B verified the findings at the time of the observation and confirmed the topical medications should be stored separate from nasal medications. RN-B verified the tubes of topical medications for different residents, should not be stored together. SOUTH MEDICATION CART At 9:06 a.m. the South Medication Cart second drawer was observed to have one white and one yellow medication tablet loose in the bottom of left section of the drawer, and one yellow tablet, one white tablet, one pink tablet and one beige tablet loose on the bottom of the right section of the drawer. A buildup of foil debris was observed in all corners. - The third drawer had one bright yellow tablet and a buildup of pulverized pills and foil debris in all corners. - Fourth drawer was observed to have a opened and partially used box of Bisac-Evac 10 mg Bisacodyl suppositories used for constipation)	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 302 stored with nebulizer medications (breathing medications). - The first small left side drawer was observed to have one unlabeled vial of Albuterol neb solution (breathing medication) stored loosely in the drawer. - The third left side drawer was observed to have a sticky red colored substance spilled on the bottom of the drawer. The substance appeared to be smeared on the bottom of the drawer, was wet to the touch and easily removed with a finger. RN-B verified the above findings and was unclear on when the medication carts were cleaned. MEDICATION ROOM At 9:21 a.m. the white medication refrigerator was observed to have a heavy buildup of frost approximately two to three inches thick which completely encased an ice pack in the frost of the freezer. NORTH MEDICATION CART At 9:24 a.m. the following was observed: R88's Novolog insulin (used to control blood sugar) was observed to have an open dated of 3/22 (no year) and an expiration date of 4/20 (no year). R88's MDS dated 2/7/14, indicated the resident had expired. - The second drawer was observed to have a white half tablet, a red gel cap loose in the bottom of the drawer; foil, paper and pulverized medication debris was observed to have built up in edges and corners of the drawer. - The third drawer was observed to have built up foil, paper and pulverized medication debris in the corners, a red, sticky, circular shaped spill on the bottom of the drawer.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 303 LPN-F verified the findings at the time of the observation. LPN-F was unclear on medication cart cleaning and stated she, does "not have time to get her medication pass done" due to it being "too heavy." LPN-F explained she had too many other responsibilities such as taking blood sugars, administering insulin verified she did not clean the medication cart. Although LPN-F stated she worked for the agency, LPN-F stated she usually worked on the North Medication cart and had worked in the facility for several weeks. EAST MEDICATION CART At 9:39 a.m. the second drawer was observed to have two white half tablets loose in the bottom of the drawer. On 5/7/14, at 11:45 a.m. LPN-E verified she was in charge of the North Unit and stated the medication carts were "a mess" and stated she believed all the carts were newer and cleaned by "the pharmacy" last week. LPN-E was unclear on the cleaning schedule of the medication carts. LPN-E stated before there was trained medication aide (TMA) responsible for the cart and a nurse responsible for the treatment cart. Explained there were "fifteen different hands" in each cart and they were not being kept clean. -At 12:00 p.m. LPN-E observed the medication carts with surveyor and verified the findings. LPN-E stated it was a new medication cart. LPN-C was present at the time of the observation and stated the medication cart was "not new." LPN-E verified eye drops, Advair Diskus inhalers, and insulin required open dates. On 5/7/14, at 1:26 p.m. LPN-A verified she was in charge of the West and East units. LPN-A stated she had not completed any cleaning audits for the	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 304	{F 431}		

medication carts and did not know if audits were completed. LPN-A stated she did not know the audit or cleaning schedules for the carts. LPN-A was unclear what the facility system was to ensure the medication carts were kept clean. LPN-A further stated she was unclear who was responsible for cleaning the medication carts and was unclear on the policy for medication cart cleaning.

On 5/8/14, at 4:21 p.m. the consulting administrator stated the facility did not have a policy or a procedure for medication cart cleaning and verified the carts should have been cleaned. The consulting administrator stated the facility was "not allowed to write policies," but could write a "procedure."

A PharMerica 3.7 Medications and Medication Labels policy dated 9/2010, directed multi-dose vials "shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)" The policy further identified all medications should have a pharmacy affixed label.

The PharMerica 4.1 Storage of Medication policy dated 9/2010, directed to store eye, internally administered, oral inhalation, nasal, oral and topical medications separately.

Medications carts were left unlock and un-supervised.
South Hallway Medication cart
On 5/5/14, at 1:39 p.m. observed the key lock to the nursing medication cart to be fully extended in the unlocked position on the South unit. Two residents were observed to wheel by the cart and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 431}	Continued From page 305 no staff was in the hallway. RN-B, was observed to follow the surveyor from the nursing station onto the South unit and approach the medication cart and open the top drawer. East Hallway Medication Cart On 5/8/14, at 3:50 p.m. surveyor observed the unlocked medication cart across the nursing station in the East Hall Way. -At 3:53 p.m. observed the administrator walk past the unlocked cart. -At 3:55 p.m. observed the director of nursing walk past the cart then walk right past the cart back to the nursing station. -At 3:54 p.m. nursing assistant (NA)-F came stood approximately 6 feet beside the surveyor on the counter typing then walked away. -At 3:56 p.m. observed resident with a cane walk past the cart to his room. -At 3:57 p.m. observed NA-G standing on the opposite side of the hallway approximately 2 foot steps from the cart still unlocked. -At 3:58 p.m. director of nursing (DON) walked past the cart again and went down the hallway. -At 3:59 p.m. observed receptionist (O)-D walked past the medication cart approximately 1 step from the cart still unlocked. -At 4:00 p.m. DON walked past the medication cart still unlocked back to the nursing station. Went into the nursing station stood at the inside of the counter looking down the hallway where the unlocked cart was stationed. -At 4:01 p.m. observed NA-I walked past the medication cart to the South hallway. -At 4:02 p.m. O-D again went past the unlocked cart approximately one foot step went to the human resource office and came right out and returned to the front desk. -At 4:04 p.m. observed NA-I walked past the cart	{F 431}		

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{F 431}	Continued From page 306 again and turned right and walked past the cart to the South Hallway. When interviewed on 5/8/14, at 4:06 p.m. LPN-D if the medication cart was supposed to left open stated, "No." LPN-D walked over to unlocked medication cart and locked it. When interviewed on 5/9/14, at 10:05 a.m. LPN-E stated, "All the medication carts are not supposed to left open." When interviewed on 5/9/14, at 1:32 p.m. RN-B stated the medication cart should be locked when staff was not around and when nurses walked away from the carts. RN-B further stated the nurse that had left the cart unlocked had acknowledged she had left the cart unlocked on 5/8/14. The facility Storage of Medication dated 9/10, directed "In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.	{F 431}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	{F 465}		7/6/14

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{F 465}	Continued From page 307 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident room carpets for 3 of 3 residents (R22, R56, R33) and an E-Z stand (a mechanical stand used for transfers) were kept in good repair, clean and in a sanitary manner. Findings include: A tour of the facility was conducted on 5/9/14, at 8:59 a.m. through 10:05 a.m. with the director of facility operations (DFO) and the following concerns were identified: Carpets: On 5/9/14, R22's portion of the room was observed. The carpet had large dark brown stain/spots from the bed to the dresser. DFO verified the carpet was not clean and stated, "I think it is filthy and trashed." R22's annual Minimum Data Set (MDS) dated 4/10/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs. R22 used both the walker and wheelchair (w/c) for mobility in his room. On 5/7/14, at 7:59 a.m. R22's carpet was observed to have dark brown spots/stain on the carpet around the bed area and to the entrance of the room. On 5/9/14, at 9:34 a.m. DFO verified R22's carpet was not clean stated "Again this is one of the rooms that I would like to have a deep cleaning and was hoping the cleaning of the carpet would have been done after pest control was here	{F 465}		

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{F 465}	Continued From page 308 yesterday." R56 was bedfast in the room. When R56's room was observed on 5/9/14, at 8:59 a.m. the carpet had several dark, black ground-in spots and stained red around the bed. R56's annual MDS dated 2/25/14, indicated R56 required extensive to total assistance with activities of daily living (ADLs) including transfers, was bed bound, used a w/c for mobility and had intact cognition. On 5/9/14, at 9:30 a.m. DFO verified the carpet in R56's room was not clean and stated, "It needs to be deep cleaned." R33 On 5/6/14, at 9:00 a.m. surveyor noticed a strong malodorous urine smell coming out of R33's room and the carpet observed to have dark brown large stain/spots from the bed to the radiator and on the area between the foot of bed and dresser (walk area). During observation a housekeeping staff was observed standing outside R33's room but was cleaning the next room. On 5/9/14, at 9:38 a.m. DFO verified the smell stated, "It's very strong and this is another room that needs to have the carpet cleaned or replaced." DFO stated, "We were supposed to get the air freshener's from Ameri-Pride today but they were supposed to be delivered on Friday." DFO further stated the carpet cleaning company had been to the facility recently and cleaned the common areas. The DFO knew the contract was expired and directed questions to the	{F 465}		

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{F 465}	Continued From page 309 administrator. R33's quarterly MDS 2/20/14, indicated intact cognition, required limited assistance with ADLs, had impairment to both lower extremities and used a walker and w/c for mobility. R33's also received a diuretic. Mechanical lift: E-Z stand handle did not have a cleanable surface. On 5/9/14, at 9:05 a.m. the E-Z stand was observed stored on the alcove on the West Hall and the left bar was observed to have vinyl peeling off exposing the foam underneath. The cracked vinyl was covered with gray duct tape and at the end the tape was exposing the sticky side of the tape making it not a cleanable surface. When interviewed on 5/9/14, at 9:07 a.m. DFO verified stated, "I was told by the vice president to put the duct tape over for now and I have a bid for cushions and guard and am waiting." When interviewed on 5/9/14, at 8:38 a.m. the administrator stated there is a carpet cleaning plan with a contractor who would be coming in to clean a couple rooms at a time. Administrator further stated, "We are going to order replacement parts for the E-Z stand, we had been told that the duct tape was sufficient." Review of the w/c cleaning schedule for Maintenance dated May 2014 indicated R36's w/c had not been cleaned. The Wheelchairs To Pull For Night Washing sheets dated 5/1/14, through 5/9/14, also indicated R36's w/c had not been	{F 465}		

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{F 465}	Continued From page 310 cleaned. The facility Maintenance Request Log Policy and Procedure revised April/2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs ..." The policy lacked information on how often residents carpets would be cleaned.	{F 465}		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a pest control program effective in the control of ants in 1 of 1 resident room (R56). Findings include: During observation on 5/7/14, at 7:42 a.m. 12 winged insects were noted on R56's bed and on the wall at the head of the bed. During observation on 5/7/14, at 7:59 a.m. R56's room was noted to have open food items, The carpeting next to the bed was heavily soiled with brown and red material, and a foul odor was noted in the room. On 5/7/14, at 8:41 a.m. an ant mound and three ants were noted in the corner of R56's room by	F 469		7/6/14

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F 469	Continued From page 311 the window. Multiple ants were noted crawling on and inside the heater under the window. When interviewed on 5/7/14, at 7:50 a.m. the director of facility operations stated the facility used Xtreme Pest Solutions for pest control. He stated staff identify any concerns with pests by documenting in the maintenance log kept behind the nursing station. When interviewed on 5/7/14, at 8:05 a.m. housekeeper-B verified there were bugs in R56's room and stated he had not seen them the prior Thursday when he'd cleaned the room. Housekeeper-B stated R56, "Has lots of sweets in her room and that may be why." On 5/7/14, at 8:09 a.m. the director of facility operations was asked to come to R56's room and stated, "We have to get her out of the room right away!" and call the pest company. He stated he was not sure what the bugs were but thought they were ants or wasps. The pest control contractor was interviewed on 5/7/14, at 12:52 p.m. and stated the bugs were a form of pavement ants and he had treated the room and the surrounding areas. He reported the ants were drawn into the room for food and the facility would need to maintain treatment to the affected areas. Review of the Service Report dated 2/13/14, included treatment for mice and rats. Review of the Service Report dated 4/3/14, included treatment for multiple targeted pests including ants. The Service Report dated 5/7/14, at 12:30 p.m.	F 469		

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F 469	Continued From page 312 included treatment for multiple targeted pests including ants and indicated four rooms on the south hall were treated as well as the exterior of the south wing. A policy regarding pest control was requested and the director of facility operations stated the facility did not have a policy.	F 469		
{F 490} SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 observation, interview and document review, the administrator failed to provide adequate supervision and oversight for residents who had known drug and alcohol (ETOH) use for 2 of 11 residents (R37, R129). In addition, the administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues being identified at F490. In addition to the IJ issues, the facility was not administered in a manner to maintain compliance with other regulations specific to meet the needs of residents for 15 of 40 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; 3 of 5 employees (E1, E2, E3) reviewed whose annual evaluations were not	{F 490}		7/6/14

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{F 490}	Continued From page 313	{F 490}		

completed; 1 of 5 nursing assistants (NA-Z) did not meet the required inservice hours; 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) did not have current license verification. These administrative failures had the potential to affect all residents of the facility.

The IJ began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by the exit date of the survey.

Findings include:

On 5/9/14, the facility had been informed of serious and immediate safety and supervision issues related to a lack of adequate supervision for residents, specifically related to resident's with known drug and alcohol use issues, and elopements. The facility had been informed these issues constituted an immediate jeopardy situation. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and/or alcohol intoxication. In addition, on 5/11/14, a vulnerable resident was able to elope from the facility on three separate occasions without staff present even though the facility had implemented a WanderGuard device.

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

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{F 490}	Continued From page 314 Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an IJ situation for R37, R129 and R116. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13). Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, develop and implement interventions for medically-related social services, for residents known to provide and/or use illegal	{F 490}		

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{F 490}	Continued From page 315 drugs and ETOH in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to ETOH abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, and supervise staff. An IJ was identified on 5/9/14, for lack of supervision related to drug and ETOH use for R37, R129, R41, R117, and for the lack of supervision for residents who were at risk for elopements, R13. On 5/9/14 the administrator, On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323). Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul	{F 490}		

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{F 490}	Continued From page 316 Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. A letter was provided to surveyors on 5/19/14 by an employee who wished to remain anonymous. The letter indicated that as of that date, the President and CEO of Videll Healthcare was informing employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together	{F 490}		

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{F 490}	Continued From page 317 a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had also been posted at the employee time clock. The IJ that began on 5/12/14, was not removed at the time of the exit from the survey because the facility failed to have developed a plan to avoid any future delay in notification of staff if serious and immediate issues were identified for any residents; failed to have developed and/or revised policies related to obtaining a drug and alcohol free facility; failed to have reviewed and/or revised their elopement policies; had not yet made arrangements to ensure all staff had received training; had not yet convened an interdisciplinary team meeting to discuss and determine how to monitor resident safety, care needs and how to prevent any future occurrence of such serious and immediate concerns.	{F 490}		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nurses and nursing	F 492		7/6/14

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F 492	Continued From page 318 assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance to ensure freedome from tuberculosis (TB) before they were assigned to work. This had the potential to affect all 67 residents residing in the facility. Findings include: The facility did not comply with the Minnesota Statute 144A.72 REGISTRATION REQUIREMENTS; PENALTIES. Subdivision 1.Minimum criteria. The commissioner shall require that, as a condition of registration: (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities. A review of the supplemental staff files revealed the following: NA-T had a negative tuberculin skin test (TST) administered on 8/26/11. There was no record to show a second TST was done. Licensed practical nurse (LPN)-C had a chest x-ray result dated 10/17/07. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-F's TB screening test result dated 4/10/14, read "Negative. M. tuberculosis infection not likely, but cannot be excluded in cases of immunosupression." There was no screening for symptoms of active TB and there was no examination done by a medical doctor after the TB screening test.	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 492	Continued From page 319 LPN-I had a first TST administered on 3/29/11. There was no evidence of a second TST having been done. LPN-J had a negative CXR results done on 12/7/09. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor. LPN-K CXR results done on 1/19/09, was read as "Unremarkable exam." There was no screening for symptoms of active tuberculosis and there was no examination done by a medical doctor. On 5/13/14, at 9:33 a.m. during a telephone interview, O-I from Soul Care staffing agency verified the above-named supplemental staff are employed by Soul Care and that the same staff had been reporting for work at the facility. He further verified all of the findings pertaining to TB screening dates and procedures for the employees named. On 5/13/24, 10:27 a.m. LPN-A, nurse manager, stated the staffing agency would provide to the facility the TB screening records of staff coming to work. LPN-A stated that it was human resources (HR's) responsibility to keep track of the records and to keep the files for the facility. On 5/13/14, at 10:55 a.m., the consultant administrator verified the list of supplemental staff provided to surveyors was current, and the staff had been working at the facility. The consultant administrator stated that supplemental staff was not treated any differently from regular facility staff with regard to TB screening. She stated Soul Care provided the TB screening records of	F 492		

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F 492	Continued From page 320 supplemental staff, and if staff were found positive for the TST results, they should have been required to undergo assessments for current TB symptoms, should have had CXR and physician's visit indicating employees were clear from tuberculosis. The consultant administrator stated HR was responsible to keep track of pool staff records and to report to the director of nursing and the administrator if issues were identified. The Clinical and Operations Manual dated 5/2012, directed the facility to administer a 2-step PPD (purified protein derivative used to do a TST) to all employees and that documented copies were to be kept in the employees' file records.	F 492		
{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility for 15 of 44	{F 493}		7/6/14

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{F 493}	Continued From page 321	{F 493}		

residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; facility failed to ensure 3 of 5 employees (E1, E2, E3) reviewed during the initial survey for annual evaluations were completed; In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed; the facility failed to ensure 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) had current license verification. In addition, the facility's governing body failed ensure vendors were paid in a timely manner. This had the potential to affect all 67 residents in the facility.

Findings Include:

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the

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{F 493}	Continued From page 322 administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.	{F 493}		

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{F 493}	Continued From page 323 Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323). Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13. Refer to F412: the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Refer to F490: the administrator failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents	{F 493}		

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{F 493}	Continued From page 324 (R37, R129, R117). In addition, administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F500: the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because they had not paid the bill to the agency. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of	{F 493}		

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{F 493}	Continued From page 325 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice on Monday, May 5th, Tuesday, May 6th, and Wednesday, May 7th. The facility had social workers scheduled, but due to not paying their bill, the social workers were not provided." For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social	{F 493}		

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{F 493}	Continued From page 326 worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 493}		
{F 497} SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of	{F 497}		7/6/14

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{F 497}	Continued From page 327 nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed. This had the ability to impact all 67 residents in the facility as the facility was a one story facility and the staff could work on all of the units. Findings include: Evaluations: On 5/12/14, at 10:00 a.m. employee performance evaluations for E1, E2 and E3 were requested of the administrator. He said he would get them; however, no evaluations were provided. On 5/13/14, at 12:41 p.m. performance evaluations for E1 through E3, from previous March 2014 survey and evaluations for all employees due for annual performance review in March 2014 and April 2014 was requested of the administrator. He said he would get the information.	{F 497}		

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{F 497}	Continued From page 328 On 5/13/14, at 3:30 p.m. unable to interview the director of nursing (DON) as the DON had resigned. On 5/13/14, at 3:35 p.m. although the evaluations had been requested, no employee performance evaluations had been provided by facility as of that time. At the time of exit on 5/13/14, at 4:30 p.m. the evaluations still had not been provided. In-service: NA-Z was hired on 4/10/11. The employee file was reviewed for continuing education and noted NA-Z had only 3.5 hours of the 12.0 required hours from 1/1/13 through 5/12/14.	{F 497}		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification of licensure for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C). These had the potential to affect all 67 residents residing in the facility. Findings include:	F 499		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 499	Continued From page 329 Licensure verification: LPN-A's employee file folder lacked verification of the LPN license. The administrator verified on 5/12/14, at 12:45 p.m. there was no proof of nursing licensure obtained from the Minnesota Board of Nursing for LPN-A. RN-C was hired on 4/8/14, indicated no licensure verification (copy of license dated 10/4/13) had been completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge for doing license verifications for new employees. The administrator further stated the HR person was terminated two weeks ago. The administrator added the facility did not ensure tracking for new employees' license verification. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, then she started full time work on her own since 4/16/14. The facility's Clinical Manual, Operational Manual dated 5/2012, directed the facility to obtain verification of nursing licensure from the State licensing board upon employment and to keep a completed "License Verification Form" in the employee's personnel file.	F 499		
{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a	{F 500}		7/6/14

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{F 500}	Continued From page 330 person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because the facility had an outstanding debt to the agency. Findings include: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. At 2:30 p.m. the administrator stated the contracted social work agency was Circle of Life Aging Services. The owner of Circle of Life, Aging Services (contracted social service), interviewed On 5/12/14, 1:18 p.m.c stated, "The reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th,	{F 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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{F 500}	Continued From page 331 Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) who needed social services interventions for alleged substance abuse and did not receive the services; and for 2 of 11 residents (R13, R103) who were alleged to have eloped and did not receive the medically needed social services.	{F 500}		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		7/6/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 502	Continued From page 332	F 502		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.

Findings include:

A Progress Notes dated 5/6/14, noted as a late entry for 5/5/14, indicated R37 was found outside of the facility and reported to staff he had gotten heroin and cocaine from another resident and had been injecting the drugs. R37 was noted to have several scattered purple bruises on his forearms.

A Physician's Orders dated 5/6/14, directed urine toxicology screen.

A Progress Notes dated 5/6/14, indicated the nurse went to R37's room to obtain a urine specimen for toxicology screen. R37 refused to provide a urine sample to the nurse. The note indicated a urine sample cup and supplies were left in R37's room with instructions to obtain a sample when R37 had the urge to void even though a urine specimen for toxicology needed to be witnessed by staff.

Review of the medical record lacked evidence of any further attempts made to obtain the urine toxicology screen or lab results.

When interviewed on 5/12/14, at 11:53 a.m. the health unit coordinator stated there was not a urine toxicology screen completed as ordered

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F 502	Continued From page 333 and the only lab work completed for R37 in May 2014 was done in the hospital. A facility policy regarding lab work was requested and not provided.	F 502		
{F 514} SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete medical records, the charts lacked nursing notes, laboratory results, behavior monitoring. and assessment and plans for initial physician assessments for 20 of 40 residents (R103, R116, R86, R71, R9, R34, R51, R129, R13, R117, R41, R62, R37, R56, R36, R123, R1, R113, R29, R91). This had the potential to affect all 67 residents. Findings include: R103 was admitted to the facility on 7/29/13, with	{F 514}		7/6/14

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{F 514}	Continued From page 334 diagnoses of multiple right sided fractures of arm, leg, rib and pelvis related to a motor vehicle accident. Last progress note on 1/5/14, at 5:30 a.m., "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility, and currently uses Foley catheter." An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter. R103 was now assessed as independent in all functional activities of daily living. The chart lacked documentation of when the Foley catheter was removed. The chart lacked a significant change MDS for improvement in more than two areas of functional status. The care plan dated 8/9/13, and revised 3/29/14, and 4/26/14, indicated, "English as a second language, required short term placement for rehab and was expected to discharge to the community within the next 3 months. R103 had impaired mobility care plan related to MVA, multiple fractures and weakness, and was to use a cane. A potential for self-care performance deficit. A potential for alteration in bowel and bladder related to disease process, unsteady gait, and cultural differences."	{F 514}		

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{F 514}	Continued From page 335 The medical record was reviewed on 5/11/14, and lacked documentation of LOA (leave of absence) or discharge. Orders dated 4/16/14 state may LOA unsupervised with medications. On 4/20/14 at 9:48 p.m. Pt went on LOA. The chart lacked documentation of return to the facility. On 5/10/14 at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA. On 5/11/14, at 10:00 a.m. the facility was asked if the resident had been discharged, or was on LOA and had returned to the facility. HUC checked to see and resident was in room. He had signed in at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had notes for R103, but knew he had been working with a relocation worker. R71 was admitted to the facility on 5/17/10, with admission diagnosis of CVA (stoke) with hemiplegia (loss of all or part of one side of the body), chronic pain syndrome, depression, and	{F 514}		

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{F 514}	Continued From page 336 diabetes. R71 was seen by the physician on 4/16/14, labs were ordered, and new medication orders dated 4/16/14, included: bendadryl 25 mg (milligrams) give 1-2, every 4-6 hours as needed for itching, and to increase gabapentin to 300 mg, give 2 every bedtime (for persistent left sided pain). On 4/18/14, a physician order to increase atorvastatin (a cholesterol-lowering medication) to 80 mg daily, and Metformin ER (used to treat type 2 diabetes) 1000 mg daily with supper. An initial primary care physician (PCP) to establish primary care on 4/16/14: noted a history of CVA (stroke), left hemiplegia (loss of use of part or all of the left side), hypertension, dyslipidemia, Major Depressive disorder, diabetes type II, tobacco abuse, and neuropathic pain. A review of medication list, and laboratory tests were ordered Hbg A1c (a indicator of diabetic compliance over a three month period), lipid panel (cholesterol testing) alt (liver test), lytes and BUN (kidney function tests). On 5/6/14, a review of the medical record revealed no results for the lab tests that had been ordered on 4/16/14. On 5/7/14, at 3:14 p.m. the health unit coordinator (HUC) verified the medical record lacked results of the 4/16/14, ordered labs, and also lacked the new PCP initial visit notes, assessment, or plan for patient treatment. R9's medical record lacked laboratory results since 7/30/13.	{F 514}		

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{F 514}	Continued From page 337 On 5/13/14, at 9:30 a.m. during review of R9's medical reviewed it was revealed R9 had been to the primary physician's office several times for routine visit since 7/30/13, but lacked laboratory results for all the tests completed during the office visits. When interviewed on 5/13/14, at 10:58 a.m. the HUC verified there were no labs in the resident chart since 7/30/13. The HUC stated the particular clinic the resident went to "always" had given her a hard time getting the notes and labs. The HUC indicated she had been told in the past that she had to call the day of the appointment to request for the information or write a note in the facility referral sheet but still nothing was being sent back with resident. Copies of R34's care plan were requested from the record. The vulnerable adult care plan for R51 was provided that had been in R34's chart. R34 and R51 have the same last name with different first names. Refer to 223: the facility failed to ensure R34 was free from verbal abuse from R36 and review of the medical records for R34 and R36, lacked documentation regarding the incident which was reported on 5/5/14, and lacked indication of how R34 would be protected from R36. Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, R9).	{F 514}		

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{F 514}	Continued From page 338 That resulted in harm for R129, R117, R41, R37. Refer to F274: the facility failed to complete a significant change assessment (SCSA) for 2 of 3 residents (R56, R116) with a decline in functional status. Refer to F275: the facility did not comprehensively assess 1 of 1 resident (R36) who required a comprehensive assessment at 366 days. Refer to F280: the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter for 1 of 3 residents (R36); and for 1 of 1 resident (R116) on Hospice who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who allegedly had substance abuse. Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F329: the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R36, R1, R89, R113, R29, R37, R91). Refer to F412: the facility failed to ensure residents were provided dental services for 1 of 3	{F 514}		

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{F 514}	Continued From page 339 residents (R36). In addition, the facility failed to ensure residents received recommended dental follow-ups for 1 of 3 residents (R9). Refer to F502: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Refer to F520: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.	{F 514}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	{F 520}		7/6/14

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{F 520}	Continued From page 340 and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 44 (R34, R37, R129, R116, R41,R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1, E2, E3) reviewed during the initial survey; the facility failed to ensure nursing assistants (NA) received the required continuing education for 1 of 5 (NA-Z); and 5 of 11 employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. Findings include: Refer to F223: the facility failed to ensure one of one resident (R34) was free of abuse. Refer to F224: an Immediate Jeopardy (IJ) was identified at F224 for neglect of care for R37 and R129, when residents were able to access drugs and alcohol and required hospitalization after the Immediate Jeopardy at F323 had been identified on 5/9/14. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7	{F 520}		

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{F 520}	Continued From page 341 residents (R129, R37, R116, R41, R10, R70, and R13). Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (RN-C, RN-D, LPN-A, NA-U, NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 11 of 11 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse.	{F 520}		

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{F 520}	Continued From page 342 Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323). Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. Refer to F490: an IJ was issued at F490 for administration failure to fully implement the March POC, and to act upon the IJ identified at F323 on 5/9/14, to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked	{F 520}		

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{F 520}	Continued From page 343 in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C. These had the potential to affect all 67 residents residing in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. facility staff stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. "For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time	{F 520}		

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CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

(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 520}	Continued From page 344 equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." On 5/19/14, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the Limited Liability Company (LLC) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 520}		

Approved MJK 08769
6/24/14

F000

Submission of this credible allegation of compliance by Camden Care Center is not a legal admission that a deficiency exists or that the statement of deficiencies were cited correctly. It is not to be construed as an admission against interest of the facility, its administrator, employees, agents or other individuals who draft or may be documented in this credible allegation of compliance. The preparation and submission of this document does not constitute an admission of agreement with the alleged deficiencies or conclusions made by the survey agency. This credible allegation of compliance is submitted due to state and federal law requirements as a condition to participate in the Medicare and Medicaid programs.

Date of Completion: 7/6/2014

F-157

It is the policy of Camden Care Center to immediately inform the resident; consult with the resident's physician, and if known, notify the residents' legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention.

For resident #13 the physician and/or family were updated on 5/8/20124. A new evaluation regarding Vulnerable Adult Assessment, smoking evaluation and elopement risk was completed. Corresponding updates have been made to the care plan, care assignment sheet. The primary physician was informed of the results on 6/20/2014 and a review of the current physician orders was completed. Education will be provided for staff members regarding notification of physician and legal representative. The preceding will be completed by July 6, 2014.

For other residents who may be affected by this practice, a comprehensive review and update of individual resident assessments (current clinical status, Vulnerable Adult Assessment, medications or treatments regime, elopement risk, smoking (as applicable) and fall risk), corresponding care plans and care assignment sheets to accurately reflect current resident status. Primary MD, resident and legal decision makers will be updated upon completion of this process. Education will be provided for direct care staff related to individual plan of care revisions and notification protocols by 7/6/2014.

The policy of incident notification was reviewed and revised as necessary. The Medical Director will review and approve the revised notification policy by 7/6/2014. Staff will be trained as it relates to their respective roles and responsibilities for the revised policies and procedures by July 6, 2014.

Audits will be completed by review of the 24 hour report form, documentation notes and Incident/Accident reports. Audits will be completed daily x4 weeks, monthly for 3 months and then quarterly on notification protocols to ensure proper notification was provided and documentation meets the facility standard. Residents are monitored for changes in condition with the provision of care, shift to shift report and weekly IDT meetings. Staff will receive additional education as needed based on outcomes of audits. The results will be reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-221

It is the policy of Camden Care Center that each resident has the right to be free from any physical restraints for purposes of discipline or convenience, and those not required to treat the resident's medical symptoms.

For Resident #89 a new assessment for physical device/physical restraints was completed on. Corresponding updates have been made to the care plan, care assignment sheet. Primary physician, resident and legal decision maker will be notified of assessment results. Consents for the physical device were obtained as warranted. Direct care staff for resident #89 will be educated on revised care interventions by July 1, 2014.

For other residents who may be affected by this practice, a review of resident with restraints will be completed to ensure medical reason for the device. Based upon this review, care interventions were updated per policy. The facility will assess new residents and those readmitted prior to the utilization of a device which meets the definition of a physical restraint. The preceding will be completed by July 6, 2014.

The policy of procedure for physical devices (assessment, medical reason and application of device during meals) was reviewed and revised accordingly. The Medical Director will review and approve the revised notification policy by July 6, 2014. IDT staff members will be trained as it relates to their respective roles and responsibilities regarding the physical device policy by July 1, 2014.

Random observation audits related to physical device utilization in accordance to individual care plan will be completed weekly for 4 weeks and monthly for 3 months. Results of audits will be reported to the QA/QI Committee for review and further recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated by a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-223

It is the policy of Camden Care Center that each resident has the right to be free from mistreatment, neglect and misappropriation if resident property.

For residents #34 and #36, a Vulnerable Adult Assessment has been completed. Assessment results have been reviewed with the resident, legal decision maker and primary physician. Corresponding updates have been made to the care plan and care assignment sheet. Behaviors have been reviewed and targeted behaviors have been identified. Direct staff responsible for the care of residents #34 and #36 have been educated on care plan updates as indicated.

For other residents who may be affected by this practice, a record review of current residents related to vulnerable adult assessments will be completed. A new vulnerable adult assessment will be completed for each current resident. Upon this review, system revisions and/or staff education will be implemented. This will be completed by July 1, 2014.

The policy for Vulnerable Adult Assessment was reviewed and revised as warranted. The Medical Director has reviewed and approved initiation of a standardized, carbon-copied 24 hour report form will be implemented to assist in the enhancement of the internal communication process as it relates to resident care and needs. Incident and accident report form has been revised to contain the necessary components. Staff members will be trained as it relates to their respective roles and responsibilities regarding implementation of 24 hour report format, targeted behaviors and Vulnerable Adult Assessment. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated.

Daily audits will be completed of the 24 hour report book to recognize any changes of condition, at risk potential for abuse/neglect for 4 weeks, monthly for 3 months, then quarterly. Audits will be completed 2x/week for one month, weekly x one month and then quarterly to observe care and staff to resident interactions.

Reviews will be completed on allegations of abuse, neglect and misappropriation of property will be completed to ensure facility protocols are followed to ensure the environment is free from abuse. Based on the audits care plans and assessments will be updated to reflect changes. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing/Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-224

It is the policy of Camden Care Center to prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

For residents #37, #129 a comprehensive assessment, a vulnerable adult assessment and elopement assessment will be completed. Care plans will be reviewed to identify risks and interventions. Corresponding updates will be made to the care plan and care assignment sheet. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly by July 1, 2014

Resident #116 expired on 6/1/2014

All residents will have a comprehensive assessment completed, care plan review and revision of the care plan and corresponding care assignment sheets as necessary along with a chart review. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. The preceding will be completed by 7/6/2014.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director will review and approve the updated policies by July 1, 2014. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations. A review of the internal communication process will be completed to determine/establish an effective interdisciplinary communication process.

On-going daily audits will be conducted of the 24 hour report, incidents and nursing documentation. This will be completed by the nurse manager on a daily basis. Audits will be completed 2x/week for one month, weekly x one month and then quarterly to observe care and staff to resident interactions. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing/Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-225

It is the policy of Camden Care Center to not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.

For resident(s) #129 a comprehensive assessment and drug regimen review were completed. For resident #37 a drug regimen review and comprehensive assessment was completed. For resident #13 a comprehensive elopement assessment was completed. For resident #41 a comprehensive assessment along with an assessment of resident's ability to operate a motorized wheelchair was completed. For resident #14 a comprehensive assessment has been completed. For resident #66 a comprehensive assessment will be completed. Corresponding updates have and will be made to the care plan, assignment sheet and communicated to the resident. A review of the current physician orders was completed with respective primary physicians based upon assessment results. Direct care staff responsible for providing care to the above residents will be educated on care intervention changes as indicated. The preceding will be completed by July 6, 2014.

Resident #116 expired on 6/1/2014

Education will be provided for staff members regarding abuse reporting, investigation, incident completion, timely notification and documentation in the clinical record by July 1, 2014.

All other residents who have the potential to be affected will have a new vulnerable adult assessment completed. All other residents who operate a motorized w/c will be assessed for their ability to operate a motorized wheel chair. Care plans and corresponding care assignment sheets will be updated as indicated. Notification of assessment findings will be completed per policy to attending physician, resident and decision makers. The preceding will be completed by July 6, 2014.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director has reviewed and approved the updated policies by July 6, 2104. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations.

Audits regarding 24 hour report, incident reports and corresponding assessments, interventions and documentation will be completed daily x4 weeks, then weekly x4 weeks, monthly for 3 months then quarterly to ensure continued compliance with facility protocol.

The Administrator and/or Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-226

It is the policy of Camden Care Center to develop and implement policies and procedures. The interpretative guidelines for this tag refer to seven key components to be reviewed by surveyors to determine if the facility is meeting the intent of F-226.

For resident(s) #37, #129, #66, #14, #41 and #13 vulnerable adult assessments along with elopement assessments will be completed. Corresponding updates will be made to the care plan and care assignment sheets. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff who are responsible for providing care for the residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

Resident #116 expired on 6/1/2104

The facility has reviewed and revised the policies and procedures for screening and training of employees, protection of resident and policies pertaining to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

All employee files have been reviewed to assure that the proper components are present including licensure, background checks and reference checks. Nineteen staff members have been suspended and/or terminated based on the checks. Facility is in the process of performing an 8 point background check on all employees. This will be completed by 6/16/2014.

For other residents who may be affected by this practice a review of the abuse policy and procedure was completed. Training of employees as it relates to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

The policy and procedure for resident protection was reviewed and revised. The policy was reviewed to ensure all components are present: screening, training, prevention, identification, investigation, protection and reporting and response. Facility orientation and agency staff orientation has been updated to reflect the revised policies and procedures as indicated. The Medical Director will review and approve the updated policies by July 1, 2104. Staff members will be trained as it relates to their respective roles and responsibilities for the policies and procedures by July 6, 2014.

New employee files will be reviewed on a continuous basis to verify licensure, background checks along with reference checks are present and appropriate action taken based on the result of the checks.

Daily review of the 24 hour report and incident reports with corresponding documentation to identify possible abuse, neglect, investigations for timeliness, reporting, documentation and notification will be completed for 4 weeks.

The results of the audits will be reported to the QA/QI committee monthly for three months for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan

The Administrator and/or Director of Nursing or designee will be responsible for compliance.

Date of correction: July 6, 2014

F-250

It is the policy of Camden Care Center to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

For resident #29, #386, #41, #37, #14, #56, #62, #9, #13, and #103 comprehensive assessments will be completed including vulnerable adult assessment, Risk of drug and ETOH assessment, smoking assessment, pain assessment, BIMs and elopement assessment. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

R#117 was discharged from the facility

For other residents who may be affected by this practice a comprehensive assessment including the following assessments; vulnerable adult, pain, smoking, BIMs, elopement, risk of drug and alcohol will be completed. Comprehensive care plan will be reviewed and revised as indicated based on the assessments. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and

decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents will been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2104.

The policy and procedures for Incident/Accidents and reporting, elopement, AMA, drug testing, LOA, smoking, controlled substance storage and documentation, 1:1 policy, change of condition were reviewed to ensure policies meet current standards of practice. The Medical Director will review and approve the revised policies and procedures by July 1, 2014. Education was provided for staff regarding revised policies and procedures and their respective roles and responsibilities. This will be completed by July 6, 2014

Daily audits for 4 weeks for the first month and weekly for two months will be completed of 24 hour report, incident/accident reports, physician orders and interdisciplinary progress notes to identify problems/concerns and follow up as needed for resolution. The audits will also review the completion of appropriate assessments, interventions and notification to physician and resident and family/legal representative as indicated.

The results of the audits will be reported to the QA/QI committee monthly for 3 months for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Social Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-274

It is the policy of Camden Care Center to conduct a comprehensive assessment of the resident when required.

For resident #56 a significant change MDS with an ARD of 4/28/14 was completed on 5/12/14. For resident #116 a significant change MDS was in progress with an ARD of 5/29/14-resident expired 6/1/2014. For resident #103 a significant change MDS has been initiated with an ARD of 6/12/2014. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals will be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

Education has been provided for staff members regarding significant change criteria, change in condition.

For other residents who may be affected by this practice a comprehensive assessment will be completed to ensure a significant change assessment was done or needs to be done when appropriate. Corresponding comprehensive care plan and care assignment sheets will be reviewed and revised to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. The preceding will be completed by July 6, 2014.

The Significant Change policy was reviewed and revised as necessary. The Medical Director has reviewed and approved this policy and procedure by July 6, 2014. Clinical staff members were trained as it relates to their respective roles and responsibilities as it relates to changes of condition and necessary assessment completion.

Daily audits of 24 hour report, incident/accident reports, and interdisciplinary notes will be completed for 4 weeks, weekly x4 weeks, with results reported to the QA/QI committee for further review and recommendations for three months. Further system revision and staff education will be provided if indicated by audits.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-275

It is the policy of Camden Care Center to comprehensively assess each resident not less than once every twelve months

For resident #36 an annual MDS with an ARD of 5/16/2014 was completed on 5/28/2014. Corresponding updates have been made to the care plan and care assignment sheet. Education will be provided for staff members regarding MDS scheduling.

For other residents who may be affected by this practice, a review of the MDS schedule was completed. Upon this review, department notification, system revisions and/or staff education will be implemented as indicated. This will be completed by July 6, 2104.

The policy for MDS scheduling protocol has been reviewed and revised as necessary per RAI guidelines. Staff members have been trained as it relates to their respective roles and responsibilities regarding the completion of the MDS according to the MDS schedule and RAI guidelines. This will be completed by July 6, 2104.

MDS audits will be completed weekly for 4 weeks, monthly for 2 months, with results reported to the QA/QI committee for review and further recommendation. Further system revision and staff education will be provided if indicated by audits.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-280

It is the policy of Camden Care Center to develop a comprehensive care plan within seven days after the completion of the comprehensive assessment.

For residents #36 and #62, corresponding care plans were reviewed and revised by the interdisciplinary team. Corresponding updates have been made to care assignment sheets. Primary care physician, resident and decision maker will be notified of assessment findings and updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2104.

Resident #116 expired on 6/1/2014

For other resident who may be affected by this practice, an audit of all resident care plans will be completed. Upon this review, care plan revisions and/or staff education will be implemented if indicated. Primary care physician, resident and decision maker will be notified of updates accordingly. Direct care staff responsible for providing care for these residents have been in-serviced on revised care interventions as indicated. The preceding will be completed by July 6, 2014.

The policy of comprehensive care plans was reviewed and revised as necessary. Medical Director has reviewed and approved the policy by July 6, 2104. Staff members will be trained as it relates to their respective roles and responsibilities regarding the updating/revision of care plans.

Care plan audits will be completed 1 x per week for 4 weeks based upon the 24 hour report status, incident/accident reports, and interdisciplinary progress notes to address identified issues/concerns. Care plan to be updated with needed interventions. The results of the audits will be reported monthly for three months to the QA/QI committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-282

It is the policy of Camden Care Center to provide care and services by qualified persons in accordance with each resident's written plan of care.

For resident's in the deficiency, the care plans were reviewed and revised by the interdisciplinary team. Corresponding updates have been made to the comprehensive care plan and care assignment sheets.

Resident #89 has been clinically reassessed for antipsychotic use and targeted behaviors. Resident #9, #22 and #36 have been clinically reassessed for smoking safety and assistance. Additionally, resident #9 has been assessed and seen by the dentist. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident will be educated on the updated care interventions. The preceding will be completed by July 6, 2014.

Resident #1 was discharged from the facility on 5-21-2014.

For other residents who may be affected by this practice, a record audit of psychotropic medication and behavior monitoring, smoking safety and assistance as well as the need for dental services will be completed to reflect current resident status. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2104.

The following policies and procedures have been reviewed and revised to reflect current standards of practice: comprehensive care plan completion, smoking safety assessment, and dental services. A review of the revised policies by the Medical Director will be conducted to determine if policies meet current standards of practice. Clinical staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by July 6, 2014.

Care plan audits will be completed weekly for 4 weeks and monthly for 3 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to

the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-309

It is the policy of Camden Care Center to provide each resident the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

For resident #56 POLST was reviewed. Advance directive was discussed with resident and husband on 5/12/2014 and the correct advance directive was placed in the chart. Corresponding updates have been made to care plans and care assignment sheets. Primary physician has been informed of assessment results and a review of the current physician orders has been completed. All staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2104.

For other residents who may be affected by this practice, an audit of all current medical records was conducted to review resident's advance directives care and advanced care planning. This was completed on June 9, 2014. Upon this review, care plan revisions and/or staff education will be implemented if indicated.

The policy for Advance Directives and Advanced Care Planning was reviewed and revised as necessary. The Medical Director has reviewed and approved the policy by July 6, 2014. IDT staff members were trained as it relates to their respective roles and responsibilities regarding advance directives and advanced care planning.

Advance Directive audits along with physician order audits will be completed weekly for 4 weeks for current residents and new admissions for one month and monthly for 2 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-314

It is the policy of Camden Care Center to ensure that based on the comprehensive assessment of a resident, a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident have pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Resident #123 expired on 4/21/14.

For other residents who may be affected by this practice a comprehensive record review of skin will be completed by July 1, 2104. Upon completion of the review, treatment and care intervention updates will be made as appropriate for each resident identified. Upon this review, care plan revisions and/or staff education will be implemented if indicated. Primary physicians have been informed of assessment results and a review of the current physician orders has been completed. Staff responsible for care for each resident has been educated on the updated care interventions. The preceding will be completed by July 6, 2014.

Wound Prevention policy and procedure was reviewed and revised as necessary. The Medical Director has reviewed and approved the revised policy for implementation by July 1, 2014. Nursing staff will be trained as it relates to their respective roles and responsibilities regarding wound documentation as it relates to wound location, staging as appropriate and documentation. This was completed by July 1, 2014.

Daily audits will be completed of weekly skin checks completed on bath day for one month. In addition, weekly audits x 4 weeks will be completed for wound documentation to include location and staging as necessary then monthly x3 months. The results of the audits will be reported to the QA/QI committee for 3 months for review and further recommendations.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-319

It is the policy of Camden Care Center that a resident assessment which did not reveal a mental, psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdraw, anger, depressive behaviors, unless the clinical condition demonstrates that such a pattern is unavoidable.

For resident #41 is showing no signs and symptoms of depression. A Vulnerable Adult, elopement, cognitive assessments have been completed. Corresponding updates have been made to the care plan, care assignment sheet. Primary physicians, resident and decision maker have been informed of assessment results and care plan updates. All staff members responsible will be educated on the Resident Leave of Absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

For other residents who may be affected by this practice, a comprehensive record review of mental and psychosocial functioning, cognitive status, and indicated behavior monitoring will be completed. A Behavioral Health Management program will be implemented. After the review, updates will be made as appropriate for each resident identified. Respective primary physicians, residents and decision makers have been informed of assessment results and care plan updates. Staff members responsible have been educated on the Resident Leave of Absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

The policy and procedure for elopement risk, psychotropic drug use and monitoring, vulnerable adult assessment, including respective processes for new and readmissions, were reviewed and revised as necessary. The Medical Director will review and approve the updated policies. Staff members will be trained as it relates to their respective roles and responsibilities on policies and procedures for leave of absence.

Audits of vulnerable adult assessment completion, psychotropic drug use and monitoring and elopement assessment completion for new and readmissions will be completed weekly x4 weeks, monthly for 3 months and then quarterly to ensure continued adherence to policies. The results will be reported for 3 months to the QA/QI committee for review and further recommendation.

The Director of Nursing, Director of Social services, or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-323

It is the policy of Camden Care Center that each resident receives adequate supervision and assistance to prevent accidents.

For resident #37, #129, #13, #41, #9, #36, #22, #14, #62, #86 and #113 the following assessments were completed to reflect current status: vulnerable adult assessment, elopement risk assessment, ETOH and Drug Abuse potential, smoking safety assessment, psychosocial assessment

and fall risk assessment. Corresponding updates were made to the care plan and individual care assignment sheet. Attending physicians, residents and legal decision makers were notified of assessment results respectively. Staff members responsible will be educated on fall risk, elopement risk, vulnerable adult risk, and smoking assessment policy and procedures.

Resident #117 was discharged on 5/9/2014
Resident #116 expired on 6/1/2014
Resident #1 was discharged on 5/21/2014

For other residents who may be affected by this practice, a comprehensive record review and updated of assessments related to fall risk, vulnerable adult, smoking safety and supervision, ETOH and Drug Abuse potential, elopement risk to reflect current status of residents residing in the facility. Corresponding updates have been made to the individual care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Respective primary physicians have been informed of assessment results and a review of the current physician orders has been completed. The facility will obtain additional psych and ETOH/ADOA professional services as indicated. 5taff responsible for care for each resident has been educated on the updated care interventions. The preceding has been completed by July 6, 2014.

The policy and procedures for vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been reviewed and revised. The Medical Director has reviewed and approved the policies by July 6, 2014. Additionally, the facility has reviewed admission and readmission processes to include updates to resident's status related to the aforementioned policies and procedures. All staff members will be trained as it relates to their respective roles and responsibilities regarding the above policies and procedures. This will be completed by July 6, 2014.

DON and or designee will conduct audits for all new admissions within 24 hours of admission/readmission to ensure vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been completed per policy for 30 days. Weekly review and audit of the 24 Hour Report, significant change of condition and Incident reports will be conducted for 2 months to ensure vulnerable adult, smoking safety and supervision, elopement, ETOH and Drug abuse potential, psychosocial assessment and monitoring, and fall risk have been completed per policy with corresponding care plan and care assignment updates.

Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing and NHA or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-329

It is the policy of Camden Care Center that each resident's drug regimen is free from unnecessary drugs.

For resident #91 review of physician orders has been completed with parameters established for administration of prn pain medication.
For resident #36 review of physician orders has been completed with parameters established for administration of prn pain medication.
For resident #37 drug regimen review has been completed. Side effect monitoring in in progress and GDR has been reviewed.
For resident #89 drug regimen review has been completed. Targeted behaviors have been identified along with monitoring of side effects for psychotropic medication.
For resident R113 a review of physician orders has been completed with parameters established for the administration of prn pain medication.
For resident #29 a review of physician orders has been completed with parameters for use of prn pain medication. Pain monitoring has been implemented.

For those residents identified, inclusion of the updates in the facility Behavior Management and Pain Management programs, as individually indicated, has been completed. Corresponding care plans and corresponding care assignment sheets have been updated as indicated. Resident attending physicians have been notified of the updates. The preceding was completed by July 6, 2014.

For other residents who may be affected by this practice a comprehensive pain assessment has been completed. Based on the assessment review of physician orders will be reviewed with parameters established as necessary for the use of prn pain medication. Pain monitoring will be reviewed for those residents receiving pain medication. For other residents who may be affected receiving psychotropic medication, drug regimen review was completed on 6/6/2013, targeted behaviors have been identified and GDR potentials have been considered. Review of appropriate indicators for the use of psychotropic medication has been completed. Corresponding care plans and care assignment sheets have been updated as necessary. Resident primary physicians have been informed of assessment results. Treatment recommendations have been obtained as indicated. The preceding steps have been completed by July 6, 2014.

The policy and procedure for pain management (including PRN medications, pain resolution and break through pain management) and psychoactive medication management (including GDR, targeted behaviors and documentation) has been reviewed and revised. The Medical Director has reviewed and approved the revisions by July 6, 2014. Clinical staff members were trained as it relates to their respective roles and responsibilities regarding pain management and psychotropic medication review and monitoring by July 6, 2014.

Audits of the 24 Hour Reports and new Physician orders will be completed monthly x3 months and then quarterly to ensure continued adherence to pain management and psychoactive medication management policies as indicated. The results will be reported to QA/QI committee for review and further recommendation.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-353

It is the policy of Camden Care Center to have sufficient nursing staff to provide nursing and related services to attain or maintain practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

For Residents # R22, R129, R1, R41,R37, R13, R86, R116, R36, R113, R117, R9, R14, R62, R 129, R1, RR22 - comprehensive clinical assessments will be completed to accurately reflect current status and care needs. Corresponding care plan, care assignment sheets and physician orders will be reviewed and updated per policy. Attending physician, resident and legal decision maker will be notified of assessment results. **Please refer to corresponding POC for F tags 224 and 323.

The nursing schedule will be reviewed and revised to include staffing ratios that are within industry standards. The policy for staffing of 1:1 was reviewed and revised. In-service on staffing policies was presented to staff members on 6/4/2014. The facility has implemented a Staffing Manager who is responsible for the time keeping and policies. Attendance and punctuality was addressed at the in-service on 6/4/2014.

Daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing levels.

The staffing patterns, scheduling coordination was reviewed and revised as warranted. Staff members were trained as it relates to their respective roles and responsibilities.

Staffing pattern audits will be completed daily for 4 weeks, monthly for 3 months and then quarterly to ensure continued compliance. The results will be reported to QA/QI committee for review and further recommendation.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-412

It is the policy of Camden Care Center to provide or obtain from an outside resource dental services to meet the needs of each resident.

For resident #9 a consent was obtained and resident was seen by the outside dental service agency on 6/4/2014. For resident #36 resident states he has found his dentures. He has adamantly refused to see the outside dental service agency that was present in the facility on 6/4/2014.

For other residents who may be affected by this practice a record review and brief oral exam of all residents will be completed regarding dental referrals, dental concerns, eating problems or nutritional concerns. Residents with dental concerns will be identified by the chart review and brief oral exam and will be placed on the list to be seen at the next dental facility visit. After the review the physician will be notified of the request for dental services for each resident identified.

The protocols/practices/contract for dental services will be reviewed and revised as necessary/warranted. The Medical Director has reviewed and approved the contract and protocols by July 6, 2014. Staff members will be trained as it relates to their respective roles and responsibilities. This will be completed by July 6, 2014.

The DON and or designee will conduct monthly record review audits for 3 months to ensure dental services are provided per revised policy. After three months, dental service audits will be conducted quarterly basis to coincide with the MDS schedule to ensure continued compliance with results reported to the QA/QI Committee for review and further recommendations.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-428

It is the policy of Camden Care Center that the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

For residents #1, #36, #37, #89, #91 and #113, a new pharmacy consultation/medication regime review was completed on June 6, 2014. Additionally, the consultant pharmacist will conduct specific reviews as indicated: Resident #91, #113 and #36 – pain medication, PRN medication parameters and break through pain management, Resident #37 and #89 - resident specific target behaviors and monitoring for

antipsychotic medication, Resident #1 for unnecessary medication and GDR. Resident Parameters for pain medication will be determined and addressed on the MAR and care plan. Behavior monitoring will be initiated if necessary along with a sleep study for those residents receiving hypnotic medication. Care plans will be reviewed for indicators of use for psychotropic medication. The attending physicians will be notified of pharmacy consultant recommendations and updated will be completed as indicated. The preceding will be completed by July 6, 2014.

For other residents who may be affected by this practice a medication regimen review will be completed by a licensed pharmacist for all residents on pain medications and antipsychotics. Upon completion of the review, the pharmacy recommendations will be reviewed with the respective attending physicians. Updates will be completed as indicated. The facility has obtained the services of a new pharmacy consultant.

The protocol/practices/contract for consultant pharmacy services will be reviewed and revised by July 6, 2014. The Medical Director will review and approve the policies by July 6, 2014. Licensed nursing staff will be trained as it relates to their respective roles and responsibilities regarding consultant pharmacy recommendations.

The facility will conduct biweekly for 3 months pain management, hypnotic and antipsychotic use drug regimen audits to ensure adherence to facility policies and procedures. This audit will include a review of pharmacy recommendations and physician response to recommendations. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-431

It is the policy of Camden Care Center to labeled drugs and biologicals in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The facility, in accordance with State and Federal laws will store all drugs and biologicals in locked compartments under proper temperature controls, while keeping medication and treatment carts clean.

The storage and dating of resident's # R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88 medications and biologicals were reviewed for expiration and cleanliness of medication cart. Residents R73, R37, R83, R115 medications and treatments are stored in the appropriate locked compartments in accordance to state and federal regulations.

Medication cart audit and organization/cleaning of the carts will be completed by June 16, 2014. The facility has developed and implemented a cleaning schedule for the medication carts will be completed by June 16, 2014.

Education to be provided to the licensed staff as it pertains to cleanliness/organization/ of the medication cart. Pharmacy representative to provide training to the licensed staff on labeling, dating of opened vials, multi -dose containers, eye drops, diskus inhalers, proper storage of insulin vials before and after opening. This will be completed by June 19, 2014.

The DON and or designee will conduct Medication cart and medication room audits to include appropriate dating and storage of medications per policy and regulations on a weekly basis for 4 weeks, monthly for 2 months. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-465

It is the policy of Camden Care Center to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

Resident # 56 has been relocated to another room. The carpeting in Resident #56 original room the carpet has been cleaned. Resident #22 the carpet has been cleaned by a professional cleaner.

Resident #33 has been discharged from the facility.

For other residents who may be affected by this practice room to room environmental audit for all resident rooms will be completed. Upon completion of the audits, the facility will clean and repair any carpet and/or furniture found in disrepair or in need of cleaning will be fixed

and/or cleaned by the maintenance/housekeeping team. Outside services to clean the carpets has been scheduled to be completed by 6/17/2014. The facility NHA and or designee will conduct a review of all mechanical lifts to ensure they are well maintained. Any identified repairs will be completed prior to utilization by nursing staff.

Policy for the mechanical lifts has been developed/reviewed/revised. Review of the process of identifying and reporting to maintenance issues in need of repair or fixing has been developed/reviewed/revised. Lock-out/Tag-out policy will be reviewed and revised as necessary. Resident room cleanliness and repair request policies have been reviewed and revised. Staff will be educated on the reporting process of items that need repair, cleaning, fixing by the maintenance department. Staff will be in-serviced on Lock-out/Tag-out process for items that need to be taken out of service due to malfunction, safety issues. This will be completed by July 6, 2014.

The NHA and Maintenance/Housekeeping will conduct resident room environmental cleanliness and repair audits will be completed weekly for 4 weeks. Additionally, Maintenance will conduct weekly mechanical lift safety checks. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-469

It is the policy of Camden Care Center to maintain an effective pest control program so that the facility is free of pests and rodents.

Resident #56 room has been treated by Pest control. No additional infestations have been noted since treatment.

The Pest control contractor was at the facility on 6/9/2014 and completed routine pest control and monitoring. All insect lights traps were serviced and all entrances were treated. All traps were checked and no evidence of mice. Exterior face of building was also treated. Contract signed 6/9/2014 includes an increase in frequency of visits to service weekly for the month of June and bi-weekly for the month of July. Pest Control contractor was at the facility on 5/7/14 and performed treatment to specific rooms and exterior of the south wing.

Facility has purchased disposable food saver containers made available for the residents to store snack, food and other small food items in their room. This was reviewed with Resident Council on 6/16/2014.

The policy for pest control will be developed/reviewed/revised. All staff members will be trained as it relates to their respective roles and responsibilities regarding storage of food items in resident rooms and the use of covered containers. This was completed by July 6, 2014.

The Director of Maintenance/Environmental Services will conduct room to room environmental rounds related to pest control on a weekly basis for 4 weeks and monthly for 3 months. Results of audits will be reported to QA/QI committee for further review and further recommendation.

The Director of Maintenance/Environmental Services or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F-490

It is the policy of Camden Care Center that our facility be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

The new managing agent has removed the NHA from the facility. A new Interim NHA with related experience and expertise with this resident population is in place effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. The INHA has notified all facility staff of the outstanding citations and serious and immediate issues that are being addressed. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC.

For residents #37, #129 a comprehensive assessment, a vulnerable adult assessment and elopement assessment will be completed. Care plans will be reviewed to identify risks and interventions. Corresponding updates will be made to the care plan and care assignment sheet.

All other residents have the potential to be affected by this practice.

-F223 (see related POC for this F Tag)- For other residents who may be affected by this practice a record review will be completed regarding vulnerable adult assessment. A new vulnerable adult assessment will be completed for each current resident. Upon this review, system revisions and/or staff education will be implemented.

The policy for Vulnerable Adult Assessment was reviewed and revised as warranted. Initiation of a standardized, carbon-copied 24 hour report form will be implemented to assist in the enhancement of the internal communication process as it relates to resident care and needs. Incident and accident report form has been revised to contain the necessary components. Staff members will be trained as it relates to their respective roles and responsibilities regarding implementation of 24 hour report format, targeted behaviors and Vulnerable Adult Assessment.

Daily audits will be completed of the 24 hour report book to recognize any changes of condition, at risk potential for abuse/neglect for 4 weeks, monthly for 3 months, then quarterly. Audits are being completed to determine if staff are assessing and planning for "at risk behavior". Reviews will be completed on allegations of abuse, neglect and misappropriation of property will be completed to ensure facility protocols are followed to ensure the environment is free from abuse. Based on the audits care plans and assessments will be updated to reflect changes. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

-F-224 (see related POC for this F Tag)- All residents will have a comprehensive assessment completed, care plan review and revision of the care plan as necessary along with a chart review.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations. A review of the internal communication process will be completed to determine/establish an effective interdisciplinary communication process

On-going daily audits will be conducted of the 24 hour report, incidents and nursing documentation. This will be completed by the nurse manager on a daily basis. The results will be reported to the QA/QI Committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

-F-225(see related POC for this F Tag)- Education will be provided for staff members regarding abuse reporting, investigation, incident completion, timely notification and documentation.

All other residents have the potential to be affected. Other residents who may be affected by this practice will have a vulnerable adult assessment completed. All other residents who operate a motorized w/c will be assessed for their ability to operate a motorized wheel chair.

The policy and procedures for abuse prevention and reporting, resident protection policies was reviewed and revised as necessary. Facility staff members were trained as it relates to their roles and responsibilities for the revised policies and procedures regarding abuse reporting, abuse allegations.

Audits regarding 24 hour report, incident reports and progress notes will be completed daily x4 weeks, then weekly x4 weeks, monthly for 3 months then quarterly to ensure continued compliance with facility protocol.

-F-226 (see related POC for this F Tag)- The facility has reviewed and revised the policies and procedures for screening and training of employees, protection of resident and policies pertaining to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

All employee files have been reviewed to assure that the proper components are present such as licensure, background checks and reference checks. Nineteen staff members have been suspended and/or terminated based on the checks. Facility is in the process of performing an 8 point background check on all employees.

For other residents who may be affected by this practice a review of the abuse policy and procedure was completed. Training of employees as it relates to prevention, identification, investigation, and reporting abuse neglect and mistreatment.

The policy and procedure for resident protection was reviewed and revised. The policy was reviewed to ensure all components are present: screening, training, prevention, identification, investigation, protection and reporting and response. Staff members were trained as it relates to their respective roles and responsibilities for the policies and procedures.

New employee files will be reviewed on a continuous basis to verify licensure, background checks along with reference checks are present and appropriate action taken based on the result of the checks.

Daily review of the 24 hour report along with nursing notes to identify possible abuse, neglect, investigation for timeliness, reporting, documentation and notification.

The results of the audits will be reported to the QA/QI committee for further review and recommendations. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan

F-250 (see related POC for this F Tag)- For resident #29, 386, #41, #37, #14, #56, #62, #9, #13, and #103 comprehensive assessments will be completed including vulnerable adult assessment, Risk of drug and ETOH assessment, smoking assessment, pain assessment, BIMs and elopement assessment. The comprehensive care plan will be reviewed and revised and the NAR assignment sheets will be updated to reflect current care needs. Appropriate referrals to be made to other professional resources as indicated.

R#117 was discharged from the facility

For other residents who may be affected by this practice a comprehensive assessment including the following assessments; vulnerable adult, pain, smoking, BIMs, elopement, risk of drug and alcohol will be completed. Comprehensive care plan will be reviewed and revised as indicated based on the assessments. Appropriate referrals to be made to other professional resources as indicated.

The policy and procedures for Incident/Accident an reporting, elopement, AMA, drug testing, LOA, smoking, controlled substance storage and documentation, 1:1 policy, change of condition were reviewed to ensure policies meet current standards of practice. Education was provided for staff regarding revised policies and procedures and their respective roles and responsibilities.

On-going daily audits will be completed of 24 hour report, incident/accident reports, physician orders and interdisciplinary progress notes to identify problems/concerns and follow up as needed for resolution. Completion of appropriate assessments, interventions and notification to physician and resident and family/legal representative as indicated.

F-309 (see related POC for this F Tag)- For resident #56 POLST was reviewed. Advance directive was discussed with resident and husband on 5/12/2014 and the correct advance directive was placed in the chart. Corresponding updates have been made to care plans and care assignment sheets.

For other residents who may be affected by this practice, an audit of all resident's advance directives care and planning will be completed. Upon this review, care plan revisions and/or staff education will be implemented if indicated.

The policy for Advance Directives was reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities regarding advance directives.

Advance Directive audits along with physician order audits will be completed weekly for 4 weeks, monthly for 3 months, then quarterly to ensure compliance with results reported to QA/QI committee for review and further recommendations.

F-314 (see related POC for this F Tag)- Resident #123 expired on 4/21/14.

For other residents who may be affected by this practice a comprehensive record review of skin will be completed by June 13, 2014. After review, updates will be made as appropriate for each resident identified.

Wound policy and procedure was reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities regarding wound documentation as it relates to wound location, staging as appropriate and documentation.

Daily audits will be completed of weekly skin checks completed on bath day. Weekly audits x 4 weeks will be completed for wound documentation to include location and staging as necessary then monthly x3 months and then quarterly to ensure compliance. The results of the audits will be reported to the QA/QI committee for review and further recommendations.

-F-319 (see related POC for this F Tag)- For resident #41 a Vulnerable Adult, elopement, cognitive assessments have been completed. Corresponding updates have been made to the care plan, care assignment sheet. All staff members responsible have been educated on the Leave of absence policy, comprehensive care plan, arranging of psych services and the internal communication process.

For other residents who may be affected by this practice a comprehensive record review of mental and psychosocial functioning and behavior monitoring will be completed. After review updates will be made as appropriate for each resident identified.

The policy and procedure for elopement risk, psychotropic drug use, and vulnerable adult assessment were reviewed and revised as necessary. Staff members were trained as it relates to their respective roles and responsibilities as it relates policies and procedures relating to leave of absence.

Audits of vulnerable adult assessment, comprehensive care plans and psychotropic drug use will be completed weekly x4 weeks, monthly for 3 months and then quarterly to ensure continued compliance. The results will be reported to the QA/QI committee for review and further recommendation.

F-323 (see related POC for this F Tag)- For resident #37, #129, #13, #41, #9, #36, #22, #14, #62, #86 and #113 a vulnerable adult assessment, elopement risk assessment, smoking assessment, psychosocial assessment and fall risk assessment will be completed. Corresponding updates will be made to the care plan, care assignment sheet. All staff members responsible will be educated on fall risk, elopement risk, vulnerable adult risk, and smoking assessment policy and procedures.

For other residents who may be affected by this practice, a comprehensive record review of fall risk, vulnerable adult, smoking, elopement risk will be reviewed and completed. After review, updates will be made as appropriate for each resident identified.

The policy and procedures for vulnerable adult, smoking, elopement, fall risk have been reviewed and revised. Staff members will be trained as it relates to their respective roles and responsibilities regarding the above policies and procedures.

Audits will be completed for all new admissions within 24 hours of admission/readmission, with a significant change in status, and quarterly to ensure all assessments are completed with appropriate changes made to comprehensive care plan and nursing assistant assignment sheets. The results will be reported to the QA/QI committee for review and further recommendations.

F-353 (see related POC for this F Tag)- The nursing schedule was reviewed and revised to include staffing ratios that are within industry standards. The policy for staffing of 1:1 was reviewed and revised as necessary. In-service on staffing policies was presented to staff members on 6/4/2014. The facility has implemented a Staffing Manager who is responsible for the staffing and scheduling. Attendance and punctuality was addressed at the in-service on 6/4/2014.

Daily schedules will be reviewed by the Director of Nursing or designee before posting to ensure appropriate staffing level.

The staffing patterns, scheduling coordination was reviewed and revised as warranted. Staff members were trained as it relates to their respective roles and responsibilities.

Staffing pattern audits will be completed daily for 4 weeks, monthly for 3 months and then quarterly to ensure continued compliance.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

F-492 Prior to working in the facility, each agency person will have a file that verifies that the appropriate screenings were completed prior to working in the facility. This verification process will include the completion of a master file which includes a two -step TB test and results prior for each agency personnel to the start of their first shift at Camden Care Center. This information will be provided from the staffing agency. This was implemented on 6/6/2014.

Development and implementation of an agency orientation has been completed on 6/6/2014. The DON and/or designee will assure that all proper paperwork is present in supplemental staff files.

The facility will conduct a daily audit of scheduled contracted staff files, to ensure all required and necessary paperwork and screenings are present prior to start of their first scheduled shift. Results of this monitoring will be presented to QA Committee for further review and further recommendation

F-497 The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision employee annual training requirements and annual review process policies and procedures. A review of the revised policies by the Medical Director will be conducted by July 6, 2014 for approval. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures by July 6, 2014.

The facility has audited and reviewed all nursing assistant employment and training files for evidence of required annual training and annual performance evaluations. Those files requiring improvement have been identified and actions for adherence to annual training requirements and annual performance evaluations will be completed by 7/1/2014.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

F-499 The facility has completed license verification for employees (LPN)-A and registered nurse (RN)-C) and filed those results in accordance to policy.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision of license and certification verification (upon hire and annually) process policies and procedures. A review of the revised policies by the Medical Director will be conducted by July 6, 2014 for approval. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all employees in a position requiring license or certification for evidence of license/certification verification. Those files requiring improvement have been identified and actions for adherence to license verification will be completed. All new employee files will be reviewed with the NHA for license/certification verification in accordance with applicable State laws.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the

corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The Administrator or designee will be responsible for compliance.

Date of Correction: 7/6/14

F-520 **CORRECTIVE ACTION**

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this 5tatement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC. The INHA has revised the Quality Assurance and Performance Improvement processes to meet current professional standards. Education for all F Tags identified in this SOD will be completed for staff members. Documentation of individual education will be completed. Competency testing, as indicated in respective F Tags, will be documented. As indicated in corresponding F Tags, the NHA and or designee has reviewed and revised employee orientation as well as agency staff orientation programs to reflect the updated policies and procedures.

All current residents clinical records will be reviewed as indicated in F Tags notated in this statement of deficiency. Updates to individual care plans, care assignment sheets for direct care staff will be completed. Notification of assessment results/record review results will be completed specifically for residents, responsible parties and primary care physicians. Physician orders will be updated as indicated. All staff responsible for those residents identified for revisions will be completed to ensure care and services are being delivered per current clinical functional level.

The Administrator and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – QAA (Quality Assessment and Assurance) program protocols based on the new guidelines to include, but not limited to: Overview of QAA Program (serves as a management process that is ongoing, multi-level, and facility wide. It encompasses all managerial, administrative, clinical, and environmental services, contracted entities. The purpose of the program is to continuously evaluate the facility systems for clinical, financial and operational focuses to provide the highest level of care and services to the residents and staff of the facility);

- Keeping facility systems in accordance with current industry standards of practice;
- Prevent deviations from care processes from arising;
- Discerning issues and concerns as identified with facility systems and utilizing root cause analysis
- protocols to determine necessary action steps;
- Facility process for identification of quality deficiencies;
- Description of QAA facility team composition; additional committee members may include the facility administrator, Medical Director –
- Description of QAA Committee functions;
- Frequency of meetings and recording processes utilized;
- Monitoring processes for action plan implementation and determination of quality improvement of necessary changes for improvement.

A review of the revised policies by the Medical Director and Quality Assurance/Compliance Committee will be completed to determine if policies meet current standards of practice.

All facility staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures related to quality assessment and assurance activities. Staff will be educated by the NHA on the QAA committee responsibility to have oversight and monitoring of the plan of correction for the recertification survey. The facility Managing Agent and INHA have added additional external consultants to assist with the facility's response to the statement of deficiency as well as QAA/monitoring activities to ensure compliance with respective regulations.

The Administrator and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including:

Development of peer review committee to assess current QAA functionality including identified QAA improvement plans and effectiveness of implemented action plans. This will be completed monthly for 4 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions for the overall Statement of Deficiency (track, trend and analysis) will be reported to the facility QA Committee monthly for 4 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA and Managing Agent will be responsible for compliance.

Date of Correction: July 6, 2014

F 492

It is the policy of Camden Care Center to operate and provide services in compliance with all applicable federal, state and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

Prior to working in the facility, each agency person will have a file that verifies that the appropriate screenings were completed prior to working in the facility. This verification process will include the completion of a master file which includes a two -step TB test and results prior for each agency personnel to the start of their first shift at Camden Care Center. This information will be provided from the staffing agency. This was implemented on 6/6/2014.

Development and implementation of an agency orientation has been completed on 6/6/2014. The DON and/or designee will assure that all proper paperwork is present in supplemental staff files.

The facility will conduct a daily audit of scheduled contracted staff files, to ensure all required and necessary paperwork and screenings are present prior to start of their first scheduled shift. Results of this monitoring will be presented to QA Committee for further review and further recommendation

The Administrator/Director of Nursing or designee is responsible for compliance.

Date of correction: July 6, 2014

F493

It is the Policy of Camden Care Center to have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and

implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC.

All residents identified in this citation (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) have been clinically reassessed and plans of care have updated as indicated in the correlating F Tag citations indicated in the SOD. Employees (E1, E2, E3) annual evaluations have been completed. Staff (NA-Z) has completed the required education. License/certification verification for RN-C, RN-D, LPN-A, NA-U, NA-Q) has been completed. Facility vendors have been notified of the receivership and vendor payment processes and needs.

Refer to specific Plan of Correction actions for F223, F224, F 225, F 226, F250, F 309, F 314, F319, F 323, F 353, F 412, F 490, F 492, F497, F 499, F500, and F520 related to resident specific changes, policy revisions and updates, staff education and monitoring activities.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA and Managing Agent will be responsible for compliance.

Date of Correction: July 6, 2014

F-497

It is the policy of Camden Care Center to complete a performance review of every nurse aide at least once every 12 months, and provide regular in-service education based on the outcome of these reviews. The in-service training will be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

Employees (E1, E2, E3) annual evaluations have been completed. Staff (NA-Z) has completed the required education.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision employee annual training requirements and annual review process policies and procedures. A review of the revised policies by the Medical Director will be conducted. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all nursing assistant employment and training files for evidence of required annual training and annual performance evaluations. Those files requiring improvement have been identified and actions for adherence to annual training requirements and annual performance evaluations will be completed.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F499

It is the policy of Camden Care Center to employ professional staff who are licensed, certified, or registered in accordance with applicable State laws.

The facility has completed license verification for employees (LPN)-A and registered nurse (RN)-C) and filed those results in accordance to policy.

The INHA and or designee has implemented measures to ensure that this practice does not recur, including: review and revision of license and certification verification (upon hire and annually) process policies and procedures. A review of the revised policies by the Medical Director will be conducted. Staff will be trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures.

The facility has audited and reviewed all employees in a position requiring license or certification for evidence of license/certification verification. Those files requiring improvement have been identified and actions for adherence to license verification will becompleted. All new employee files will be reviewed with the NHA for license/certification verification in accordance with applicable State laws.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F500

It is the policy of Camden Care Center that if the facility to employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an approved arrangement.

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. Facility vendors, including contracted Social Services Agency, have been notified of the receivership and vendor payment processes and needs.

The facility INHA is currently working with the contracted social services vendor and external social services resources for the provision of medically related social services. Refer to F 250 for the specific plan of correction actions for those residents identified in the citation, all residents potentially affected by this practice, revision and implementation of policies and procedures, staff orientation changes , staff education as well as monitoring activities. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect.

The INHA and new Managing Agent will review accounts payable on a weekly basis for 3 months to ensure vendor invoices are processed and paid in accordance to the individualized agreements.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F 502

It is the policy of Camden Care Center to provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services

Resident #37 labs were obtained while in the hospital.

For other residents who may be affected by this practice a comprehensive review of laboratory orders was completed for all residents residing in the facility. Review results were discussed with the corresponding attending physicians for updates or revisions as indicated.

A review of policies by the Medical Director will be completed to ensure current standards of practice are in place. Staff members were trained as it relates to their respective roles and responsibilities regarding the policy and procedures.

Lab audits will be completed weekly for 4 weeks and monthly for 2 months compliance with laboratory services policies and procedures. Monitoring results will be reported to the QA/QI Committee for review and further recommendation for 3 months.

The Director of Nursing or designee will be responsible for compliance.

Date of Correction: July 6, 2014

F514

It is the policy of Camden Care Center to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented, readily accessible; and systematically organized. The clinical record contains sufficient information to identify the resident, record of the resident's assessments, plan of care and services provided, and the results of any preadmission screening conducted by the State.

Residents (R103, R116,R86, R71, R9, R34, R51, R129, R13, R117, R41,R62, R37, R56, R36, R123, R1, R113, R29, R91) identified in this statement of deficiency clinical records have been reviewed for completion of all applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. Updates have been completed as indicated per record review. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders will be completed. All staff responsible for care for each resident identified has been educated on updated care interventions.

For other residents who may be affected by this practice, an audit of all current resident records for completion of applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. Updates have been completed as indicated per record review. Corresponding updates have been made to the care plan, care assignment sheet and communicated to the resident and/or designated decision maker. Primary physician has been informed of assessment results and a review of the current physician orders will be completed.

The Director of Nursing and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – medical record protocols including - completion of applicable assessments , MDS, comprehensive care plan, physician order updates, physician progress notes, behavior tracking as applicable, laboratory services as ordered and respective nursing documentation. A review of the revised policies by the Medical Director will be conducted to determine if policies meet current standards of practice was completed.

Clinical staff were trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures .

The Director of Nursing and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including: Conduct random record review to ensure the aforementioned policies and procedures are in place and practice. This will be completed 3 times per week for 4 weeks.

In addition, a weekly review of new/re admission records will be completed to ensure the aforementioned policies and procedures are in place and practice per new and re admission processes. This will be completed one time per week for four weeks.

Upon completion of all reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions (track, trend and analysis) will be reported to the facility QA Committee monthly for 3 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

F520

It is the policy of Camden Care Center that the facility maintains a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility and at least 3 other members of the facility staff. This meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary and develop appropriate plans of action to correct identified quality deficiencies.

CORRECTIVE ACTION

The State of MN has appointed a new managing agent to provide oversight for the facility. The managing agent has placed a new Interim NHA with related experience and expertise with the facility resident population effective May 30, 2014. The INHA and designees have developed and implemented specific plans of corrections for each correlating citation in this Statement of Deficiency. Additional consultation and resources have been brought in to assist the INHA and facility staff to assess all residents as indicated in each citation and revise care processes and policies to address all areas identified. All policy revisions have been approved by the Medical Director and Managing Agent. The Managing Agent and INHA have instituted clinical monitoring across shifts to resident safety and care needs. This was implemented on May 30, 2014 and remains in effect. The INHA has revised applicable policies and procedures in accordance to professional standards as indicated in the respective F Tag POC. The INHA has revised the Quality Assurance and Performance Improvement processes to meet current professional standards.

As of July 6, 2014 education for all F Tags identified in this SOD was completed. Documentation of individual education is completed. Competency testing, as indicated in respective F Tags, is documented as indicated. As indicated in corresponding F Tags, the NHA and or designee has reviewed and revised employee orientation as well as agency staff orientation programs to reflect the updated policies and procedures.

All current residents comprehensive records will be reviewed as indicated in respective F Tags notated in this statement of deficiency, have been completed. Updates to individual care plans, care assignment sheets for direct care staff have been completed. Notification of assessment results/record review results were completed specifically for residents, responsible parties and primary care physicians. Physician orders have been updated as indicated. All staff responsible for those residents identified for revisions was completed to ensure care and services are being delivered per current clinical functional level.

The Administrator and/or designee will implement measures to ensure that this practice does not recur, including: review and revision as indicated of the following policies and procedures – QAA (Quality Assessment and Assurance) program protocols based on the new guidelines to include, but not limited to: Overview of QAA Program (serves as a management process that is ongoing, multi-level, and facility wide. It encompasses all managerial, administrative, clinical, and environmental services, contracted entities. The purpose of the program is to continuously evaluate the facility systems for clinical, financial and operational focuses to provide the highest level of care and services to the residents and staff of the facility);

- Keeping facility systems in accordance with current industry standards of practice;
- Prevent deviations from care processes from arising;
- Discerning issues and concerns as identified with facility systems and utilizing root cause analysis
- protocols to determine necessary action steps;
- Facility process for identification of quality deficiencies;
- Description of QAA facility team composition; additional committee members may include the facility administrator, Medical Director –
- Description of QAA Committee functions;
- Frequency of meetings and recording processes utilized;
- Monitoring processes for action plan implementation and determination of quality improvement of necessary changes for improvement.

A review of the revised policies by the Medical Director and Quality Assurance/Compliance Committee will be completed by July 6, 2014 to determine if policies meet current standards of practice. QAA meeting is scheduled for the week of June 23, 2014.

All facility staff was trained as it relates to their respective roles and responsibilities for the aforementioned reviewed and revised policies and procedures related to quality assessment and assurance activities. As of July 6, 2014 staff will be educated by the NHA on the QAA committee responsibility to have oversight and monitoring of the plan of correction for the recertification survey. The facility Managing Agent and INHA have added additional external consultants to assist with the facility's response to the statement of deficiency as well as QAA/monitoring activities to ensure compliance with respective regulations.

The Administrator and /or designee will monitor the corrective actions to ensure the effectiveness of these actions, including:

Development of peer review committee to assess current QAA functionality including identified QAA improvement plans and effectiveness of implemented action plans. This will be completed monthly for 4 months. Upon completion of reviews/audits, corrective actions, if applicable will be completed immediately. Additional education will be provided as derived from the reviews. Failure to adhere to educated protocols will result in corrective counseling. The results of monitoring of the corrective actions for the overall Statement of Deficiency (track, trend and analysis) will be reported to the facility QA Committee monthly for 4 months. Upon this review, system revisions and/or staff education will be implemented if indicated via a prescribed corrective action plan.

The INHA will be responsible for compliance.

Date of Correction: July 6, 2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An onsite resurvey was conducted on May 5, 6, 7, 8, 9, 10, 11, 12, and 13, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on March 18th, 2014. An IJ at F224 began on 5/10/14, when R37 was admitted to the hospital following the use of illicit drugs while in the facility and was identified on 5/12/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey. An IJ at F323 began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization and was identified on 5/9/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of additional components to the IJ related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey. An IJ at F490 began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by the exit date of the survey. An extended survey was conducted by the	{F 000}		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Minnesota Department of Health on May 12 and May 13, 2014. The post certification re-visit survey was exited without removal plans having been approved for any of the deficiencies identified at a scope/severity of IJ: F224, F323 and F490.	{F 000}		
{F 157} SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 157}	Continued From page 2	{F 157}		

the address and phone number of the resident's legal representative or interested family member.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the physician and family member(s) was promptly notified for 1 of 1 resident (R13) observed to elope from the building during the survey on 5/6/14.

Findings include:

On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 exited the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 157}	Continued From page 3	{F 157}		

smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to be smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to finish smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair using her feet to propel the wheelchair towards 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly (posted speed limit was 30 miles per hour). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor that R13 had been observed on the city sidewalks. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 157}	Continued From page 4	{F 157}		

driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, assisted her to wheel back to the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, identified diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had a history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples' belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, the assessment indicated R13 was required to have supervised LOAs (Leave of Absences) only, and that R13 had a past history of drug abuse.

A LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and that the resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, included; "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which

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{F 157}	Continued From page 5	{F 157}		

can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of daily living (ADLs).

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, indicated R13 had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "WanderGuard in place." An intervention dated as initiated 3/16/12, directed,

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{F 157}	Continued From page 6	{F 157}		

"Resident has been assessed and may not leave this facility without supervision."

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. The receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident." Although the note indicated a message had been left for the NP, the NP and family member(s) were not called until three days after the incident.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 157}	Continued From page 7 On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, did O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. registered nurse (RN)-C stated she was in the room when O-C had reported R13 had eloped. RN-C stated the announcement was made and RN-C, licensed practical nurse (LPN)-E, LPN-A and dietary manager (DM) was present for the announcement. RN-C stated she had not reported the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; and would be responsible to notify the family and physician regarding the elopement.	{F 157}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 221} SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) reviewed for restraint, was free of physical restraints while directly supervised by staff during meals. Findings include: On 5/7/14, at 8:28 a.m. R89 was observed to be at a meal in her wheelchair (W/C) with the right break locked. Anti-rollbacks (devices which engage and keep wheelchair from rolling back when a resident stands) were observed to be applied to the back of the W/C. A nursing assistant (NA)-V was observed to be sitting directly to R89's left and assisted R89 to eat. When asked why the W/C brake was locked, NA-V stated "we lock one brake," and verified the left brake was unlocked. NA-V explained "brakes" needed to be locked "to protect her [R89]." NA-V further explained R89 needed to protect from "falling." NA-V was unclear why the left brake was left unlocked. The right side of the W/C was observed to be flush to the table. During the observation, R89 was observed to stand repeatedly, had worried expression on her face and repeated in an anxious voice, "I gotta go!" On 5/8/14, at approximately 8:30 a.m. R89 was	{F 221}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 221}	Continued From page 9	{F 221}		

observed to be at the dining room table in the same location. R89 was observed to have both W/C brakes locked; the anti-rollback device remained appropriately applied to the W/C. R89 attempted to stand multiple times, appeared worried when standing, then immediately sat back down.
- From 8:30 a.m. until 9:40 a.m. R89 remained at the breakfast meal. NA-V was observed to provide R89 her breakfast, set up the breakfast and sit directly next to R89 and assist her to eat. At no time were W/C brakes unlocked. R89 was observed to stand repeatedly throughout the meal, pushing back slightly with her legs as she stood. The W/C was flush to the top of the table, preventing R89 from leaving the table.

The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a W/C and had "N/A [non-applicable]" written by hand in the section. Review of the clinical record lacked evidence R89 was assessed for restraints.

R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 221}	Continued From page 10	{F 221}		

use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint.

The Care Area Assessment (CAA) for activities of daily living (ADLs) Function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA.

The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease.

The clinical record lacked evidence R89 had been assessed for restraint use, including locked W/C brakes and having the W/C pushed flush to the table.

R89's care plan dated as last reviewed on 3/28/14, identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 221}	Continued From page 11	{F 221}		

did not include direction to place R89 against a desk or table. The care plan was updated on 4/30/14, to include, "Anti-roll back brakes installed onto wheelchair to prohibit wheelchair from rolling backwards when resident offloads independently. Least restrictive safety device while in wheelchair."

On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E stated R89 "was not restrained" and stated "anti-rollback brakes were placed on the wheelchair." LPN-E stated R89's W/C was "looked at by therapies" and therapies had assessed R89 for the use of the anti-rollbacks on the W/C. LPN-E was unclear whether the locking of R89's W/C brakes had been assessed as a form of restraint.
- At 9:28 a.m. LPN-E stated the therapy department had only made a "recommendation" and since R89 was not on the therapy case load, they "didn't document the evaluation." LPN stated direct care staff had been "educated" not to lock R89's brakes or restrain her against a desk or table. LPN-E verified if R89 was directly supervised by a staff person, the W/C brakes should not have been locked.

On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of anti-rollbacks and the use of potential restraints, such as having both brakes locked and the W/C pushed flush to a table. DON repeatedly stated he thought "physical therapy assessed the use of the anti-rollbacks" but was unclear if R89 was assessed for restraints. DON verified therapy assessments should have been documented in R89's clinical record.

On 5/12/14, at 12:28 p.m. the physical therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 221}	Continued From page 12	{F 221}		

assistant and rehab manager (PTA), occupational therapist (OT), and physical therapist (PT) were interviewed together in the therapy gym. All denied having assessed R89 for the use of the anti-rollbacks, W/C brake locking, or restraints. PTA stated the anti-rollbacks had been an idea that had been "brought up" in the morning meeting as "a way to keep her [R89] safe without locking the brakes." The OT stated therapy staff had "helped maintenance order the device," and stated since maintenance had not seen the device before, therapy staff had assisted him to "apply it." The PT stated no therapy staff had actually assessed R89 because there was no "physician's order" and because R89 "was not on case load." All therapists verified they would not "assess" a resident without a physician's order and stated they were unclear when they should "get involved." All verified they were employees of Videll Healthcare Limited Liability Company (LLC), but then stated, "The facility doesn't have polices to let us know our responsibilities."

On 5/12/14, at 12:23 p.m. R89 was observed to be in her W/C at the lunch meal. NA-V was observed seated directly to the left of R89. NA-V was interacting with R89 before the meal. R89 was observed to have the W/C pushed up flush against the table and both W/C brakes were observed to be locked which caused R89 to be restrained. The left anti-rollback arm was observed to be twisted off R89's left W/C tire (rendering the anti-rollback ineffective). The surveyor alerted NA-V to the anti-rollback being ineffective.
- At 12:26 p.m. R89 was observed to be provided her meal. NA-V setup the meal and remained with R89. R89 was observed to remain in the dining room throughout the meal with the brakes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 221}	Continued From page 13 locked. NA-V sat next to R89 until approximately 1:20 p.m. NA-V then unlocked both brakes and wheeled R89 away from the table and into the activity room on the South unit. On 5/13/14, at 9:03 a.m. LPN-E verified R89 should not have been restrained at the table while supervised during the meal. The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lap buddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking a resident's W/C brakes, seating a resident up against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DON or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each shift and released according to physician's orders. The policy did not address the release of restraint devices, such as releasing the restraint every two hours, during supervised activities, or while the resident was supervised at a meal.	{F 221}		
{F 223} SS=D	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	{F 223}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 14	{F 223}		

The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse from another resident (R36).

Findings include:

On 5/6/14, at 9:49 a.m., 5/6/14, at 11:32 a.m., 5/6/14, at 2:48 p.m., 5/7/14, at 1:40 p.m., 5/8/14, at 9:29 a.m., 5/8/14, at 2:08 p.m., 5/10/14, at 12:45 a.m. R34 and R36 were both observed on the smoking patio.

The annual Minimum Data Set (MDS) dated 4/1/14, for R34 included a Brief Interview of Mental Status (BIMS) score of nine which indicated moderate cognitive impairment and a Patient Health Questionnaire (PHQ-9) score of five which indicated mild depression. The MDS indicated R34 did not have delusions or hallucinations.

The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/3/14, lacked a summary regarding R34's cognitive status.

A Vulnerable Adult Assessment date 3/18/14, indicated R36 was verbally abusive and condescending towards others.

A Vulnerable Adult Assessment dated 4/4/13, indicated R34 had behaviors which made her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 15	{F 223}		

susceptible to abuse by others.

A Social Service Note dated 4/17/14, indicated R34 had reported on 4/15/14, R36 was verbally abusive towards her. The note indicated when R36 was interviewed on 4/16/14, he stated he calls R34 "a parasite every time I see her because that is what she is." The note indicated R36 was told calling other residents names was verbal abuse and verbal abuse was not tolerated.

A Progress Notes dated 4/17/14, indicated the contracted licensed social worker (CLSW) met with R34 on 4/16/14, and R34 indicated R36 "calls her every name in the book, he is just mean."

A Progress Notes dated 4/17/14, indicated social services met with R36 and R36 stated he was going to "do what he wants" and would continue to call R34 a parasite. R36 was informed calling R34 names was verbal abuse and R36 responded "I don't care."

The Admission Record dated 4/28/14, indicated R34 was admitted to the facility on 3/28/13, with diagnoses which included dementia and depressive disorder.

A copy of an Incident/Accident Report dated 5/5/14, was provided on 5/8/14. The Incident/Accident Report indicated R34 had reported R36 had pushed her into a patio chair and R34 had become stuck when the patio chair fell over. It was noted the incident had occurred on 5/4/14, at night with no exact time. R36 was noted to have denied the incident; the police were called and spoke with R34. On 5/7/14, at 3:10 p.m. a copy of the facility investigation was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 16	{F 223}		

requested. The Incident/Accident Report lacked any additional investigation into the incident.

A Progress Note dated 5/9/14, indicated R34 reported she did not like R36 because "he is an old drunk." The note indicated R34 had agreed to stay away from R36 and that R34 had stated she was used to handling old drunks, and had showed staff an old scar she reported was from when her late husband broke her leg.

When interviewed on 5/7/14, at 2:41 p.m. R34 stated R36 called her names "all the time." When asked how being called names made her feel, R34 stated she had filed a police report because R36 had "assaulted her" two nights ago. When asked what she meant by assaulted, R34 stated R36 waited until nobody was around and then pushed her. R34 reported the director of operations helped her file a police report. Review of the medical records for R34 and R36, lacked documentation regarding the incident which was allegedly reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

When interviewed on 5/7/14, at 3:10 p.m. the director of operations reported he was aware of the incident which had occurred during the evening of 5/5/14, and confirmed he'd helped R34 call the police. During the interview, the administrator stated he was aware of the incident and that it had been reported to him on 5/6/14. The administrator reported R34 and R36 "spar all the time."

Upon interview on 5/8/14, at 11:36 a.m. the director of nursing (DON) reported he had received the Incident/Accident Report on 5/8/14.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 17	{F 223}		

The DON stated he was not sure whether the incident was reportable because it had occurred on 5/5/14, and it was a "resident to resident altercation."

The director of operations was interviewed on 5/12/14, at 9:20 a.m. and stated R34 was very upset about the incident from 5/5/14, and had wanted the police called because it was not the first time, and that R34 had felt assaulted and wanted to press charges.

Upon interview on 5/12/14, at 9:24 a.m. the administrator stated the incident on 5/5/14, had been reported to the state agency and that he would provide documentation regarding the report made.

R34 was interviewed on 5/12/14, at 1:31 p.m., R34 stated R36 was abusive to her every day but that she'd heard he had gotten sent to another nursing home. R34 stated she felt what R36 was doing to her was both verbal and physical abuse.

When interviewed on 5/12/14, at 1:52 p.m. the administrator and consultant administrator reported R34 and R36 have had an ongoing fight going on. The administrator stated R34 and R36 allege physical things and then change their stories. The consultant administrator stated that although the police had been called regarding the incident on 5/5/14, R36 had denied it happened and R34 had no visible injuries noted. The administrator stated when allegations of abuse are made, an incident report was to be filled out and a supervisor consulted to determine whether a report was needed. The administrator said the residents would be separated, an assessment would be made, the incident would be reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 18	{F 223}		

the Common Entry Point (CEP) if appropriate, would be presented at their stand-up meeting the next day, and an investigation would be started. The administrator stated incidents were reported to the administrator, DON or CLSW but verified, "that system has not always been working." The administrator stated the incident form 5/5/14, had not been reported to the State Agency (SA) or to the CEP and acknowledged things needed to be reported right away and then investigated.

Minneapolis Police Department officer (MPD)-E was interviewed on 5/12/14, at 3:38 p.m. and confirmed the police department had come to the facility regarding the incident between R34 and R36 on 5/5/14. MPD-E stated the facility was aware the residents called each other names and stated it was a facility problem.

The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated May 2012, indicated staff must not permit "anyone" to engage in verbal or physical abuse. The policy indicated the facility would implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. The definition of verbal abuse was described in the policy as, "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." The policy indicated the facility would protect residents from harm during the investigation and would "report allegations to the state survey and certification agency and any other state agencies pursuant to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 223}	Continued From page 19 state regulations."	{F 223}		
F 224 SS=J	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. The IJ began on 5/10/14, when R37 was admitted to the hospital following the use of illicit drugs while in the facility and was identified on 5/12/14. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ at 3:15 p.m. on 5/12/14. The immediate jeopardy was not removed by the exit date of the survey. Findings include:	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 20	F 224		

On 5/9/14, the facility had been informed of serious and immediate safety of the residents related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present.

R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. According to documented progress notes, R37 had been found with ETOH/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14 and 5/10/14. The record also indicated R37 had required hospitalizations related to the use of alcohol and or drugs on 2/22/14, 4/23/14, and 5/10/14.

During observations of R37 the following was observed:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was "crazy".
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 21	F 224		

without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and speak to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left rear pant pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. Nursing assistant (NA)-L approached R37 and stated she was with him today. NA-L verified she was assigned to provide the 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken out of the facility to an ambulance.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 22	F 224		

for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, R37 removed the WanderGuard (departure alert system) and refused a new one to be placed.
- On 5/3/14, R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limousine and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a notation had been made indicating it was a late entry for 5/5/14, at 6:00 p.m., the note indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 23	F 224		

scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on one to one (1:1) [to be within arm's length at all times] observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 24	F 224		

his credit card to R117 on 5/9/14. A second note indicated R37 returned from leave of absence (LOA) accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's Orders and Nurse Practitioners (NP) Orders were reviewed and the following was noted:
- On 1/8/14, included a diagnosis of ETOH abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's ETOH, to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 25	F 224		

encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered.
- On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain, and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 26	F 224		

appointments without supervision but was not safe to go on other unsupervised LOAs.
- The depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending Alcoholics Anonymous (AA) or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA.
- A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the WanderGuard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH use, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 27	F 224		

to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusal noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated the resident had received a first offense of the facility's smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 had obtained the ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money for ETOH, and stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 28	F 224		

has heard about exchanges but could not remember who he'd heard about it from.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. The HUC said R37 had told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14, or 5/6/14, she had observed R37 in the parking lot, and had been told there was nothing they could do about it by the facility administrator. She said she'd requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested that the safety monitor put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of ETOH withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 29	F 224		

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 had refused to go to the bank with R37 and that friend-A had signed R37 out. The DON said the consultant administrator had been going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH and three plastic containers with the labels removed, which nursing indicated were methadone containers, had been found in R37's room.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on LOA and that R37 had returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 30	F 224		

stated the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 having left on LOA, she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and that she'd told friend-A that R37 could not go there. CLSW-A said friend-A had reassured her he had been sober for ten years and would never take R37 to a liquor store. The CLSW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and had informed her that friend-A was R1's drug dealer. CLSW-A stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing did not find the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 31	F 224		

R129 was identified by the facility to have a history of drug seeking and ETOH dependency. Although the facility had determined R129 required a 1:1 staff member since at least 3/18/14, according to a Vulnerable Adult (VA) assessment, the appropriate supervision was not implemented and/or effective.

According to review of the progress notes in R129's record, on 5/3/14, R129 had reported to the facility that she had obtained and consumed cocaine. The documentation indicated R129 had a staff assigned as a 1:1 at the time of the incident.
An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she had taken and indicated R129 then "confessed" to having taken cocaine. The report documentation indicated R129 had been sent to the emergency room (ER) and included, "She said, 'I knowingly took cocaine'.. Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1...remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others."

A North Memorial Medical Center (NMMC) Emergency Department (ER/ED) note dated 5/3/14, identified R129 had reported she'd taken cocaine at the nursing home. The ER note indicated R129 had taken the cocaine to "help with the pain" in her abdomen. "Patient [R129] is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 32	F 224		

triaged directly back to ED." The Clinician History of Present Illness section of the form identified R129 had reported to hospital staff she had snorted cocaine "5 hours ago."
On 5/11/14, at 4:00 a.m. the progress notes indicated R129 had obtained and consumed a life threatening amount of ETOH, causing her to require hospitalization in an intensive care unit (ICU) with subsequent intubation (mechanical ventilator assisted breathing) as a result of a blood ETOH level of 0.323. (According to Minnesota Statute 169A.20, 0.08 is considered impaired for driving). A 1:1 staff was supposed to have been in place at the time of the incident.

The resident's record included a note documented by the facility's HUC on 5/11/14, at 10:09 a.m. which indicated NMMC had called the facility "requesting" R129's medication administration records (MARs). The note indicated the registered nurse (RN) from the hospital had notified the HUC that R129 had been admitted to the ICU, and had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of 0.323."

The record also included a note documented by the director of nursing (DON) on 5/11/14, at 10:55 a.m. The DON's note recapitulated R129 had been sent to the hospital, identified the time of transport as "around 4 a.m." on the night shift, and identified R129 had been sent in "for intoxication." The DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the nursing assistant (NA) staff assigned to the 1:1 was called. The note indicated the NA assigned to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 33	F 224		

R129 "reported that resident has been in and out of [R14's room number] but that she had not noticed any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident [R129] is visiting." In addition, the DON's documentation indicated R14 had denied giving or knowing how R129 had obtained the ETOH, and documented R14 had "mentioned that resident had alcohol overnight."

An additional progress note, dated 5/11/14, at 2:49 p.m. had been written by the DON indicating NMMC had been contacted to request updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."

Additional record review revealed an admission MDS dated 2/1/14, that indicated R129 had a BIMS score of 15, indicating R129 was cognitively intact. The MDS identified R129 was independent with all ADLs. The MDS identified R129 rejected cares and wandered one to three days during the assessment period. R129's comprehensive assessment analysis (CAA) for mood state dated 2/7/14, identified R129 as having intact cognition, with poor decision making and as having diagnoses of "substance induced psychotic disorder, opiate dependence, and ETOH dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug ETOH use" and depression. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAA lacked documentation of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 34	F 224		

interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment.

A Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had behaviors including a history of rummaging through others' belongings and "drug use." The assessment indicated R129 had been placed on 1:1 due to rummaging in other resident rooms.

R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and required a "1:1" which was spelled out in large

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 224	Continued From page 35	F 224		

bold print.

On 5/12/14, at 10:26 a.m. DON was interviewed about R129 having obtained ETOH and/or drugs while on a 1:1. The DON verified the 1:1 should have been within arm's length of R129 at all times. The DON denied having any knowledge of how R129 had obtained ETOH.

On 5/13/14, at 2:21 p.m. the administrator stated during interview that the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and ETOH use.

On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 224	Continued From page 36	F 224		

Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.

The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed:

"If staff have reasonable suspicion that a resident has used, has in their possession, or has distributed to other residents in the facility ETOH, street drugs, or other pharmacological substances not prescribed by treating physician the facility staff, under the direction of administration, shall:

· Search the residents room and remove such substances
· Notify the physician and obtain an order for blood and urine drug testing
· Notify the family and/or responsible party of the event

If the tests return positive the resident with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 37	F 224		

positive results will be immediately discharged for placing the resident population at risk for abuse. If ETOH, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified."

The facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The policy also included "Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision." Appendix A of the policy included examples of neglect including: "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision) which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety."

According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 38	F 224		

which had been implemented to prevent the resident's elopement.

Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance."

A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 39	F 224		

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 40	F 224		

the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 41 On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or	F 224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 224	Continued From page 42	F 224		

designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed. The ombudsman stated she wanted to be sure the state agency surveyors were aware that resident's of the facility were purchasing ETOH and drugs. The ombudsman reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff were finding ETOH bottles. In addition the ombudsman reported R37 had been found intoxicated several times and she was involved in discussing abuse prevention planning and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. The ombudsman stated the police had been notified and had been to the facility "quite often". She also stated she was aware R129 was on a 1:1 and had somehow obtained and consumed an "illegal drug [cocaine]" in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 224	Continued From page 43 On 5/7/14, at 10:05 a.m. the administrator verified during interview that the ombudsman had been called 5/6/14, to speak with the facility regarding R37 having given his credit card to R117 to purchase ETOH because R37 had been "drunk for days." The IJ that began on 5/10/14, was not removed at the time of the exit from the survey because the facility failed to have developed and/or revised policies related to obtaining a drug and alcohol free facility; residents with a WanderGuard system or who had been identifed as at risk for elopement had not been re-assessed; facility elopement policies had not been reviewed or revised; no efforts had been established to ensure all staff were aware of how to supervise, care for or protect the residents. In addition, adminsitration had not yet convened an interdisciplinary team meeting to discuss and determine how to effectively monitor resident safety and care needs, and how to prevent any future occurrence of such serious and immediate concerns.	F 224		
{F 225} SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 225}	Continued From page 44 or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Findings include:	{F 225}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 45	{F 225}		

R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 46	{F 225}		

also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH).

R116 had eloped and the facility did not report to the administrator or SA in a timely manner.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 47	{F 225}		

R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 48	{F 225}		

Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care.

On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 225}	Continued From page 49	{F 225}		

Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m.

R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated.

R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 50	{F 225}		

obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 225}	Continued From page 51	{F 225}		

receptionist on the sidewalk."

The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 225}	Continued From page 52	{F 225}		

R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified.

On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified.

On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 225}	Continued From page 53 ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."	{F 225}		
{F 226}	483.13(c) DEVELOP/IMPLMENT	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 226} SS=E	Continued From page 54 ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their Prohibiliton of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Propery policies for immediate reporting and thorough investigation were implemented for 8 of 9 residents (R37, R66, R70, R14, R41, R13, R129, R116) reviewed with allegations of such; the facility also failed to screen new employees for reference checks, back ground studies and license/certification verification for 6 of 6 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q, NA-W). Findings include: The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment,	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 226}	Continued From page 55	{F 226}		

or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency (SA) and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."

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{F 226}	Continued From page 56	{F 226}		

R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH).

R129: An Incident/Accident Report dated 5/3/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 226}	Continued From page 57	{F 226}		

at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 226}	Continued From page 58	{F 226}		

interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him until then.

A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk."

The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

On 5/9/14, at 1:43 p.m. LPN-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the form did not identify when the administrator or SA was notified.

On 5/12/14, at 10:26 a.m. director of nursing (DON) stated he was not in the facility at the time of R13's elopement and had not been informed until 5/8/14. The DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 59	{F 226}		

unescorted and stated residents with a WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. The DON also verified the incident had not been thoroughly investigated.

R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated.

R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 226}	Continued From page 60	{F 226}		

indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 226}	Continued From page 61 R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified. On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified. R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.	{F 226}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 226}	Continued From page 62	{F 226}		

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 226}	Continued From page 63	{F 226}		

notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care.

On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 226}	Continued From page 64	{F 226}		

On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified.

EMPLOYEE SCREENING:
On 5/12/14, at 10:00 a.m. the employee files were reviewed and the following was observed:

Licensure verification:
Licensed practical nurse (LPN)-A's employee file folder lacked verification of the LPN's license. The administrator verified at 12:45 p.m. there had been no proof of nursing licensure obtained for LPN-A from the Minnesota Board of Nursing.

Registered nurse (RN)-C's employee personnel file indicated RN-c had been hired on 4/8/14, and that a back ground study request had been submitted on 4/8/14, however there were no results yet. In addition, no licensure verification completed, only a copy of a license with expiration of 10/4/13.

Background study:
RN-D's file indicated RN-D had been hired 4/16/14, and that a background Study Request had been submitted on 4/14/14. However, the background study incorrectly indicated NA-U's background study information.

Nursing assistant (NA)-U's file was reviewed and was found to include a statement that NA-U had a Minnesota Department of Human Services Background Study (MN DHS BS) form dated 5/25/14, which indicated NA-U "cannot provide

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 226}	Continued From page 65	{F 226}		

Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The administrator verified that NA-U could not provide care but had been providing care unsupervised, from 4/23/14, through 5/12/14.

NA-U had RN-D's BS in NA-U's employee file. Also, RN-D's BS was in NA-U's employee folder. RN-D's BS indicated that RN-D could not perform cares unsupervised. However, during the survey the administrator obtained the blue BS form which indicated RN-D could perform cares unsupervised.

NA-Q was hired on 3/6/14. The facility received a yellow MN DHS BS on 3/10/14, which indicated NA-Q "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The white BS computer genreated copy request indicated the form was submitted on 3/6/14, and passed as of 3/10/14, however the employee file lacked the information as the facility provided the information during survey. The facility did not have system in place to ensure BS were being monitored for the employees ability to work unsupervised.

Reference checks:
RN-C was hired on 4/8/14, and no reference checks had been completed.

RN-D was hired 4/16/14, and no reference checks, could be located in the employee file.

LPN-A's file lacked a hire date and no reference checks were completed as the facility policy had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 226}	Continued From page 66 directed staff to complete. NA-W hired 4/23/14, had no reference check completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge of doing license verifications and background checks for new employees. The administrator further stated the HR person had been terminated two weeks ago and no one else had been designated to follow-up on background checks that had been flagged. The administrator acknowledged the facility had not ensured tracking for new employees' license verification and background checks. On 5/13/14, at 8:10 a.m. NA-U verified during interview that she was a NA and had started orientation on 4/23/14. When asked if she worked under supervision, NA-U stated she had received "a couple of days training" and had started working on her own on 4/28/14. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, but stated she had been working full time on her own since 4/16/14.	{F 226}		
{F 250} SS=H	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 250}	Continued From page 67	{F 250}		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) for alleged substance abuse, and for 2 of 11 residents (R13, R103) who allegedly eloped from the facility.

Findings include:

Alleged substance abuse:
On 5/8/14, at 8:02 a.m. a list of residents allegedly bringing drugs and alcohol (ETOH) into the facility, as well as a list of residents known to use drugs or alcohol in the facility was requested. A list provided by the administrator at 11:00 a.m. included R129, R86, R41, R37, R14, R56, R117, R62 and R9 as alleged substance users.

R129 was not provided consistent medically related social services to address ongoing drug seeking behaviors and sustained harm. Although R129 was assigned a one to one (1:1) as of 3/14, the clinical record lacked evidence of social service assessment and interventions. On 5/3/14, R129 reported to facility staff, that she had obtained and consumed cocaine while under 1:1 supervision. On 5/11/14, at 4:00 a.m. R129 had obtained and consumed ETOH while supervised 1:1 by facility staff. This resulted in harm when R129 required hospitalization in an intensive care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 68	{F 250}		

unit (ICU) where she was intubated (mechanical ventilator assisted breathing) for a blood ETOH level of 0.323.

R129's admission Minimum Data Set (MDS) dated 2/1/14, revealed a Brief Interview of Mental Status (BIMS--a tool to determine cognitive status) score of 15, indicating the resident was cognitively intact. In addition, it was noted R129 was independent with all activities of daily living (ADLs), rejected cares, and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R129 displayed poor judgment, and had impaired cognition and poor decision making skills. The CAA identified diagnoses including "substance induced psychotic disorder, opiate dependence, and alcohol dependence," as well as hepatitis C, "Hx [history] of drug alcohol use" and depression. Although the history of drug and ETOH dependence was identified, the CAAs lacked documentation of interventions to promote sobriety, such as but not limited to offering chemical dependency (CD) treatment.

The Vulnerable Adult Assessment (VAA) dated 3/18/14, identified R129 had a history of ETOH abuse and "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse related to substance use and required supervision with leaves of absence (LOAs) from the facility. It was noted R129 had a history of rummaging through others belongings and "drug use," and 1:1 staffing was initiated due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, directed staff to "monitor for ETOH use or over

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 69	{F 250}		

sedation."

A Pain Evaluation and Management Plan dated 5/1/14, identified R129 had daily chronic pain, and a history of pain and seeking drugs. "Resident is on a restricted recipient program [where only one pharmacy may fill narcotic prescriptions to deter drug seeking behavior] due to drug seeking...MD [medical doctor] is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." R129 was described as "very sweaty, weak and tired...she looked very sleepy," and pupils were "large and nonreactive to light." When the nurse asked the resident what she'd taken, she "confessed" to taking cocaine. The report noted, "She said, 'I knowingly took cocaine'...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The resident's history of drug use and receipt of drugs from others was noted, as well as the fact that the resident had current 1:1 staffing. Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14.

An Emergency Department Chart [from the hospital ER] dated 5/3/14, identified R129 reported to have taken cocaine while residing at the facility to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 70	{F 250}		

Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "'5 hours ago.'" Although R129 was identified as requiring the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use, only pain. The laboratory (lab) reports indicated various pertinent lab values were checked, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of Dilaudid (narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the designated State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug had been obtained while the resident had 1:1 staff supervision.

A unlabeled typed page insert in the front of R129's paper chart dated 4/15/14, read "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program...All scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their on call MD."

On 5/7/14, at 10:24 a.m. the a return call was made to the ombudsman who had requested contact. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she visited the facility on 5/6/14, and spoke with various residents as well

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 71	{F 250}		

as management staff regarding drug, alcohol and discharge planning concerns. The ombudsman, facility staff, and residents were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [cigarettes, alcohol and drugs] for them." The ombudsman stated the police had been notified and responded "quite often." Allegedly residents who were chemically dependent were drinking in their rooms and facility staff were conducting room checks each shift and "finding empty alcohol [vodka] bottles" in resident rooms, and residents had been found "intoxicated." The ombudsman specifically reported R129 had 1:1 staffing, yet had "somehow" obtained and consumed an illegal drug (cocaine). Although the facility had employed "three temporary social workers, social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified the resident was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated 4/11/14, directed staff to provide "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru [sic] their personal belongings."

Review of the undated Group 7 nursing assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 72 (NA) assignment sheet (for quick reference guide providing care-related direction) indicated R129 was independent with ADLs and "1:1" was noted in larger bold print. Pertinent Nursing Progress Notes read as follows: 1) On 3/14/14, at 6:18 p.m. R129 "had an appointment yesterday and was immediately transferred to the hospital...while on the way home [unclear on prior destination] stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams (mg) (a narcotic and Tylenol pain medication)...failed to alert staff and stated that there were no new orders." The hospital, on call MD and triage nurse were updated on R129's "history of narcotic use." 2) On 3/16/14, at 6:34 a.m. R129 was "caught going through another resident's belonging...opening her purse." The note indicated R129 admitted going in the room but denied taking "any money." 3) On 3/17/14, at 3:34 p.m. "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the record lacked documentation when the 1:1 staffing was initiated. At 10:17 p.m. "called on call [physician]," reported two incontinent episodes, "lower extremities [sic] hurts" and edema (abnormal build up of fluid in the tissues). Was encouraged to "sit and rest the leg" but refused and reported the pain was "unbearable." R129 wanted to be evaluated at the hospital, and "called 911 herself." Although a previous note indicated R129 required 1:1 staffing, it was noted R129 planned to "take care of her own transportation to ER...left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 73	{F 250}		

4) On 3/18/14, at 3:56 a.m. R129 returned from the ER at 3:30 a.m. with a "New order. No new concern at this time." At 2:31 a.m. R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.

5) On 3/20/14, at 10:08 a.m. the physician R129 identified as her new primary care physician (PCP) was contacted to inform the provider R129 lived in a health care facility, and orders needed to be coordinated with the facility. The PCP was provided an update regarding R129 changing her PCP, trips to the ER and drug seeking behavior. The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "Went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (hypnotic used to promote sleep). "Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. Patient will be monitored for increased sedation." Although the previous note indicated the transportation company was directed not to make any stops during transport, R129 had been brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription had been written and a report the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 74	{F 250}		

script was lost had been reported by R129. The physician denied taking R129 on as a patient, however, and referred the facility to R129's current PCP.

6) On 3/28/14, at 11:52 a.m. R129 met with social services and "Also spoke with resident regarding her drug seeking. [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."

7) On 4/4/14, at 7:11 p.m. R129 met with psychologist, as well as the DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's...informed her she was on 1:1's because of her frequent drug seeking...admits that she has urges to seek medications to manager her pain...denies addiction." Inpatient treatment was discussed such as drug and emotional counseling, which R129 rejected. The note indicated the psychologist agreed with the need for treatment, "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."

8) On 4/7/14, at 10:47 a.m. R129 remained, but requested she be removed from 1:1 supervision, which was noted as required "for going into other resident rooms."

9) On 5/4/14 12:03 a.m. R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [R1's room number]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 75	{F 250}		

to to the ER for evaluation. "The nurse requested for toxicology screen and a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129's involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified,and toxicology screening was obtained. Although R129 had an assigned 1:1, the record lacked evidence as to how the resident obtained and ingested the drugs, the incident was not immediately reported to the administrator and SA, nor was it investigated. In addition, the record lacked evidence R129 had received a CD evaluation or were immediate changes made in the monitoring and supervision provided for the resident's safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice...remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.

10) On 5/4/13, at 12:12 p.m. an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they were only accepting on-call emergencies. Staff would notify doctor the morning of 5/5/14. The resident returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, she immediately requested pain medication upon return to the facility (the note was not closed or signed by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 76	{F 250}		

writer).

On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room. The door was open and R129 was dressed and was lying in bed with her eyes closed. NA-K reported she was assigned as a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

The following day at 8:30 a.m. NA-M (1:1 staff) followed R129 down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length and looking in the opposite direction from R129 and talked with another staff person in the smoking area. R129 stood with other residents and smoked out of direct sight of NA-M. At 8:33 a.m. R129 sat on a bench with another resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same staff person. NA-M was not near enough to R129 to intervene should there have been a concern. At 8:37 a.m. staff spoke to each other and then NA-M turned his back on all smokers (including R129) and spoke to a male who was in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the staff directly. NA-M was not within arm's length or direct eye sight of R129. At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 77	{F 250}		

directly behind her into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway. At 9:34 a.m. R129 pushed R62 in her wheelchair out of the facility and onto the smoking patio. R62 held out a cigarette for R129 ask she pushed the chair, and R129 concealed the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129. At 9:35 a.m. a staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents who were unsupervised. At 9:37 a.m. R117 came out of the facility, lit a cigarette at the front entrance, jumped up onto the cinder landscape block planter with ease, and walked across the top of the planters with a skipping gait. Neither the smoking monitor nor another female staff in the area intervened. R117 was observed to speak briefly with the female smoking monitor, approached R36, pulled out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter. NA-M was not within arms reach nor eyesight of R129, and was not supervising the resident. NA-M remained with the other female staff, with his back to R129. At 9:40 a.m. R129 stood and pushed R62's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 78	{F 250}		

wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 pushed the wheelchair down the hallway with NA-M walking beside R129. At 10:19 a.m. R120 walked out to the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retrieved a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14. At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make eye contact with R129 and was not in arms reach as he spoke with the smoking monitor. At 10:25 a.m. NA-M and R129 went inside with NA-M walking within arms reach of the resident.

On 5/8/14, at 11:22 a.m. R129 was observed lying in bed, NA-E was making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, which she had reported to facility staff. When asked when this occurred, R129 stated it was "on Saturday" (5/3/14)." When asked where she snorted the the cocaine, R129 replied, "not in the facility...down the block." When asked if she received the cocaine from another resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 79	{F 250}		

the person's name, description, or gender. R129 said she snorted "about $20 worth." When asked what happened then R129 stated, "They sent me to the hospital...They accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day by the 1:1 assigned to her that day. R129 stated the 1:1's name (NA-G) who was to be with her at all times. She said the reason for the 1:1 was because she was accused of "rummaging" in other residents rooms. R129 reported she had a 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 said she was "a recovering addict," but denied social services had been provided by facility staff, including assistance to obtain CD treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the ER, but was given two shots of Dilaudid. R129 explained she "thought" that was going to happen, yet admitted she was "surprised" to have received the narcotic pain medication. Although R129 was relaxed during the interview, she was hesitant to answer some questions and did not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified the responsibility of the 1:1 staff was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated was unaware of alcohol or drugs were being exchanged on "my shift," but stated was aware of situation "weeks ago" when she came to work and noticed R14 was not in his room. NA stated she asked where

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 80	{F 250}		

he was and a NA "who was [R129's] 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated had not witnessed any exchanges and stated if she had she would have reported it to the nurse.

On 5/8/14, at 11:40 a.m. NA-S reported seeing alcohol bottles in residents' rooms and smelled alcohol on a resident and reported it to a nurse, but was unclear when it had occurred. NA-S "heard rumor" of a resident dealing drugs in the facility, and recalled seeing a resident with marijuana in January or February, and "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she overheard residents talk about it. NA-S believed R117 was a drug dealer, as the resident left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was from an "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. housekeeper (H)-A when asked, reported she had seen "empty pint bottles" of vodka in the trash by the front doors. The last time had been, "a few months ago," and she had reported any bottles she found. " H-A was unsure which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew how the bottles had been obtained, she was unsure, but thought they may have been brought in by family members.

On 5/8/14, at 12:03 p.m. LPN-H stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 81	{F 250}		

confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, as well, but it was unclear how it was being provided. LPN-H verified R129 was on 1:1 which meant within arms reach. LPN-H was unaware R129 had obtained cocaine in the facility.

On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. The HUC stated there was "always hearsay between residents...their selling [drugs and alcohol] to each other...it's always stories," including hearsay stories regarding heroin and cocaine. The HUC had put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program, and R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." R129 "refuses to tell" about the prescriptions, and the HUC went to the social worker to report these concerns. R129 denied having pills, "but I know she did get them...every week" R129 was finding a new doctor, and not providing the correct paperwork, or altering paperwork. The HUC was aware residents consumed alcohol in the facility, and some became intoxicated, however, it was unclear how they had obtained it. "I feel like we're supposed to do something, 'cuz no one will take charge." The HUC was aware R129 obtained cocaine and was sent to the ER, but was unsure if a toxicology screen had been done, although she had asked for them in the past. The HUC said she and other staff believed R129's (making quotation gestures) "son" was R129's dealer, and described him as a man she referred to as her son, who was at the facility at the time the resident snorted the cocaine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 82	{F 250}		

Further review of the nursing progress notes also revealed indicated the following:
1) On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (narcotic pain medication) refills and determined 110 Percocet tablets had been delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
2) On 5/11/14, at 10:09 a.m. a note written by the HUC indicated North Memorial Medical Center (NMMC) called "requesting" R129's Medication Administration Records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 had been able to obtain and ingest a life threatening amount of alcohol. Although the administrator was updated, the clinical record lacked evidence the SA was also immediately notified of the incident. The record lacked documentation at the time of the incident, as well as pertinent assessment information such as vital signs and symptom descriptions. In addition, the record lacked evidence of an immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time.
2) On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." R129 had "become weak" and needed to be lowered to the floor." Two LPNs were contacted and the NA staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 83	{F 250}		

assigned to the 1:1 was called. The NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting...." R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained the alcohol.

3) On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."

4) On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait." R129 was identified at risk for falling, was verbally aggressive to staff and stated, "'I'm drunk.'" The room was checked and no evidence of alcohol was found. R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening that was "reducing her hours to once a week." Both verified they had not specifically

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 84	{F 250}		

worked with R129 regarding CD treatment and verified was last offered to R129 on 4/4/14 and had not revisited CD treatment options after R129 reported cocaine use on 5/3/14. Neither was aware R129 had been hospitalized for alcohol toxicity and said they "should have been notified." CLSW-A and B had not worked the previous few days, as facility had not paid the contracted company's bill. CLSW-B expressed concern for the residents, and said R129 should have been reassessed after she had obtained and used cocaine, and both SWs felt R129 had been harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R86 was committed as mentally ill and chemically dependent per Hennepin County Commitment papers dated 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. R86 was placed at harm as R86 was hospitalized due to alleged substance abuse. On 3/16/13, R86 was admitted to the facility per the Admission Record. Diagnoses include hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 85	{F 250}		

thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness.
A care conference dated 1/2/13 [sic -2014], lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.
A progress note dated 2/22/14, at 11:00 p.m. "Pt was found smoking 'pot' in his room. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."
A progress note dated 2/23/14, at 10:33 a.m., "Resident left with family member in a VAN for unknown destination at this time, hoping to return today. We will follow up with resident safe returned."
A progress note dated 2/23/14, at 10:23 p.m., "Resident returned from visiting with a family. The nurse checked resident. No injury observed."
A progress note dated 2/24/14, at 4:38 a.m., "Resident had been very confused and having difficulty to settled [sic] down in bed. judgment [sic] has been non-intact [sic] and appeared restless with a lot of tremor. He attested to this writer that when he goes LOA he smokes marijuana but never drink alcohol at all. He state [sic] "If I drink I will die". His platelet has been dangerously lower [sic] thus posing him at a risk for bleeding. Update on call doctor about resident change in condition, who then mandate this writer to send resident to the emergency room for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. " The resident was admitted to the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 86	{F 250}		

A progress note dated on 2/24/14, at 3:32 p.m., " Writer called PCP and updated on his current use of marijuana, as well as updating that he is in the hospital."
A progress note on 2/27/14, at 3:59 p.m."Nurse from U OF M,updated writer about resident current status, stating that, resident is alert and oriented x 3, appear to be quiet stable, but a little restless" and that R86 will "arrive at 1445 at facility, will pass this info to p.m. nurse."
A progress note dated 3/4/14, at 6:11 a.m., "While executing initial nursing rounds this shift, this writer smell [sic] and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staffs [sic] that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinue. He had flexeral [sic- Flexeril (cyclobenzaprine) is a muscle relaxant used to treat skeletal muscle conditions] with some benefit noted. He want [sic] another sleeping pills [sic] at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg [milligrams] of Trazodone [an antidepressant], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment."
A progress note dated 3/15/14, at 09:48 a.m., "[R86] having behaviors which are not in line his norms. Behaviors like going into other resident's room and sitting on their bed, coming in the hallway half naked. Patient at time have uncontrolled coughing as well."
A progress note dated 3/15/14, at 10:22 a.m., "Resident left the facility this morning around 10:20 am for the Fairview ER [emergency room].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 87	{F 250}		

He was escorted by two paramedics and admitted to the hospital."
A progress note dated 3/17/14; at 8:21 p.m. R86 came back from hospital at 3:45 p.m.., "Resident is alert and oriented. A progress note dated 5/10/14 at 10:04 p.m. R86 did not sign out when leaving facility. Writer called resident. Resident states he will be back by 11 p.m.."
A progress note on 5/11/14, at 6:30 p.m., "Writer not able to assess and talk to resident in relation to his h/o [sic history of] chemical dependency due to resident being LOA at this time. Writer will approach at a later time."
A progress note dated 5/19/14, at 1:37 a.m. indicated: at about 11:00 p.m. " Res noted with increased confusion, coughing constantly, and emesis X 2 [two times]. Cough meds admin per HSO [house standing orders] with no relief. Refused VS [vital signs]. Call placed to on-call MD at 12:10 a.m. Returned call from [MD ' s name] with an order to send resident to UMFH for eval [evaluation]. MPD [Minneapolis Police Department] non-emergency called at 12: 30 a.m. to request for transportation. "
A progress note dated 5/21/14, at 5:05 p.m., "Resident readmitted to facility from Fairview Medical Center. LOA safety assessment completed. Resident assessed to be appropriate to leave the facility unsupervised without medications and supervised with medications except narcotics due to history of chemical abuse. MD faxed for LOA orders and clarification of all other admitting orders. Resident is able to make needs known and removed himself from unsafe situations. Able to verbalize steps to take should a situation arise while out in the community. Able to verbalize LOA policy. Risk of drug/alcohol assessment/re-assessment completed. Resident is at risk for drug/alcohol

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 88	{F 250}		

abuse. Has a dx of depression and ETOH abuse. Was recently discharged from the hospital. Has had no room or other significant changes in routine since return to the facility. Medication side effects remain on MAR. Offered and resident refused social service visits, spiritual counseling, in house psych, outside psych, and AA/NA. Bio-psychosocial assessment of drug and alcohol use in the facility completed. Resident denies any drug/alcohol use and reports using only his prescribed medications. Declined all resources offered. Repeatedly said throughout interview, 'If I drink it will kill me.' Smoking assessment completed, resident denies any tobacco use. Risk of elopement/wandering assessment completed. Resident is not at risk for elopement/wandering. Has no history of elopement/wandering. Is alert and oriented x 3. Able to make needs known. Uses call light appropriately. Katherine Leslie, responsible party, called and updated on assessments and residents readmission to facility at 1635. Care plan updated to reflect assessments."

A vulnerable adult assessment dated 3/18/14, noted "past and recent chemical abuse. Fluctuating cognitive deficits related to liver damage, chemical use. Needs supervised LOA due to fluctuating cognition and chemical use."

A smoking assessment dated 3/18/14, indicated "reports of smoking marijuana outside, and recent drug use reported by resident."

A LOA safety assessment dated 3/18/14, indicated "mental illness, fluctuating cognition related to liver disease. Needs supervised LOA due to fluctuating cognition and chemical use. (Lacked mention of committed to the facility related to substance abuse and mental illness."

An annual MDS dated 3/22/14, had a "BIMS score of 15/15. R86 required setup for dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 89	{F 250}		

and meals and was independent with all other cares."
On 4/13/14, a care conference indicated: "long term placement waiting for liver transplant. Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past."
The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse.

The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse.

Per CLSW-B, "tried to build report with him. He had been given 30 day notice for Marijuana in his room, but it was not a proper notice and he had not been given another." R86 planned to stay in the facility until he received a liver transplant. CLSW-A stated, "I thought people would not be eligible for a liver transplant if they were actively doing drugs."

R86's The medical record lacked evidence of psychiatric or supportive treatment for chemical/substance abuse. R86 was committed to prevent exposure to alcohol and chemical substances of abuse. The facility lacked coordination of care between departments and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 90	{F 250}		

lacked review of facilities own progress notes, which verified substance abuse, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided.

R41:
The facility failed to provide supervision to prevent ingestion of alcoholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m., 5/9 at 3:00 p.m., 5/10 at 2:30 p.m., 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m. On 5/11/14, at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 91	{F 250}		

Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 92	{F 250}		

was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 93	{F 250}		

resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as alcoholics anonymous (AA) or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.

The medical record lacked evidence that social service intervention had been put into place since his last MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression was identified at 7 out 15. The Care Area Assessments indicated he would be seeing the house psychologist and R41 had not been seen by the house psychologist. The medical record also lacks any staff intervention for providing information for his drinking such as like AA and referral to any place for help. Therefore, he was still drinking for depression and left the facility unsupervised. R41 remains at harm.

The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 94	{F 250}		

Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. #. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate admissions if required.
R37's Progress Notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism.

Observations of R37 revealed the following:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the HUC and in a loud voice stated he was crazy.
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 95	{F 250}		

gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 was intoxicated, when he was friendly and chatting.

The Nutritional Status CAAs dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 96	{F 250}		

following was noted:
- On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed.
- On 5/3/14, indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait.
- On 5/5/14, at 10:25 p.m. indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, which indicated it was a late entry for 5/5/14, at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 97	{F 250}		

found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to alcohol withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 98	{F 250}		

positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's Orders and NP Orders were reviewed and the following was noted:
- On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered.
- On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 mg orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 99	{F 250}		

- On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week. The interventions included; encourage attending AA or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 100 other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37's alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA. The quarterly MDS dated 3/18/14, indicated	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 101	{F 250}		

R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 102	{F 250}		

the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. LPN-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN-B stated she did not know where R37 got alcohol from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:19 p.m. the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 103	{F 250}		

administrator was approached after several staff reported they had not been informed of the immediate jeopardy (IJ) that was called on 5/9/14, at 2:02 p.m. The consultant administrator stated she wanted the administrator to indicate why staff was not informed of the IJ and asked "are we in trouble?" The administrator approached and stated, yesterday when the IJ was called, by the time we were done with a meeting with our boss, the nurse managers had gone for the day. The administrator stated he thought they would come up with a plan and would have an all staff meeting 5/10/14, to inform staff of the IJ. The administrator further stated a meeting was scheduled at 1:45 p.m. and verified staff had not been informed of the IJ.

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes).

On 5/12/14, at 8:59 a.m. RN-B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and friend-A signed R37 out. The consultant administrator was going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 104	{F 250}		

reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. CLSW-A stated during a room search a quart bottle of alcohol had been found in R37's room and three plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A and had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and the DON had not told him about the order for no LOA and friend-A's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and R37 could not go there. Friend-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 105	{F 250}		

reassured her he had been sober for ten years and would never take R37 to a liquor store. The SW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and friend-A was R1's drug dealer. She stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping alcohol under the edge of his mattress and she could not understand why nursing did not find the alcohol when they made the bed. R37 remained at harm as he did not receive the requested services to assist him with the self-reported drug/ETOH abuse.

R14 was not provided medically-related social services to address known illegal drug use in the facility as recently as 5/3/14.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knee amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others one to three days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA was all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. The CAAs did not identify any history of drug use.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 106	{F 250}		

R14's Vulnerable Adult care plan dated as revised on 4/26/14, defied R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility.

A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a NA reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician was notified and R14 was sent to the ER for evaluation.

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified R14 had the lab for "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, but not limited to: immediate notification of the administrator and SA, thorough investigation of the incident to determine potential source(s) R14 may obtained the illegal drug from, notification of law enforcement, follow up assessment of R14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 107	{F 250}		

safety, evaluation of R14's access to leave the facility, such as to smoke; documentation of how they would prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically-related social services.

On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "epileptic." R14 denied awareness of illegal drug and alcohol activity in the facility. When asked what R14 would do if she observed illegal drug or alcohol activity in the facility, R14 stated he would "tell the resident not to do it," but would not notify staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!"
On 5/12/14, at 10:26 a.m. the DON was interviewed, verified had not read the plan of correction and did not know what the plan was. DON verified he was not aware of changes made and reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. Stated he read the survey results from 2013 and stated he was not given an accurate picture of the facility problems. Verified there was no system for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 108	{F 250}		

screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up.

R56 had conflicting advanced directives dated 4/21/14 and 4/26/14, in her record.

Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live.

A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband.

A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of intravenous (IV)/intramuscularly (IM) antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56.

The annual MDS dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 250}	Continued From page 109	{F 250}		

(cognitively intact).

Review of the facility care plan dated 4/23/14, indicated R56 was DNR/do not intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice.

Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE."

A Physician's Order dated 4/18/14, directed ok for hospice to evaluate and treat and ok for in-house psych to see.

A nurse practitioner progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition.

A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST.

A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56 about her POLST. R56 reported to CLSW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. CLSW-B indicated she placed the correct POLST information in the advanced directives section of the medical record.

A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 110 On 5/13/14, at 8:41 a.m. a review of the Physician's Orders signed 4/9/14 continued to direct "Full Code." On 5/7/14, at 9:31 a.m. RN-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. LPN-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. CLSW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care.	{F 250}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 111	{F 250}		

On 5/7/14, at 12:14 p.m. the HUC verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14.

When interviewed on 5/7/14, at 12:26 p.m. NA-D stated he does not know what hospice does for R56, he sees them come in but that's it.

Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14 with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment.

When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14 and verified his expectations were R56 was DNR and comfort care only.

On 5/12/14, at 1:50 p.m. CLSW-B stated she had followed up with hospice and the intent is for R56 to be DNR and CLSW-B would make sure that was in place.

RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the Physician's Orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency.

The facility Social Services/Social Work policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 112	{F 250}		

(undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided.

R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents.

R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression.

The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility.

R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 113	{F 250}		

aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called."

The progress notes were reviewed and noted:
- On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator."
- On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 250}	Continued From page 114	{F 250}		

facility."
- On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware."
- On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time."
- On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 115	{F 250}		

- On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident."
- On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding."
- On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning."
- On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 116	{F 250}		

materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks."

- On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen."

- On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated.

- On 5/2/14, at 2:00 p.m. a progress note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 117	{F 250}		

indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes."
- On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 118	{F 250}		

meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "
- On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a DM did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.
- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 119	{F 250}		

1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).
- On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on."
- On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility."
- On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
- On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
- On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 120	{F 250}		

unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic."
- On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office."
- On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital."
- On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 121	{F 250}		

a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating."
- On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and CHF condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen.
- On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 122	{F 250}		

knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" resident stated "yes." Police and EMT then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 123	{F 250}		

PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time."
- On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified."
- On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information."
- On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 124	{F 250}		

substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present."
- On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road.
- On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called."

On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed.

When interviewed on 5/12/14, at 2:43 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 250}	Continued From page 125	{F 250}		

CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

R62 had documented drug use on the facility grounds without any social service interventions developed to address substance abuse.

R62 was admitted on 8/31/13, with diagnoses that included memory loss, dementia and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 126	{F 250}		

cerebrovascular accident (CVA). Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident.

Review of the most recent Social Services Quarterly review dated 2/25/14, indicated no changes to the LOA Safety, Vulnerable Adult and Smoking Assessment.

Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport.

R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes.

Review of R62's Progress Notes revealed the following:
-On 1/24/14, at 5:03 p.m. indicated "a resident approached writer alerting us that another resident is sitting out front smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 127	{F 250}		

consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any."
- On 1/24/14, at 5:17 p.m. indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor."

During an interview on 5/13/14, at 10:18 a.m. the DM stated, "I did what the 1/24/14, progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember."

During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were un-aware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14, identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month." CLSW-B stated she has been at the facility since 3/19/14, a day after the Vulnerable Adult Assessment had been completed.

During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 verified she was smoking 'weed' and told them she did not have anymore. RN-B stated they did not search R62's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 128	{F 250}		

room for drugs and "I would assume that administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 was offered chemical dependency assistance.

No social service interventions had been developed for R62 for assistance for services associated with substance abuse even though it had been identified and verified by the facility.

R9 had been identified as "Known pot smoker" but was not provided medically-related social services to address known illegal drug use at the facility.

On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke.
-At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area.
At 10:14 a.m. R9 lit another cigarette leaned very

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 129	{F 250}		

far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.
-At 10:19 a.m. R9 returned back to the building.

R9's significant MDS dated 3/24/14, identified R9's diagnoses included Schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease (COPD). The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with ADL's. The nutritional status CAA dated 3/25/14, had identified R9 had history of tobacco abuse. R9's Vulnerable Adult care plan revised 10/20/11, identified R9 was a vulnerable adult related to cognitive limitations and physical limitations. The care plan goal indicated R9 would "remain safe within Camden Care Center at all times." The care plan identified R9 required supervision for LOA's from the facility. The care plan lacked to indicate R9 was a "Known pot smoker"

A Vulnerable Adult assessment dated 3/18/14, indicated R9 had history of aggression to others, had mental illness/poor judgment, had no history of chemical abuse and "Cannot leave the facility unsupervised." The assessment did not indicate R9 was a "Known pot smoker."

When asked on 5/13/14, at 8:36 a.m. regarding smoking "Pot" R9 stated "It's a deem lie that am using any pot" and kept repeating same statement to the surveyor.
Social Service Notes were reviewed which revealed:
-Social Service Note dated 4/23/14, indicated R9 had gone to social worker (SW) requesting to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 130	{F 250}		

her tobacco materials that had been taken from her roommate side back and had indicated they were hers. SW's reported to R9 the materials taken from the room were not on her side of the room and was informed her family was encouraged to come and get the plastic bag of smoking things as well as the cigarette roller "since her roommate would no longer be able to do this for her." Note indicated social service would follow as deemed necessary.
-Social service Note dated 4/30/14, per request of director of maintenance both social workers accompanied him to R9's room. Neither R9 nor her roommate was in the room. "Per regulations, the bottle of "Shout" was removed from the room." R9 was outside the room and the director of maintenance had reported to R9 the bottle of "Shout" was taken. R9 was upset and turned her w/c away from staff and the bottle of "Shout" along with R9's raw tobacco & other materials (for the tobacco to be rolled) were placed in the Administrators office so it was more convenient for the family to pick up when they visit. Note indicated social service would follow as deemed necessary.
When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 131	{F 250}		

issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up.

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found in roommates side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family was very upset on the staff removing the roller out of room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Known pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not gotten the list of residents who had been thought to have substance abuse issues. Additionally both stated the facility lacked consistent documentation of incidents, interventions, communication and follow up.

Elopements:
R13 eloped from the facility on 5/6/14, after staff allowed the resident to transport to and from the designated smoking area without staff. R13 was not provided with medically-related social services to address her elopement risk and smoking.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

On 5/6/14, at 8:30 a.m. R13 was observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 132	{F 250}		

wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly 30+ miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 133	{F 250}		

notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, R13 was identified to require supervised LOAs only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 134	{F 250}		

from the facility and thus wears a wanderguard [sic-departure alert system] to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs.

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 135	{F 250}		

goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard [sic] in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/9/14, at 11:00 a.m. R13 was observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 136	{F 250}		

wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building.

On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and dietary manager (DM) were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or State agency (SA) would be notified. When asked if and when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 137	{F 250}		

the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if this occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement. RN-C provided a copy of a corresponding nursing progress note dated 5/8/14

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

R103 was admitted to the facility on 7/29/13, per the Admission Record with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

A progress note on 1/5/14, at 5:30 a.m. "Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 138	{F 250}		

is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility."

An MDS quarterly assessment dated 1/31/14, indicated R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

Physician's Orders dated 4/16/14, indicated R103 may have a LOA unsupervised with medications.

A progress Note dated 4/20/14, at 9:48 p.m. read, "Pt went on LOA." The chart lacked documentation of return to the facility. The medical record was reviewed on 5/11/14, and lacked documentation of LOA or discharge. The facility could not locate the Patient Sign In/Sign Out log sheet for that date.

On 5/10/14, at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA.

On 5/11/14, at 10:00 a.m. facility staff were asked whether the resident had been discharged, was on LOA, or had returned to the facility. The HUC checked to see and resident was in room. He had signed out on the Resident Sign Out sheet on 5/10/14, and R103 had signed in on the Resident Sign Out sheet on 5//11/14, at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 250}	Continued From page 139 On 5/11/14, at 10:10 a.m. RN-A was interviewed and was unaware R103 had left the building for ten and a half hours. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had any documented notes for R103, but knew he had been working with a relocation worker. They verified R103 had not received any social service interventions for planning for discharge. The Videll Healthcare Limited Liability Company (LLC) Elopement policy dated as effective 5/2012, identified, "Videll Healthcare LLC facilities shall provide a safe environment for resident who are assessed at risk for elopement." The policy defined elopement as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure directed if exit seeking behavior was identified to immediately implement interventions to "manage exit seeking behaviors" such as applying "personal security devices such as WanderGuard..." The procedure to directed staff to complete a "thorough" investigation of the event, document a factual account of the occurrence in the medical record and to update/complete an elopement risk evaluation. Although the policy included pertinent direction for searching if a resident eloped, the policy did not address risks such as smoking and access to the designated smoking area.	{F 250}		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive	F 274		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 274	Continued From page 140	F 274		

assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 residents (R56, R116) who had sustained a decline in functional status; and for 1 of 3 residents (R103) who had experienced a significant improvement in activities of daily living (ADLs).

Findings include:

R56's record was reviewed. A SCSA minimum data set (MDS) assessment was initiated with an assessment reference date (ARD) of 4/26/14, and when reviewed on 5/7/14, at 9:00 a.m. the MDS was noted as in progress with an expected completion date of 5/12/14, twenty-two days after the change in status had been identified.

When interviewed on 5/7/14, at 10:40 a.m. registered nurse (RN)-C stated the SCSA MDS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 274	Continued From page 141	F 274		

was scheduled to be completed on 5/12/14, and the care plan would be completed seven days later on 5/19/14.

When interviewed on 5/13/14, at 9:53 a.m. RN-C stated she had never done MDSs before and had only received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident.

A MDS policy was requested and was not received.
R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression.

The admission MDS dated 1/26/14, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which showed no cognitive deficit, and a Patient Health Questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. According to the admission MDS, R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene.

On 4/15/14, at 10:49 p.m. a nursing Progress Note indicated, "Pt is declining. He is very weak and needs a lot of assistance." The quarterly MDS dated 4/24/14, depicted R116 as needing assist of one person for bed mobility, ambulation in and out of room, dressing toilet use and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 274	Continued From page 142	F 274		

hygiene. R116 had also deteriorated and required supervision for eating and transfers.

On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that "a significant change MDS should have been done when it had been determined his condition declined in two areas of functional status." Although the resident had declined in bed mobility, transfers, toileting, dressing, ambulation and personal hygiene, no significant change MDS had been conducted. The quarterly MDS (ready to export, but not exported) did show the extensive assist that R116 now required but interim MDS coordinator verified "it should have been a significant change MDS."

R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

The progress note dated 1/5/14, at 5:30 a.m. indicated R103 was oriented X 3, able to communicate needs and wants. In addition, the notes indicated R103 was independent with movement and bed mobility, and currently utilized a Foley catheter.

An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter was in use. R103 was assessed as independent in all functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 274	Continued From page 143 activities of daily living. Although R103 had improved in more than two functional areas, no significant change MDS had been completed as a result of the improved status. According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident 's condition is not expected to return to baseline within two weeks."	F 274		
{F 275} SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 3 residents (R36) who required an annual comprehensive assessment. Findings include: The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12.	{F 275}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 275}	Continued From page 144 On 5/13/14, at 9:52 a.m. the electronic record (Point Click Care) was reviewed and revealed R36 had an admission Minimum Data Set (MDS) completed on 5/29/13. The Quarterly MDS's were completed on 8/29/13, 11/21/13, and 2/18/14. A fourth quarterly MDS had been initiated with an assessment reference date of 5/14/14. An annual comprehensive MDS was not initiated as required. When interviewed on 5/13/14, at 9:53 a.m. registered nurse (RN)-C verified she had initiated a quarterly MDS instead of the required annual MDS and confirmed that an annual MDS should have been implemented. RN-C stated she had never done MDSs before and received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS scheduling and completion policy was requested and was not received.	{F 275}		
{F 280} SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs,	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 280}	Continued From page 145 and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter use for 1 of 3 residents (R36); for 1 of 1 resident (R116) who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who had substance abuse issues. Findings include: Review of R36 ' s quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 did not have a Foley catheter in use. Review of the care plan for R36 dated 3/18/14, identified a focus topic; " alteration in elimination". The care plan further indicated R36 had a temporary indwelling Foley catheter in place due to diuretic use. Interventions listed; change R36 catheter as needed per Physician ' s Orders and to irrigate the catheter as needed. When interviewing R36 on 5/7/14, at 7:41 a.m. he stated he did not have a catheter and used the toilet independently. During interview on 5/7/14, at 1:45 p.m. with	{F 280}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 280}	Continued From page 146	{F 280}		

registered nurse (RN)-A, she confirmed R36 did not have an indwelling Foley catheter.

During interview on 5/13/14, at 11:41 a.m. with RN-B, she indicated R36 previously had an indwelling Foley catheter but no longer used one. RN-B confirmed the care plan should have been updated to reflect R36's current status.

A care plan policy was requested and was not provided.

R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression.

R116 was receiving hospice care since 1/21/14, the resident was independent in self-cares, transfers, and mobility.

The admission MDS dated 1/26/14, identified a brief interview for mental status (BIMS) score of 15/15, which showed no cognitive deficit, and a patient health questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. The MDS further indicated R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene.

Review of the quarterly MDS dated 4/24/14, indicated R116 as requiring 1assistance with bed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 280}	Continued From page 147	{F 280}		

mobility, ambulation in and out of room, dressing, toileting and hygiene. The MDS further indicated R116 required supervision for eating and transfers.

Review of the progress notes for R116 on 4/15/14, at 10:49 p.m. indicated R116 condition was declining and requiring more assistance with ADL's.
Review of R116 ' s care plan with a revision date of 5/2/14, indicated, "Cognition intact and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis." The care plan had not been revised to depict the changes in ADLs.

On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that R116 care plan was not current to reflect R116 decline in health status that required assistance with ADL's updated with the needed assistance with ADLs.

R62 was admitted to the facility on 8/31/13, with diagnoses that included; memory loss, dementia and cerebrovascular accident (CVA) per the Admission Record. Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, verified that she had smoked marijuana, denied having more marijuana and verbalized understanding regarding discharge if she continued this behavior. Review of the most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the residents health status

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 280}	Continued From page 148 Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 as having "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 required supervised LOA (leave of absence) except for appointments with scheduled transport. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, R62 denied she was smoking marijuana Review of R62's care plan with a revision date of 4/26/14, identified R62 having a history of being in an abusive relationship, and as having impaired cognitive function/dementia. Interventions included "approach resident in a calm manner, assess and report any change in mood/behavior and provide the resident with resources as needed. R62 has been assessed and may not leave the facility without supervision." The care plan had never been revised to include R62's known alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment dated 3/18/14, and documented in the nursing progress notes on 1/24/14. During an interview with the facility contracted licensed social worker (CLSW)-A and CLSW-B confirmed the plan of care had not been revised to reflect R62's substance abuse.	{F 280}		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	{F 282}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 149	{F 282}		

accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to ensure the care plan was followed and target behaviors were monitored for the use of Zyprexa (olanzapine-an antipsychotic medication) for 1 of 1 resident (R89), and failed to ensure smoking interventions were followed in accordance with the care plan for 4 of 4 residents who smoked (R36, R1, R9, R22), and failed to ensure the care plan was followed for 1 of 3 residents (R9) who required dental services.

Findings include:

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 as having a physician order for Zyprexa (an antidepressant) related to "potential injury to self or others, dementia, agitation and pick [sic] disease." The care plan directed the staff to administer the medication as ordered, monitor/document for side effects and effectiveness of the medication. The care plan further directed the staff to "discuss with MD [physician], family regarding ongoing use of the medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of target behaviors such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 150	{F 282}		

the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

Review of the clinical record indicated R89 was not monitored for target behaviors.

Review of the Consultant Pharmacist Recommendations dated 4/17/14, identified olanzapine (Zyprexa) 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist (CP) review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call.

Observations of R36 on 5/6/14, at 11:32 a.m. the resident was observed retrieving a cigarette from the inside of his coat and lit it with a lighter from his right pocket. The smoking monitor personal was directed away from the resident and approximately 20 feet away.

Observations of R36 on 5/7/14, at 7:07 a.m. the resident was observed smoking a cigarette without a smoking apron on. The smoking monitor personal was approximately ten feet away from the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 151	{F 282}		

Observations of R36 on 5/7/14, at 7:41 a.m. the resident was observed to have multiple burn holes in his gloves.

Observation of R36 on 5/7/14, at 8:18 a.m. the resident obtained a cigarette from inside his coat and a lighter from his right pocket and lit the cigarette. R36 did not have a smoking apron on. The smoking monitor personal did not offer R36 a smoking apron.

Observations of R36 on 5/7/14, at 9:21 a.m. the resident was observed smoking without a smoking apron on and the smoking monitor personal was approximately 20 feet from R36 and was focused on the street and not the resident.

Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed in his room with a pack of eight cigarettes in his shirt.

Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed smoking without a smoking apron. The smoking monitor personal was approximately 15 feet from R36.

Observations of R36 on 5/7/14, at 3:15 p.m. the resident was observed smoking without a smoking apron and the smoking monitor personal was not within arm's reach.

Observations of R36 on 5/8/14, at 9:29 a.m. the resident was observed smoking a cigarette; the smoking monitor personal offered a smoking apron to R36 but the resident refused. The staff did not encourage the resident to wear.

Observations of R36 on 5/8/14, at 2:08 p.m. the resident was observed smoking without a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 152	{F 282}		

smoking apron on. The smoking monitor personal was approximately 15 feet away and was looking in the opposite direction.

Observations of R36 on 5/9/14, at 7:15 a.m. the resident was approached by facility staff to wear a smoking apron. R36 stated he wouldn't wear one after what happened yesterday. R36 stated when staff put a "bib" on R34, R34 took it off and threw it on the ground. R36 stated if she (R34) did not have to wear one, he did not either. R36 wheeled to the smoking patio and smoked a cigarette without an apron on.

Observations of R36 on 5/12/14, at 11:38 a.m. the resident wheeled by the smoking monitor personal and lit a cigarette and smoked without an apron on. The smoking monitor personal did not offer R36 a smoking apron.

Review of R36 ' s care plan dated 6/14/13, identified R36 as having impaired cognitive function/dementia, alteration in decision making, and/or impaired thought processes. The care plan further indicated R36 required supervision when smoking, and that the resident was to smoke only in designated areas utilizing adaptive equipment apron for safety.

An undated list of facility smokers indicated R36 was a supervised smoker and indicated staff keeps smoking material with directions to wear a smoking apron and stay within arm's reach.

When interviewed on 5/7/14, at 7:33 a.m. nursing assistant (NA)-B stated she offers to lock the cigarettes in the facility locked box for residents who are unsafe to keep them on their person. NA-B stated if a resident refuses to follow the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 153	{F 282}		

smoking rules, such as refusing to turn in their smoking materials, refusing to wear aprons, or smoking in non-smoking areas, she makes a note in the smoking monitor log.

R1 was observed on 5/5/14, and consecutive days 5/6/14, 5/7/14 and 5/8/14, smoking without wearing an apron, keeping her smoking material's on her and not smoking in the facility designated areas.

When interviewed on 5/8/14, at 10:03 a.m. NA-E stated R1 had a pack of cigarettes and a lighter when she got off the transportation van. NA-E stated "She is very stubborn".

When interviewed on 5/8/14, at 11:32 a.m. R1 indicated she had left to the appointment with five cigarettes and her lighter because it was going to be a long time without smoking and when she returned to the facility she had handed the cigarettes back to the smoking monitor.

Review of R1's smoking evaluation dated 3/17/14, identified R1 as having a history of unsafe smoking practices when heavily medicated and or tired and falls asleep while smoking. R1 cannot safely utilize lighter/matches and cannot safely handle lit smoking materials and was a supervised smoker.
The smoking care plan dated 3/12/14, identified R1 was a smoker. The goals were "Will follow all guidelines regarding smoking at Camden Care Center and will remain safe while smoking." The care plan directed R1 will smoke only in designated smoking areas, was a supervised smoker and had refused Cigarettes and lighter to be kept at nursing station for safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 154	{F 282}		

When interviewed on 5/9/14, at 1:59 p.m. the director of nursing (DON) stated R1 had been educated about leaving her smoking materials in the cart and had been asked to take the cigarettes one at a time. The DON confirmed the plan of care had not been followed.

On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to a covered ash tray. During observation NA-B noticed R9 smoking and covered her with a smoking apron at that time.

Observation at 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.

On 5/6/14, at 2:45 p.m. when interviewing R9, surveyor observed a cigarette box in each of her socks. When R9 was asked why she was storing the cigarettes in her socks she stated "You can leave now, go now".

The smoking care plan dated 10/20/11, identified R9 as a smoker. Goal "R9 will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker.

When interviewed on 5/6/14, at 3:06 p.m. the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 155	{F 282}		

DON verified R9 was a supervised smoker which meant she should relinquish her cigarette and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. .

When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified R9 did not have cigarettes in the facility locked box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box.

Observation on 5/6/14 at 8:05 a.m., staff was observed assisting R22 to the smoking area, applied a smoking apron and placed a blanket around his shoulders. Staff remained near but not within an arms-length as R22 held a handful of Kleenex while smoking.

Observation on 5/7/14, at 9:27 a.m. R22 was observed outside in the designated smoking area sitting in his w/c next to the building pillar. R22 was holding a cigarette on the right hand and the other hand holding a the self-extinguishing ash tray. R22 was not wearing a smoking apron and had a blanket across his lap. R22 dropped his cigarette on to his shirt/blanket, was able to pick it up himself. The smoke monitor personal was not at arms-length and did not observe this happen. NA-B was standing approximately six feet away from the resident. At 9:31 a.m. R22 continued to smoke with no smoking apron, he dropped his cigarette for the second time on to his lap and was able to pick it up himself. NA-B was observed standing by the smoking cart approximately 5 feet away from the resident and was not at arms-length to quickly assist the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282}	Continued From page 156	{F 282}		

Review of R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "(R22) will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was wear smoking apron while smoking. Staff to intervene is resident displays unsafe smoking behaviors or refuses safety interventions, and R22 was a supervised smoker.

Review of R22's Smoking Evaluation dated 4/22/14, indicated R22 had a history of smoking in inappropriate places, burn holes in his clothing , was a supervised smoker and smoking materials were secured by staff.

When interviewed on 5/7/14, at 9:33 a.m. NA-B stated she had not witnessed R22 drop his cigarette at 9:27 a.m. and again at 9:31 a.m. even though she was standing near the smoking cart and designated to monitor resident during smoking.

When interviewed on 5/9/14, at 1:59 p.m. the DON confirmed the plan of care had not been implemented related to R22 smoking privileges and safety.

Review of the annual Minimum Data Set (MDS) dated 10/11/13, did not identify R9 dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene.

R9's care plan reviewed 4/9/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 282}	Continued From page 157 teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." R9 had diagnoses which included Schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and 12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful." On 5/6/14, at 2:45 p.m. R9 was observed to have missing teeth during an interview in her room. On 5/7/14, at 3:28 p.m. LPN-A was interviewed and stated "I went thru the progress notes and I don't see anything that addresses the dental exam. " During an interview on 5/7/14, at 3:30 p.m. household unit coordinator (HUC) stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this."	{F 282}		
{F 309} SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in	{F 309}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 309}	Continued From page 158	{F 309}		

accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Findings include:

R56's annual Minimum Data Set (MDS) dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact).

A physician's order dated 4/18/14, gave approval for hospice to evaluate and treat and for in-house psychiatry services to be provided.

A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated 4/21/14, was signed by R56's husband.

Review of the facility care plan dated 4/23/14, indicated R56 was DNR/Do Not Intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice.

A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 309}	Continued From page 159	{F 309}		

Conditions and included interventions and treatments of IV/IM antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56.

A nurse practitioner (NP) progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition.

Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live.

Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE."

A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST.

A Progress Note dated 5/12/14, indicated contracted licensed social worker (CLSW)-B spoke with R56 about her POLST. R56 reported to SW-B she wanted to be DNR/comfort cares and that was also what her husband wanted. SW-B indicated she placed the correct POLST information in the advanced directives section of the medical record.

A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 309}	Continued From page 160	{F 309}		

On 5/13/14, at 8:41 a.m. a review of the physician's orders signed 4/9/14, continued to direct "Full Code."

On 5/7/14, at 9:31 a.m. registered nurse (RN)-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR.

When interviewed on 5/7/14, at 10:43 a.m. licensed practical nurse (LPN)-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer.

On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband.

Upon interview on 5/7/14, at 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband.

When interviewed on 5/7/14, at 12:04 p.m. CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. SW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 309}	Continued From page 161	{F 309}		

On 5/7/14, at 12:14 p.m. the health unit coordinator (HUC) verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14.

When interviewed on 5/7/14, at 12:26 p.m. nursing assistant (NA)-D stated he does not know what hospice does for R56, he sees them come in but that's it.

Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14, with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment.

When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14, and verified his expectations were R56 was DNR and comfort care only.

On 5/12/14, at 1:50 p.m. SW-B stated she had followed up with hospice and the intent is for R56 to be DNR and SW-B would make sure that was in place.

RN-B was interviewed on 5/13/14, at 11:41 a.m. and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the physician's orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 309}	Continued From page 162 On 5/13/14, at 1:50 p.m. RN-B provided a copy of the POLST signed by the hospice physician and stated the NP was aware of the code status because she had given orders for hospice. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided.	{F 309}		
{F 314} SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers at the time of admission to the facility. Findings include: R123's Hospital Nursing Progress Note dated 4/11/14, indicated R123 had three pressure ulcers which were connected to continuous wound vacuum (vac) suction and the dressings	{F 314}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 314}	Continued From page 163	{F 314}		

were intact. The pressure ulcers locations and stages were not identified.

R123 was admitted to the facility on 4/18/14, and deceased on 4/21/14. R123's diagnoses included: spastic paralysis due to multiple sclerosis (MS), pressure ulcers, physical deconditioning, generalized weakness, abnormal pain, diabetes, cerebral palsy, and weakness of both legs obtained from the Discharge Orders and Plan dated 4/18/14.

Admission Nursing Assessment dated 4/18/14, indicated a full skin assessment had been completed and a right hip pressure ulcer area with measurements 6.5 centimeters (cm) length (L) x 3 cm width (W) x 2.2 cm depth (D) and 2.5 cm tunnel at 6 o'clock position, right buttock with measurements 4.6 cm (L) x 2.0 cm (W) X 0.0 cm (D) cm and right heel area measured 1.2 cm (L) x 1.0 cm (W) x 2.0 cm (D) had all been identified. The form did not indicate if the areas were pressure related nor were the areas staged.

Progress Notes dated 4/18/14, indicated a full skin assessment had been completed with measurements as noted on the Admission Nursing Assessment dated 4/18/14. On the right hip area a wet to dry dressing had been removed and wound bed consisted of moist yellow, pink, red tissue with moderate amount of yellow, red odorless drainage were observed and the surrounding wound tissue had no redness, warmth, or tenderness noted and wound vac dressing had been applied. On the right buttock foam dressing had been removed from with wound bed consisting of dry pink and red tissue, no drainage, no redness, warmth, or tenderness noted to the tissue surrounding the wound and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 314}	Continued From page 164	{F 314}		

non-adherent dressing applied. On right heel foam dressing had been removed ulcer observed with wound bed consisting of moist red and yellow tissue with scabbing, large amount of odorless drainage noted, no redness or warmth noted to the tissue surrounding the wound and non-adherent dressing was applied. The Progress Note did not also indicate if the areas neither were pressure related nor were the areas staged.

A Physician's Order dated 4/18/14, directed staff to "Apply non-adherent dressings to right ischial tuberosity wound and right heel until needed supplies are received."

The facility Initial/Temporary Care Plan dated 4/18/14, identified R123 had pressure areas marked and indicated with wound vac. However, the medical record lacked evidence of any other interventions being put into place to prevent and/or minimize potential further skin breakdown such as turning and repositioning, wound care, and pressure relieving mattress.

During document review it was revealed a Braden Scale-For Predicting Pressure Sore Risk dated 4/21/14, indicated R123 had a score of 11 which indicated R123 was at high risk and the Comprehensive Evaluation of Skin Risk Factors dated 4/21/14, identified the risk factors but lacked immediate interventions to minimize further potential skin breakdown.

R123's admission Minimum Data Set (MDS) dated 4/21/14, indicated R123 required limited to extensive assist of one to two with activities of daily living (ADL's) including bed mobility and transfers; had impairment on one side on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 314}	Continued From page 165	{F 314}		

lower extremity with limited range of motion (ROM) and had one Stage 1 (a Stage I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching) and two Stage 2 pressure ulcers (a Stage 2 is partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS noted R123 was not on a turning and repositioning schedule and did not have wound care treatments that were completed in the last seven days.

When interviewed on 5/12/14, at 9:58 a.m. registered nurse (RN)-C MDS coordinator verified the temporary care plan had been developed but there without interventions to minimize further potential skin breakdown. RN-C further indicated "I believe there should have been more interventions listed than just the wound vac as resident had already pressure ulcers."

On 5/13/14, director of nursing was unavailable for interview.

The facility policy entitled Skin Integrity Management, dated 5/12, directed director of nursing services (DNS) or designee and the interdisciplinary team (IDT) were responsible to ensure the development and implementation of a comprehensive plan of care including prevention and wound treatments as indicated. The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 314}	Continued From page 166 issues, maintain function and improve quality of life.	{F 314}		
{F 319} SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate treatment/services were offered for 1 of 1 newly admitted resident (R41) who had expressed difficulty with adjustment related to chemical dependency. Findings include: R41 was admitted to the facility on 2/4/14, according to the Admission Record from another long term care facility. The Admission Record indicated R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily functional problems). The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15 which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which	{F 319}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 319}	Continued From page 167	{F 319}		

indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

A LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 319}	Continued From page 168	{F 319}		

use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 had become intoxicated while off the facility property on a LOA. Upon his return to the facility, R41 had driven his electric w/c off the curb of the driveway to the facility. R41 had been found lying on the pavement on his right side and his speech was slurred, but R41 remained alert and oriented. The notes indicated, "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 911 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, documentation in the record indicated R41 had been readmitted to the facility from the hospital at 1:43 p.m. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. progress note documentation indicated facility staff had met with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 319}	Continued From page 169	{F 319}		

the resident to discuss the incident that occurred on 5/1/14, the facility had obtained an order for a supervised LOA. According to the progress note, R41 had stated he was drinking because he was depressed. The only new intervention was that the facility placed a WanderGuard on R41's wheelchair (w/c).

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk as the facility staff continued to silence the alarm at the front desk and let him out of the facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention to help with adjustment at the facility had been offered, even though staff were aware the resident had depression and had acknowledged he continued to drink related to depression. No referrals had been made to meet the resident's needs such as referral to alcoholics anonymous (AA), or referral to any other counseling services to help or support R41.

The medical record lacked evidence that interventions had been developed or initiated since R41's MDS dated 2/10/14 was completed. The MDS depicted R41 as having depression, scoring a 7 out 15 on the depression scale.

The Temporary Social Work Contract dated 3/15/14, indicated services provided included: 1. Conduct and document psychosocial assessments. 2. Complete the MDS, care plan and any other required paperwork. 3. Participate in care conferences. 4. Facilitate discharge planning. 5. Communicate with resident families as needed during the course of providing stoical services and discharge planning. 6. Facilitate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 319}	Continued From page 170 admissions if required.	{F 319}		
{F 323} SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in an Immediate Jeopardy (IJ) for these four residents. A second IJ component was identified for 2 of 3 vulnerable residents at risk for elopement (R13, R116), due to the facility's failure to ensure adequate supervision and protection to prevent elopement from the facility. In addition to the resident(s) identified in the IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113) and failed to ensure 3 of 3 residents (R1, R36, R22) who smoked cigarettes did so in a safe manner as determined by their plans of care. The IJ began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization. The administrator, consulting	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 323}	Continued From page 171	{F 323}		

administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of the additional IJ concerns related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. The IJ was not removed by the exit date of the survey.

Findings include:

Alleged substance abuse:
R37's progress notes indicated the resident had required hospitalizations 2/22/14, 4/23/14 and 5/10/14, related to ETOH/drug use. The Admission Record dated 1/14/14, indicated R37 had been admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and a history of alcoholism. Progress note documentation indicated R37 had been found with ETOH/vodka while in the facility on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14.

Observations of R37 revealed the following:
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. This surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 172	{F 323}		

push another resident's wheelchair down the West hallway and was observed outside R9's room. There was no staff with R37 when during the observation. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and the HUC asked him where his partner was. Nursing assistant (NA)-L approached at that time and told the HUC she was the 1:1 for R37 today.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance.

Additional review of R37's record revealed these Progress Notes:
- On 11/26/13, the notes indicated chemical dependency (CD) treatment/Alcoholics Anonymous (AA) was discussed. R37 had stated he'd participated in AA services in the past and he'd had success including three years of sobriety before a recent relapse. The note indicated nursing had reported two episodes of ETOH intoxication while in the nursing home since the last visit and R37 had acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no ETOH use with nursing to monitor. The NP indicated there were "clear dependency concerns."
- On 1/8/14, the notes indicated the resident had a history of ETOH abuse which had also occurred since living at the facility.
- On 2/21/14, the notes indicated R37 had been drinking vodka and that an empty bottle had been found. The notes also indicated R37 had been observed to be distributing money to staff and residents. When R37 had noticed he had no money to buy vodka, he had gone to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 173	{F 323}		

automatic teller machine (ATM) machine to get money. The notes indicated staff were concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. a note had been documented which indicated R37 was handing out his money to "anyone who would listen" and staff had taken $116.00 dollars from him to lock up.
- On 2/22/14, at 10:14 p.m. the notes indicated R37 had called 911 to send himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift had taken a bottle of vodka from him. The notes indicated R37 had asked the p.m. shift to return the vodka or pay him $25.00.
- On 2/27/14, at 1:13 p.m. the notes indicated R37 wanted to leave on a leave of absence (LOA), was advised he could not go on an unsupervised LOA, but had left the facility.
- On 2/27/14, at 10:07 p.m. indicated R37 was "drunk" and had a blood pressure of 147/105.
- On 3/2/14, indicated R37 was "drunk" and was noted to have a blood pressure of 176/98 and a pulse of 99.
- On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital.
- On 4/13/14, the notes indicated R37"seemed intoxicated" and one full bottle of vodka and one quarter full bottle were removed from the room.
- On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37's room. At 12:04 p.m. staff checked R37's room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink ETOH at the facility. R37 was offered a transfer to a facility that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 174	{F 323}		

allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of ETOH. R37 stated he would like to get help to have ETOH removed from his body. Staff called 911 and police escorted R37 to detox.
- On 4/24/14, at 9:30 a.m. the notes indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of ETOH. At 12:01 p.m. on that day, the notes indicated R37 approached staff and "again was clearly intoxicated." The notes indicated the contracted licensed social worker (CLSW)-A and a police officer had entered R37's room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assaultive in any way.
A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 had been observed earlier walking into and out of R117's room and "seemed to be like an exchange of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for ETOH consumption. Further the note indicated, "A few hours later" R37 was shouting and appeared "intoxicated" and a 75% emptied bottle of vodka was found in R37's room.
- On 4/25/14, at 9:58 a.m. notes indicated R37 was "clearly inebriated", had slurred speech and could barely wake up. R37 refused to provide the source where he continued to get ETOH.
- On 4/25/14, at 3:24 p.m. notes indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and still smelled like he had ETOH on his breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 175	{F 323}		

- On 5/2/14, notes indicated R37 had removed a wander guard and refused a new one to be placed.
- On 5/3/14, notes indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. the notes indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of ETOH and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and had said he was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. the notes indicated R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. the notes indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a note, which indicated it was a late entry for 5/5/14 at 6:00 p.m., indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 had stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 176	{F 323}		

bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. the progress notes indicated R37 had been placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, notes indicated R37 "was clearly intoxicated" and that an empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, notes indicated R37 had been observed giving his credit card to R117 on 5/9/14. A second note indicated R37 had returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 177	{F 323}		

pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, the progress notes indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for Methadone.

The Physician (MD) and Nurse Practitioner (NP) orders indicated they were aware of R37's alcohol use. Notes included:
- On 1/8/14, included a diagnosis of ETOH abuse and a note the resident continued to have problems while living in the facility.
- On 2/5/14, indicated R37 had recently been found with a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH.
- On 2/28/14, an order directed staff to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, an order directed; "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, notes indicated R37 had been hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement. the notes indicated R37 had been treated for sepsis and required thoracentesis.
A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's use of alcohol, to encourage R37 not to use, and that even if R37 appeared intoxicated it was ok to administer all medications as ordered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 178	{F 323}		

- On 5/6/14, an order directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, an order directed "no LOA-supervised or other". In addition, the NP included an order for a WanderGuard, and to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and ETOH counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The Depression care plan dated 3/11/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 179	{F 323}		

included ETOH abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA.
- A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 180	{F 323}		

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had a history of significant ETOH use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of ETOH intoxication and ETOH withdrawal noted 9/23/13, and substance abuse noted 2/23/14.

A Care Conference Summary dated 4/1/14, indicated a discharge plan of "discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37 had a history of drinking and bringing ETOH in the building or going on unsupervised LOA and R37 had stayed in the building with no ETOH use since 3/3/14.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 181	{F 323}		

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing ETOH and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding ETOH bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase ETOH and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 got ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or ETOH and stated he has heard about exchanges but could not remember who he had heard it about.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 182	{F 323}		

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for Delirium tremens (DTs-significant withdrawal symptoms). During interview on 5/12/14, at 8:59 a.m., registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy (stated name) a friend of R1" went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware of who R1's friend was. The DON stated the 1:1 had refused to go to the bank with R37 and that the friend of R1 had signed R37 out. The DON stated the consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 183	{F 323}		

administrator was going to go with R37 and R1's friend to the bank until it was decided the facility was not comfortable with her (the consultant administrator) going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA, but stated the administrator, consultant administrator and the social worker had decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH had been found in R37's room and 3 plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on a LOA, and stated R37 had returned with a card from Walgreens so they knew he hadn't followed his agreement to only go to the bank. The administrator stated the friend of R1 would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOA and that he had believed CLSW-A and had not checked the chart himself. The administrator stated he was also not aware of R1's relationship with the friend and that the DON had not told him about the order for no LOA or the relationship between R1 and the friend.

Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she had been informed by nursing (she could not remember who) that R37 could leave the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 184	{F 323}		

with supervision. CLSW-A reported she'd made it clear to the person taking R37 out, R1's friend, that R37 could only go to the bank and nowhere else. She stated she'd told R1's friend that R37 would try and talk him into going to the liquor store but that R37 could not go there. CLSW-A said R1's friend had reassured her he had been sober for ten years and would never take R37 to a liquor store. CLSW-A stated it was not until after R37 had left, that nursing (did not remember who) told her R37 had orders for "no LOA" and that R1's friend was a drug dealer. CLSW-A said it would have been nice to have known that information before she'd allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she'd trusted nursing to know the correct information. She also stated she was aware R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing hadn't been finding the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs or aware that R1's friend was her drug dealer prior to having allowed R37 to leave with R1's friend on an LOA.

R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times). R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed ETOH on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 185	{F 323}		

(mechanical ventilator assisted breathing) for a blood ETOH level of .323.

The admission MDS dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's CAA for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with ADLs. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering CD treatment.

The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 186	{F 323}		

identified to "monitor for ETOH use or oversedation."

The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the DON on 5/5/14.

An Emergency Department Chart [a form from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 187	{F 323}		

the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or ETOH use. R129 was given two doses of Dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1.

A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD."

On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 188	{F 323}		

to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, ETOH and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 189	{F 323}		

prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings."

Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print.

Nursing Progress Notes:
- On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 mg [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."
- On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money."
- On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 190	{F 323}		

1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment.
- On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
- On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 191	{F 323}		

notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP.

- On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
- On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 192	{F 323}		

continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
- On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms."
- On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal drugs was identified, reported to the administrator immediately, reported to the SA or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety.
At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 193	{F 323}		

resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.
- On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer].

On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 194	{F 323}		

R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M.
- At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern.
- At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129.
- At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway.
- At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129.
- At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 195	{F 323}		

behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking beside (to the left) of R129.
- At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 196	{F 323}		

watch R129. R129 sat on planter side and spoke with R14.
- At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor.
- At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk.

On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 197	{F 323}		

stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and ETOH treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of ETOH or drugs being exchanged on "my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 198	{F 323}		

shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse.

On 5/8/14, at 11:40 a.m. NA-S stated they had seen ETOH bottles in residents rooms and smelled ETOH on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January 2104 or February 2014. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. a housekeeper (H)-A was asked if they were aware of any residents drinking ETOH in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any ETOH bottles found in the facility "and has." H-A

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 199	{F 323}		

was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the ETOH bottles came from, H-A stated she was unclear, but thought they may have been provided by family.

On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated ETOH from R37. LPN-H verified ETOH was provided to R37 and suspected to other residents of the facility, but was unclear how the ETOH was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility.

On 5/8/14, at 12:10 p.m. the HUC stated she was aware of resident drug and ETOH use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming ETOH in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the ETOH was coming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 200	{F 323}		

from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and ETOH use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
- On 5/11/14, at 10:09 a.m. a note written by the HUC indicated NMMC called the facility "requesting" R129's medication administration records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 201 R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough ETOH to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the ETOH and/or if the assigned 1:1 was interviewed at the time. - On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two LPNs were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of ETOH. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving R129 ETOH, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her ETOH. - On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 202	{F 323}		

chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."
- On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of ETOH was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."
- Was asked regarding R129 obtaining ETOH or drugs while on a 1:1, DON verified the information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 203	{F 323}		

observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and ETOH while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained ETOH, but verified R129 was harmed by the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for CD treatment and verified was last noted to be offered to R129 on 4/4/14. Both verified they should have revisited CD treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for ETOH toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. CLSW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 204	{F 323}		

obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much ETOH in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

R41:
The facility failed to provide supervision to prevent ingestion of alocholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m. , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 205	{F 323}		

legs that can create sensory, motor and bodily function problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detected depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 206	{F 323}		

unsupervised LOA.

A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 9-1-1 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 207	{F 323}		

included, "No longer okay to leave unsupervised LOA's." A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as AA or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist.

R117:
R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents.

R117 was admitted to the facility 1/21/14, with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 208	{F 323}		

admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression.

The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility.

R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 209	{F 323}		

R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called."

The progress notes were reviewed and noted:
- On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator."
- On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility."
- On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware."
- On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 210	{F 323}		

environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time."
- On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours."
- On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident."
- On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 211	{F 323}		

means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding."
- On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning."
- On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks."
- On 4/26/14, (no time) a progress note indicated, officer from the Minneapolis Police department (MPD) came regarding the seven credit cards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 212	{F 323}		

that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen."
- On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated.
- On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 213	{F 323}		

facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes."
- On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "
- On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 214	{F 323}		

and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.
- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 215	{F 323}		

survey exit) and today (5/7/14).
- On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on."
- On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility."
- On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
- On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
- On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic."
- On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 216	{F 323}		

Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office."
- On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital."
- On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating."
- On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 217	{F 323}		

the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and congestive heart failure (CHF) condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen.
- On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 218	{F 323}		

him "you are leaving the facility against medical advice?" Resident stated "yes." Police and emergecnt medical technician (EMT) then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 323}	Continued From page 219	{F 323}		

stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time."
- On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified."
- On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information."
- On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 220	{F 323}		

the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present."
- On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road.
- On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called."

On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed.

When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 221	{F 323}		

the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency.

ELOPEMENT:
On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 222	{F 323}		

On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly The speed limit was 30 miles per hour (MPH). The smoking monitor was observed to be behind a pillar with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 223	{F 323}		

his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 224	{F 323}		

independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard.

R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs.

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 225	{F 323}		

R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 226	{F 323}		

would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then.

The SA form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk."

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 227	{F 323}		

time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building.

On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and DM were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or SA would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if that occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 228	{F 323}		

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a WanderGuard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement.

Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 229	{F 323}		

permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance."

A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 230	{F 323}		

unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 231	{F 323}		

updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.

Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m.

On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 232	{F 323}		

investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door.

On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby.

On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door.

The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 233	{F 323}		

the care plan would be reviewed and revised.
The administrator of designee reports the event to the appropriate state agency (SA).
R9 was not supervised during smoking, was keeping smoking materials and was an alleged "Pot smoker."

On 5/6/14, at 7:40 a.m. R9 was observed smoking cigarettes out front on the designated smoking patio with no staff in attendance.

On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area, she retrieved cigarettes and a lighter from her right sock and placed them on the table next to a covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and started to smoke. During observation, NA-B went over to the smoking cart to get a smoking apron, applied the apron on R9, and sat directly across from R9.
-At 9:05 a.m. NA-B continued to watch R9 as she smoked.
-At 9:08 a.m. R9 was observed wheeling herself into the building. No burn holes noted on the front of her shirt or clothing.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke.
-At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area.
At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 234	{F 323}		

her socks and continued to lean forward multiple times as she smoked.
-At 10:19 a.m. R9 returned back to the building.

On 5/6/14, at 2:45 p.m. when interviewing R9 surveyor observed a cigarette box in each white sock on each inner leg. When R9 was asked why she was storing the cigarettes in the socks she stated "You can leave now, go now". Surveyor left the room as requested.

When interviewed on 5/6/14, at 3:06 p.m., the DON stated he was not sure if R9 was supposed to be supervised during smoking, and indicated he had been given a list of smokers who required supervision just that day. Upon review of the list, the DON stated R9 was a supervised smoker which meant she should relinquish her cigarettes and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. Following the interview, the DON was observed to approach R9 at the smoking area and speak to her, and to return to tell the surveyor R9 had refused to give him the cigarettes she had in her socks.

When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified after looking through the locked cigarette box on the cart R9 did not have cigarettes in box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box.

When interviewed on 5/6/14, at 3:20 p.m. the administrator, DON and LPN-A (the resident care manager for R9) all stated if a resident was a supervised smoker they were supposed to relinquish all smoking materials but many refused. They said they couldn't force them to do

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 235	{F 323}		

it as the residents were part of the supervised program. LPN-A further stated "They have been told that they have to do this and we had a meeting with all smokers last week. They were given a copy of the smoking policy by social services and were supposed to sign it, but some refused. We have told them the rules and when they are or aren't allowed to keep them [their cigarettes], but they don't care. [R9] should be in there, but she won't give them to us."

When interviewed on 5/6/14, at 3:25 p.m. the DON stated, "We have a smoking policy updated and it does include that they should relinquish, are still supervised, the smoking monitor makes sure they are safe with their usage, that is why they are out there and we are still keeping them safe, we have tried to get her lighter and cigarettes on repeated effort but have not been able to do so."

When interviewed on 5/6/14, at 3:43 p.m. LPN-A stated "Problem is if I took her cigarette and lighter, she would just get the cigarettes from somewhere else probably gives someone money to go buy a pack of cigarettes. We tried this morning to take them from her and she stated "I'm not giving them to you because you will sell them to another resident". LPN-A stated the policy had been explained and R9 had asked what would happen if they did not abide and LPN-A had stated they were consequences. LPN-A further stated the NA who was monitoring the smoking had a book on the cart and documented when a resident refused or when they are not safe. When asked by surveyor if the smoking monitor had reported off to her LPN-A stated she was not sure maybe the social worker had been reported to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 236	{F 323}		

When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found on the roommate's side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family had been very upset about staff removing the roller from the room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not received the list of all the residents who had been thought to have substance abuse issues.

When R9 was interviewed on 5/13/14, at 8:36 a.m., and asked whether she smoked "pot', R9 stated "It's a lie that I am using any pot" and kept repeating same statement to the surveyor.

R9's MDS dated 3/24/14, identified R9's diagnoses included schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease. The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with transfers, dressing, hygiene, and R9 was did not use any mobility devices yet R9 used a w/c during the course of the survey around and off the unit for mobility. The nutritional status Care Area Assessment dated 3/25/14,, had identified R9 had history of tobacco abuse.

The smoking care plan dated 10/20/11, identified R9 was a smoker. Goal "[R9] will follow all

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 323}	Continued From page 237	{F 323}		

guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker.

Smoking Evaluation dated 10/7/13, indicated R9 was independent with smoking and smoking materials. After concern was brought to the facility attention on 5/6/14, another Smoking Safety Assessment was completed which indicated R9 was to remain as a supervised smoker, facility was to store tobacco products but may choose to wear apron or not.

Progress Note dated 4/30/14, indicated the director of facility operations and two social workers had been to R9's room and a bottle of "Shout", raw tobacco and other materials (for the tobacco to be rolled) had been removed from the room and placed in the Administrator's office for the family to pick up when they visited.

The undated and untitled list of Unsupervised and Supervised Smokers, revealed R9 was identified as a supervised smoker,did not need to wear a smoking apron, but was supposed to be within an arms distance from the smoking monitor.
R14 was observed to ingest an unknown substance, was sent to the hospital and tested positive for THC (the active substance in marijuana) on 5/3/14, R14 was not evaluated for substance abuse, assessed for safety or provided supervision to prevent potential future access to illegal drugs.

R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knew amputation. R14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 238	{F 323}		

significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others 1-3 days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA were all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. CAAs did not identify any history of drug use.

R14's Vulnerable Adult care plan dated as revised on 4/26/14, indicated R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility.

A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a nursing assistant (NA) had reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician had been notified and R14 had been sent to the ER for evaluation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 239	{F 323}		

A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified the laboratory report had been obtained for R14 due to "drug ingestion."

Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, investigation of the incident to determine potential source(s) R14 may have obtained the illegal drug from, notification of law enforcement, any follow up assessment of R14's safety, an evaluation of R14's access to leave the facility, such as to smoke; documentation of how to prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically related social services.

On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "eplileptic." R14 denied awareness of illegal drug and ETOH activity in the facility. When asked what R14 would do if she observed illegal drug or ETOH activity in the facility, R14 stated he would "tell the resident not to do it," but would not notifiy staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!"
On 5/12/14, at 10:26 a.m. the DON was interviewed, and verified there was no current system in place for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 240 On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R62 was identified by the facility to have past/recent substance abuse. R62 had diagnoses that included memory loss, dementia and cerebrovascular accident (CVA). The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the quarterly MDS, dated 2/25/14, indicated R62 had moderate cognitive impairment. Review of facility progress note dated 1/24/14, at 17:03, indicated "a resident approached writer alerting us that another resident (res) is sitting outfront smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any".	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 241	{F 323}		

Review of facility progress note dated 1/24/14, at 17:17, indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor".

Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport.

R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address ETOH and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes.

Review of a facility provided list of residents with questionable or known ETOH and drug use dated 5/8/14, at 8:02 a.m. identified R62 for drugs.

During an interview on 5/13/14, at 10:18 a.m., the DM stated "I did what the 1/24/14 progress note says and reported it to the social worker, director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 242	{F 323}		

of nursing and the interdisciplinary team...I did not search her room that I remember."

During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were unaware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14 identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month". SW-B stated she has been at the facility since 3/19/14.

During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 had verified she'd been smoking 'weed' but had told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume the administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 had ever been offered any chemical dependency assistance.

R86 had been committed as mentally ill and chemically dependent on 10/31/12, which was amended on 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker.

According to the Admission Record dated 3/16/13, R86 had been admitted to the facility with diagnoses including: hepatic encephalopathy (confusion related to liver failure) and cirrhosis of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 243	{F 323}		

the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness.

A care conference dated 1/2/13[sic] (2014), lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable.

A progress note dated 2/24/14, at 4:38 a.m. " Resident had been very confused and having difficulty to settled down in bed. judgement [sic] has been non intact and appearing restless with a lot of tremor. He did attested [sic] to this writer that when he goes LOA he smokes marijuana but never drink ETOH at all. He state "If I drink I will die. " His platelet has been dangerously lower thus posing him at a risk for bleeding. Update DR smiley about resident change in condition, which then mandate this writer to send resident to the emergency for thorough evaluation at this time. Meanwhile, writer had been trying to touch base with family members but unable. We will continue to follow up with his condition. "

A progress note dated 2/24/14, indicated at 11:00 p.m. "Pt was found smoking 'pot' in his room. His roommate was in the room at that time. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out."

A progress note dated 3/4/14, at 6:11 a.m. noted, " While executing an initial nursing rounds this shift, this writer smell and noted a medicine bottle fill up with marijuana. Upon conversation, this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 244	{F 323}		

resident did urge this staff that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinued. He had flexeral [sic]with some benefit noted. He want [sic] another sleeping pills at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg of Trazodone [sic], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment. "

An annual MDS dated 3/22/14, had a BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares. A vulnerable adult assessment dated 3/18/14, noted past and recent chemical abuse. R86 had fluctuating cognitive deficits related to liver damage, chemical use and needed supervised LOA due to fluctuating cognition and chemical use.

A smoking assessment dated 3/18/14, indicated reports of smoking marijuana outside, and recent drug use reported by resident.

A LOA safety assessment dated 3/18/14 indicated mental illness, fluctuating cognition related to liver disease. R86 needed supervised LOA due to fluctuating cognition and chemical use (no mention of committed to the facility related to substance abuse and mental illness.

On 4/13/14, a care conference indicated: long term placement waiting for liver transplant. " Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 245 Discussed AA (alcoholics anonymous), stated he has tried in the past. " The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. R86 was committed to prevent exposure to ETOH and chemical substances of abuse. The facility lacked coordination of care between departments, and failed to provide an environment free of chemical/alcoholic substances, or to transfer R86 to a secured environment where appropriate care could be provided. R113 was a known alleged narcotic seller by the facility staff. On 5/12/14, at 12:36 a.m. R113 was observed ambulating across the nursing station with his walker as he conversed to both residents and staff as he ambulated to his room down the hallway. On 5/12/14, at 1:53 p.m. R113 was observed sitting on his bed back facing the door and was observed rolling cigarettes using a cigarette roller. R113 asked if it was okay to continue to roll the cigarettes as surveyor talked to him. -At 1:54 p.m. R113 stated he knew exactly who	{F 323}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 246	{F 323}		

started the rumor about the narcotics. R113 indicated he is currently trying to resolve his marriage and his wife who would not allow him to come out to her house for visits if she found out he had ETOH and drugs issues. R113 stated he remembered the incident when the therapy staff had intervened when he had been approached by another resident for cigarettes and he remembered being talked to by the administrator and social worker about the policy. R113 further stated he also took his medications in front of the nurses as he knew this was going to be a concern/issue and also indicated he knew of ETOH being used at the facility by other residents but because he was a recovered alcoholic he kept his nose out of all trouble to get back with his wife.

When interviewed on 5/12/14, at 1:57 p.m. RN-A stated he always watched R113 take all his medications and made sure he swallowed them then took the medication cup out of the room.

When interviewed on 5/12/14, at 2:18 p.m. both CLSW-A and CLSW-B stated they were not aware of R113 using any illicit drugs at the facility. CLSW-A stated she remembered talking to R113 for less than ten seconds when he had asked if he would continue to roll the cigarettes and had told him not to until he was told otherwise.

R113's significant MDS dated 2/14/14, indicated R113's diagnoses included acute ETOH hepatitis, ETOH withdrawal, ETOH dependence and insomnia. The ADL Functional/ Rehabilitation Potential CAA dated 2/14/14, indicated R113 had history of ETOH abuse.

The mood/Behavior care plan dated 4/28/14,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 247	{F 323}		

identified R113 had history of ETOH abuse, had history of depression and had recent amputation of toes due to frost bite.

Resident List Report dated 5/8/2014, provided by the administrator indicated R113 was selling narcotics.

Smoking Evaluation dated 3/17/14, indicated R113 had no history of unsafe smoking practices and was independent with smoking and smoking materials.

Vulnerable Adult Assessment dated 3/17/14, indicated R113 had history of chemical abuse but no recent history.

Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only.

Progress Notes review revealed the following:
-Progress note dated 4/24/14, indicated R113 was in therapy when another resident approached him and asked to buy rolled cigarettes from him. Therapist stopped transaction to check facility policy. R113 and therapist approached social services to ask about policy and were directed to the administrator but the administrator was unavailable and a note was left for administrator to please visit with R113 regarding policy. R113 was instructed not to sell any rolled cigarettes until cleared by administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 248	{F 323}		

-Social Services Progress Note dated 5/2/14, indicated R113 had declined to attend the smokers meeting to be updated on the facility policy and procedure regarding smoking. The administrator and social worker had met with R113 and was given a copy of the facility policy and discussed the rules regarding smoking. R113 was also educated on rolling cigarettes for other residents and informed until further notice he could not be not allow to give, sell, trade, or buy cigarettes with other residents which R113 acknowledged.

R1 was not smoking at the designated area, was not wearing an apron, had known alleged drug involvement at the facility and was keeping her smoking materials.
On 5/5/14, at 1:50 p.m. during the initial tour R1 was observed to be assisted to light a cigarette while outside on the smoking patio. At 1:52 p.m. staff provided R1 with a smoking apron and attempted to apply but R1 was observed to shake head no. At 1:54 p.m. R1 still had no smoking apron applied but continue to smoke in the front designated smoking area and staff was within arms-length reach of R1.

On 5/7/14, at 7:34 a.m. R1 was observed with a lit cigarette right outside the front door with no smoking apron on. NA-E got into the front seat of the transport van and R1 was observed throwing her cigarette over her shoulder prior to getting into the van.
On 5/7/14, at 8:47 a.m. R1 was asked to look at her clothing for burn holes, since she was observed smoking without an apron that morning in front of the building prior to getting in the van. R1 agreed, and a review of her closet verified no new holes were observed in the clothing. R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323}	Continued From page 249 stated "I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing. Now because I have a 1:1 R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." On 5/8/14, at 9:45 a.m. R1 was observed getting out	{F 323}		
{F 329} SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by:	{F 329}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 250	{F 329}		

Based on observation, interview and document review, the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R91, R36, R37, R89, R1, R113, R29).

Findings include:

R91 had physician orders for PRN Tylenol, Ibuprofen and Oxycodone (pain medications) without identified parameters for when to use which medication.

Review of the Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13 with a diagnosis of osteoporosis.

The significant change in status Minimum Data Set (MDS) dated 4/1/14, indicated R91 had frequent pain rated at a six.

Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain and lacked parameters for use.

Review of the Medication Administration Record (MAR) dated 4/1/2014-4/30/2014, revealed R91 did not receive any PRN Tylenol and Ibuprofen and received multiple doses of PRN Oxycodone.

R36 had physician orders for PRN Tylenol and Oxycodone without identified parameters for when to use which medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 251	{F 329}		

The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12 with diagnoses of femur fracture and alcoholic cirrhosis of the liver.

The quarterly MDS dated 2/18/14, indicated R36 had occasional pain rated at a four.

The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (tid) as needed and Oxycodone 10 mg tid both for pain and lacked parameters for use.

Review of the MAR dated 4/1/2014-4/30/2014, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight.

When interviewed on 5/7/14, at 1:51 p.m. registered nurse (RN)-A reported he would usually do a pain assessment for PRN pain medications and for a pain level below three he would not give Oxycodone.

When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist stated he would expect parameters written by the physician to clarify when to give which PRN pain medication.

On 5/9/14, at 8:46 a.m. licensed practical nurse (LPN)-B was interviewed and stated when there is multiple PRN pain medications ordered, she would assess pain level and start with the lowest pain medication unless the resident's pain was "really bad" or something else worked for the resident.

Upon interview on 5/12/14, at 9:40 a.m. RN-B stated she would start with Tylenol first and see if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 252	{F 329}		

it works, then would document if it was ineffective and then try Oxycodone unless there was a specific physician order.

The facility Pain Management policy revised May 2013, lacked direction regarding parameters for PRN pain medication.

R37 had physician orders for Seroquel (an antipsychotic medication) without adequate indications for use, without side effect and symptom monitoring and lacked evidence of a gradual dose reduction (GDR) or documentation of a clinical contraindication.

The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism.

The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/7/13, indicated R37 was receiving antidepressant and antipsychotic medications; however, lacked a comprehensive assessment summary regarding the medications in use.

A Psychotropic Medications care plan revised on 3/16/14, included Seroquel was used for psychoses and directed to monitor for side effects and consult with pharmacy and physician to consider dosage reduction when clinically appropriate.

The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 253	{F 329}		

Review of the Physician's Order Sheet dated 5/1/14, lacked a diagnosis for the medication. The Information and Consent for Psychotropic Medications dated 9/19/13 and 2/26/14, indicated the diagnosis to support use were "agitation/sleep."

A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur.

Physician and nurse practitioner notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist (CP) stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident.

Upon interview on 5/12/14, at 3:57 p.m. the nurse practitioner (NP) stated R37 received Seroquel for psychosis, verbal outbursts and generalized anxiety which were mainly problematic when R37 was drinking. The NP stated she believed a different medication was used when R37 was in the hospital prior to admit and was unsuccessful because of liver disease. The NP stated she had not reviewed R37's medications because he had been in the hospital frequently and she tries to do dose reductions quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 254	{F 329}		

When interviewed on 5/13/14, at 8:46 a.m. LPN-A stated the indication for use for Seroquel was not listed and she would have to check with the physician. LPN-A stated she was not sure what target behaviors were being monitored for Seroquel. LPN-A stated orthostatic blood pressures were recorded in the electronic record. After review of the Weights and Vitals Summary, LPN-A verified there were no orthostatic blood pressures recorded for R37 since December 2013.

A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received.

The facility Psychoactive Medication Management policy revised May 2013, directed the DNS [director of nursing services] or designee was responsible to ensure timely medical consultation when a psychoactive medication requires a medical review.

R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic medication). In addition, R89 was not monitored for potential side effect of orthostatic hypotension (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position).

R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 329}	Continued From page 255	{F 329}		

MDS identified R89 had hallucinations, delusions, and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects."

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 256	{F 329}		

response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg.

The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis.

A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 257	{F 329}		

Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.

A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg [milligrams] daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 258	{F 329}		

meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective."
The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more."

The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia.

On 5/5/14, at approximately 1:40 p.m. R89 was observed to be laying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Observations of R89 on 5/7/14, at 8:28 a.m.; 5/8/14, at 8:30 a.m.; and 5/12/14, at 12:23 p.m.

Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89.

On 5/12/14, at 9:24 a.m. the LPN-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 259	{F 329}		

orthostatic blood pressures were checked on R89 since January.

On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of antirollbacks and restraints. DON verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication.
The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data.

Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 260	{F 329}		

Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the consultant pharmacist was called and a message left. The consultant pharmacist did not return the call.

R1 was not monitored for potential side effects related to use of Trazodone and Venlafaxine (an anti-depressants) and Zolpidem (a hypnotic).

Findings include:

R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day.

The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 261	{F 329}		

was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness.
Physician's Orders dated 2/26/14, indicated R1 received the following medication:
-Trazodone 100 Milligrams (mg) by mouth at bedtime (HS) for insomnia
-Venlafaxine (Effexor) 150 mg by mouth daily for depression
- Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose."

Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction.

When interviewed on 5/7/14, at 1:40 p.m. RN-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring.
When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 262	{F 329}		

just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently.

When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others.

When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently.

The Psychoactive Medication Management policy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 263	{F 329}		

dated as reviewed 5/2013, indicated the care plan would identify side effects of the use of any psychoactive medications but lacked monitoring of side effects of anti-depressants and sleep study/logs for resident who were taking medication to aide sleep.

R113 lacked parameters for as needed pain medication Oxycodone.

R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14.

Physician's Order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only.

R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders.

R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered.

Pain Assessment dated 4/25/14, indicated R113

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 264	{F 329}		

had pain daily and was predictable and the pain did not prevent resident from doing or results in mood or behavior. The assessment indicated the pain was worse and/or breakthrough pain with therapy and dressing change. Summary indicated the pain was from the amputation sites to his both feet toes and was aggravated by therapy and wound care but was relieved by treating with PRN medications prior to treatment and resident reported current pain regime was effective.

When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider.

When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you."

DON was not unavailable to interview on 5/13/14, regarding pain medication parameters.

The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.

R29 had physician orders for PRN morphine (pain medication) with no parameters for use, in addition no pain monitoring was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 265	{F 329}		

Review of the Admission Record dated 4/28/14, indicated R29 was admitted on 1/15/14, with diagnoses that included chronic pain, diabetic polyneuropathy (nerve damage) and adult failure to thrive. The quarterly MDS dated 4/17/14, indicated R29 had frequent pain rated at a pain level of six. The CAA dated 1/28/14, indicated R29 "has chronic back pain, she gets Neurontin, OxyContin and oxycodone PRN, it has been effective at time". The CAA did not indicate diseases or conditions that may cause the pain, characteristics or frequency of the pain, but indicated it adversely affects mood.

During observation on 5/12/14, at 9:10 a.m. R29 was observed to be very thin, awake in a darkened room, in bed and when surveyor asked to enter room, resident stated "no".

During observation on 5/12/14, at 2:01 p.m. R29 was in darkened room, in bed sleeping.

During observation on 5/13/14, at 850 a.m. R29 was observed lying in bed, dressed in a hospital gown in a darkened room. R29 stated "I am not doing well today, the pain is constant, the meds help for a while, then it starts again". R29 stated she does go to a pain clinic.

Review of the physician's order sheet dated 5/9/14 included an order for morphine 30 mg four times daily as needed.

Review of the MAR dated 4/1/14 to 5/31/14, revealed R29 received multiple doses of PRN morphine.

Review of the pain evaluation and management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 266	{F 329}		

plan dated 4/17/14, indicated R29 had occasional pain in back and feet, current pain regimen was effective and nursing would continue to monitor and update MD/NP as needed.

R29's care plan with revision date of 4/12/2014, identified R29 was on pain medication therapy due to foot surgery and chronic back pain. Interventions included: pain assessment per facility policy, administer medication as ordered and to frequently review for pain medication efficacy.

During an interview on 5/12/14 at 3:29 a.m., LPN-E stated that for R29, "some days are good, some days are bad, she is on quite a bit of meds for pain" and that on 5/9/14 R29's primary physician increased some meds, "that may be why she is sleepy". LPN-E stated R29 was not on her caseload, but she would have put short term implementations of pain monitoring in place when there is a change in meds. LPN-E verified that it looks like every three to four hours the morphine is given and that the order should be more specific "like every 4 or 6 hours [hrs]". LPN-E verified there was no pain monitoring being completed, "it must have fallen thru the cracks when we went from paper to the computer".

During an interview on 5/13/14, at 10:58 a.m. LPN-G stated he had not given any morphine yet today and would ask the resident if she has any pain. LPN-G further stated he would expect the order to be more specific such as "every 4 or 6 hrs" in addition to PRN, but would ask the nurse manager for more clarification.

Review of Medication Administration General Guidelines, section 7.1, page 3 of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 329}	Continued From page 267 Nursing Care Center Pharmacy Policy & Procedure Manual date 2007, indicated that medications are administered in accordance with written orders of the prescriber. If a dose seems excessive....or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. The DON was not available to interview on 5/13/14, regarding pain medication parameters and monitoring. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.	{F 329}		
{F 353} SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.	{F 353}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 353}	Continued From page 268	{F 353}		

Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide adequate staff to meet the individual needs for safety, supervision and care for 13 of 44 residents reviewed during the revisit (R22, R129, R1, R41, R37, R13, R86, R116, R36, R117, R9, R14, R62). In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect each of the 67 residents who resided at the facility.

Findings include:

The facility has started using agency staff, licensed nursing and nursing assistants (NA) from Soul Care LLC 1521 Como Ave Southeast Minneapolis, 55414. On 5/6/14, orientation was requested for any agency staff that has worked since the last survey. A review of the orientation files verified that the facility did not ensure staff had background checks, and had received the required tuberculin skin testing (TST).

A review of the facility schedules dated from 4/5/14 through 5/17/14, indicated the facility staffing plan called for on the day shift: two licensed nurses with 13 nursing assistant (NA's); on the evening shift: two licensed nurses with 13 NA's and on the night shift: two licensed nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 353}	Continued From page 269	{F 353}		

with 6 NA's.

Open nursing and NA shifts in the two week block of time from 5/4/14 through 5/17/14, included nine nursing day shifts and 53 NA's open day shifts, 17 open evening shifts, and 30 open night shifts.

Two additional staff was being used for 1:1's for R1 who was alleged by the facility to both ingest and provide illicit substances to residents within the facility and R129 after she had obtained and ingested cocaine within the facility and required hospitalization. An undated facility typed document titled 1:1 Observation Staff Responsibilities indicated: only one staff person performs the 1:1 observation with only one resident during the assigned time, and follows the resident wherever he/she goes and maintains a distance no further than arm's length at tall times. When the resident is in the room, staff will be either sitting outside or inside his/her room and make sure that they maintain residents visual at all times. Notify nurse/supervisor with any suspicious activity observed on resident. Will accompany resident if he desires to go out and smoke and make sure that appropriate clothing is worn, and oxygen is removed 5 minutes before going out to smoke. Nursing was to oversee the 1:1 observations and respond to concerns reported.

One additional staff per shift was used as a smoke monitor. The Smoking Monitor Responsibilities (undated document) directed the monitor to ensure the smoking areas are monitored at all times, carry a list of smokers, and the smoking assessment results at all times. The monitors were to use the list to determine which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 353}	Continued From page 270	{F 353}		

residents require close supervision or other interventions and ensure the interventions are in place. "Supervised smokers must be within direct line of sight at all times. Those requiring assistance with smoking materials must be within reach of the smoking monitor.... Direct all smokers to the designated smoking areas only... No smoking will be allowed in front of the building. Notify supervisor immediately if: a resident not on the list is smoking. A resident refused indicated interventions, such as wearing a smoking apron or staying within the designated smoking area."

On 5/7/14, at 9:27 a.m. and again at 9:31 a.m. R22 (a resident identified by the facility as a supervised smoker required to wear a smoking apron) was observed by surveyors to drop a lit cigarette onto his shirt, both times the resident was able to pick it back up. When interviewed at 9:32 a.m. the smoke monitor NA-B stated she had not observed R22 dropping the cigarette at 9:27 a.m. or 9:31 a.m. and verified that she had been more than an arm ' s length away from the smoker. R22's clothing was checked and no burn holes were noted in his shirt, or in the blanket that had been covering his lap. NA-B stated that R22 was supposed to be a supervised smoker with a smoking apron, but the resident had refused to wear the smoking apron. NA-B verified she had given R22 a cigarette to smoke, even though she knew he was assessed to require a smoking apron. NA-B stated when R22 or any resident refused to wear the smoking apron, or follow the rules; they would record it in the smoke monitor notes. The smoke monitor notes were reviewed and revealed that notes started on 3/15/14, and were present for March 16th through 21st, 24th through 27th, 28th was blank, 29th and 30th, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 353}	Continued From page 271	{F 353}		

the 31st was blank. On April 28th and 30th and May 2nd-3rd, and 4th were left blank. On all of the days listed residents had refused to wear smoking aprons, and/or relinquish the smoking materials. The administrator stated he thought the other logs had been collected, but stated he had not reviewed them for compliance with the smoking policy.

Residents within the facility were able to obtain, ingest and allegedly sell alcohol and drug substances within the facility while the smoking monitor, safety monitor and 1:1 staff were in place for R129 and R1. Immediate Jeopardy (IJ) was identified at F323 for lack of supervision to prevent alcohol and drug use that lead to hospitalization for (R41, R129, and R37) and elopement by R13, a resident with a WanderGuard (an alert system that lets the facility know a resident has left the building) who was let outside to smoke and went from there to the public sidewalk, the facility had to be notified by surveyors of the elopement) Refer to F323 on 5/9/14.

After the IJ was identified on 5/9/14, two Residents (R129 and R37) who both had one to one (1:1) staff (defined by the facility administrator as being within arm's length of the resident to prevent incidents from occurring) were able to obtain and ingest alcohol and drug substances on 5/10/14.

On 5/10/14 at 1:07 p.m. R37 was taken to North Memorial Medical Center for intoxication. R37 was animated and chatting with the medics as he was taken, and the health unit coordinator (HUC) stated that is how you know he is intoxicated, he was friendly and chatting, when not intoxicated he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 353}	Continued From page 272	{F 353}		

was usually very quiet. It was reported from the hospital that the resident had alcohol and methadone (a drug he had not been prescribed) in his system. The administrator stated the 1:1 staff assigned to R37 should have been able to prevent him from obtaining and consuming alcohol and methadone.

On 5/11/14, at 10:55 a.m. the administrator notified surveyors he had not been notified that R129 was sent to emergency room, at 4:00 a.m., after she had reported to a staff member that she was intoxicated. A blood alcohol level was determined to be .323 (more than three times the legal limit) and R129 was in the intensive care unit, intubated and assisted to breath by a mechanical ventilator. The administrator stated the 1:1 staff assigned to R129 should have been able to prevent her from obtaining and consuming alcohol. After investigation it was noted by contracted licensed social work (CLSW)-A that R1 accelerated away from her 1:1 staff at a high rate of speed in her electric w/c and was able to make an exchange with R117 (a former resident), R1 and R129 were noted to make an exchange later in R129's room, both had 1:1 staff who did not report the exchange, and failed to protect the residents on 1:1 observation.

A special Staffing - One to One Assignment policy dated May 2012 and revised May 2013 included: one to one staffing assignments are in place based on an assessed need until appropriate permanent alternative arrangements can be made reasons may include, but are not limited to: treat of suicide by a resident, altered mentation that may dislodge treatment lines or devices, escalating exit seeking behavior, altered cognition in an agitated state that is not easily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 353}	Continued From page 273	{F 353}		

redirected., or not respected the boundaries of other residents. The procedure stated "to keep the one to one within arm's reach at all times. (if not suicidal may have visual privacy for toileting). Alternatives to one to one assignment are investigated as timely as possible. (alternative care setting, medical evaluation), family or responsible party are notified to see if they are available to provide this heightened level of supervision. Documentation of the one to one assignment is made in the clinical record; appropriate care plan/review/revision is made during the one to one assignment. IDT [interdisciplinary team] will meet to determine the appropriateness of removing a one to one and under what circumstances it may be reinitiated."

The one to one staff, and safety monitor were not effective in preventing residents from obtaining and consuming drugs and alcohol within the facility, the facility lacked an analysis of that staffing failure and lacked additional interventions to safe guard residents.

Refer to F224: the facility failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, the facility failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents (R13). These facility failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. This had the potential to affect all 67 residents in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 353}	Continued From page 274 F323: the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in Immediate Jeopardy (IJ) on 5/9/14, at 2:03 p.m. Also a second IJ was identified for 2 of 3 residents (R37, R129) on 5/12/14, at 2:51 p.m. In addition, the facility failed to ensure residents with WanderGuard were supervised when leaving the facility for 2 of 3 residents (R13, R116) observed to elope from the facility. R13 was observed on 5/6/14, to leave the facility with a WanderGuard attached. This resulted in IJ on 5/9/14, at 2:03 p.m. R116 was observed to leave the facility on 5/11/14, at 9:30 a.m. This resulted in IJ on 5/12/14, at 2:51 p.m. In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113). Also, the facility failed to ensure residents were smoking safely according to the plan of care for 3 of 3 residents (R1, R36, R22).	{F 353}		
{F 412} SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 412}	Continued From page 275 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed without dentures during the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m. When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s) (edentulous); maintained oral care independently and R36 had reported he had dentures at home	{F 412}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 412}	Continued From page 276	{F 412}		

not at the facility.

Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him.

Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums.

The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..."

The Camden Care Center Quarterly Care Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet.

R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns.

The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or dentures and is able to chew adequately without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 412}	Continued From page 277	{F 412}		

his teeth and noted weight as stable.

Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested.

When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care.

When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms.

When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him.

When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..."

On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 412}	Continued From page 278	{F 412}		

while ago and would like new ones if his old ones could not be found.

On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones.

The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided.
The facility plan of correction indicated by 4/28/14, social service and nursing would coordinate getting R36 fitted with dentures and these activities would be clearly documented in the clinical record to include any and all communication with the guardian.
Review of R36's record on 5/7/14, at 1:50 p.m. lacked evidence of a dental visit.
When interviewed on 5/7/14, at 2:10 p.m. the health unit coordinator (HUC) stated reported she had spoken to R36 and he stated his dentures were in a storage locker and he did not want new ones and stated the information was in the progress notes.
The HUC was again interviewed on 5/8/14, at 8:17 a.m. and she stated she was unable to locate any documentation regarding her conversation with R36 regarding his dentures and she verified she had not offered R36 a routine dental exam. At 2:32 p.m. the HUC reported R36 had agreed to a dental visit and would be scheduled for one.
When interviewed on 5/13/14, at 2:29 p.m. licensed practical nurse (LPN)-E stated the facility did not have a dental policy and the corporate consultant stated it was on a case by case basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 412}	Continued From page 279	{F 412}		

The facility Medical Services policy dated May 2012, indicated the social services director or designee was responsible to arrange dental services to meet the needs of the residents.

R9 had a dental exam on 2/27/14, which indicated that more dental treatment was needed, however had not received dental follow up as recommended.

The annual MDS dated 10/11/13, did not identify R9 had any dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene.

Review of R9's care plan dated 4/10/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." The careplan indicated R9 had diagnoses that included schizophrenia, diabetes mellitus, and orofacial dyskinesia.

Review of In House Senior Services, LLC (limited liability company) Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and #12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful. Res was cooperative, though has difficult time holding her mouth still, and her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 412}	Continued From page 280 tongue is very active." During an interview on 5/6/14, at 2:45 p.m. R9 stated "I can chew. I saw a dentist here. I'm missing some teeth but he said they have to fall out before I can get dentures." During an interview on 5/7/14, at 3:28 p.m. LPN-A stated "I went through the progress notes and I don't see anything that addresses the dental exam." During an interview on 5/7/14, at 3:30 p.m. HUC stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this." Review of the facility Medical Services policy with revision date of May 2013, indicated the facility will ensure each resident has access to dental/vision/hearing/podiatric services to meet their individualized needs, resident needs are identified at the time of admission and additionally through the RAI [resident assessment indicator] process and daily assessment/monitoring of resident condition and change in condition also alerts staff to the need for medical services.	{F 412}		
{F 428} SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 428}	Continued From page 281	{F 428}		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the consultant pharmacist failed to identify lack of medication parameters for as needed (PRN) pain medications for 2 of 7 residents (R91, R36), failed to identify a lack of adequate indication for use, resident specific target behaviors and monitoring for antipsychotic medication for 2 of 7 residents (R37, R89) and failed to identify a lack of side effect monitoring and sleep monitoring for antidepressant medications for 1 of 7 residents (R1) reviewed for unnecessary medications.

Findings include:

R91's Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13, with a diagnosis of osteoporosis.

Review of the Medication Regimen Reviews (MRR) for R91 from 10/17/13 through 5/7/14, lacked evidence the missing parameters for PRN pain medications were identified.

Review of the Medication Administration Record (MAR) dated 4/1/14 through 4/30/14, revealed R91 did not receive any PRN Tylenol (a mild amalgesic) and Ibuprofen (an anti-inflammatory medication) and received multiple doses of PRN Oxycodone (a narcotic).

Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 428}	Continued From page 282	{F 428}		

mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain. R91 had orders for multiple PRN pain medications which lacked parameters for use.

R36's Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12, with diagnoses of femur fracture and alcoholic cirrhosis of the liver.

Review of the MRR for R36 from 4/22/13 through 5/6/14, lacked evidence the missing parameters for PRN pain medications were identified.

Review of the MAR dated 4/1/14 through 4/30/14, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight.

The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (TID) as needed and Oxycodone 10 mg TID, both for pain, and lacked parameters for use. R36 had orders for multiple PRN pain medications which lacked parameters for use.

R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism.

Review of the MRR for R37 on 11/14/13, indicated R37 was taking Seroquel for psychosis, however lacked direction for target behavior monitoring. Review of the MRRs from 9/25/13-4/18/14, revealed the CP failed to identify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 283	{F 428}		

the need for a gradual dose reduction or documentation of the clinical contraindication.

Physician and Nurse Practitioner (NP) Notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction.

The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety.

A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. R37 received Seroquel (an antipsychotic medication) daily without adequate indication for use, monitoring or an attempt at a gradual dose reduction.

When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist (CP) stated he would expect parameters written by the physician to clarify when to give which PRN pain medication.

When interviewed on 5/7/14, at 3:09 p.m. the CP stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident.

A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 284 The consultant pharmacist did not identify the lack of monitoring for resident specific target behaviors and the lack of orthostatic hypotension side effect monitoring for R89's use of Zyprexa (an antipsychotic medication). R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects."	{F 428}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 428}	Continued From page 285	{F 428}		

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg.

The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis.

A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 286	{F 428}		

indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia.

Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.

A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 428}	Continued From page 287	{F 428}		

s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective."

The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more."

The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia.

On 5/5/14, at approximately 1:40 p.m. R89 was observed to be lying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door.

Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 288	{F 428}		

record lacked evidence resident specific target behavior monitoring was completed for R89.

On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January.

On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication.

The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 289	{F 428}		

and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data.

Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor."

On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call.

The consultant pharmacist did not identify monitoring of R1's side effects for Trazodone and Venlafaxine (Effexor-both anti-depressants) and sleep monitoring was lacking.

R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 290	{F 428}		

yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day.

The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness.
Physician's Orders dated 2/26/14, indicated R1 received the following medication:
-Trazodone 100 mg by mouth at bedtime (HS) for insomnia
-Venlafaxine (Effexor) 150 mg by mouth daily for depression
- Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose."

Review of the Monthly Medication Regimen (MMR) from 3/18/14 forward, revealed the consultant pharmacist had reviewed R1's medications, both were undated and unsigned. The MMR's failed to identify side effects monitoring, and sleep monitoring were lacking, as indicated in the plan of correction dated 4/28/14.

Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 291	{F 428}		

not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction.

When interviewed on 5/7/14, at 1:40 p.m. registered nurse (RN)-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring.

When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction.

When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently.

When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 428}	Continued From page 292	{F 428}		

further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others.
When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently.

R113 CP failed to identify lack of parameters for as needed pain medication.

Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15mg) by mouth every four PRN, Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only.

When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 428}	Continued From page 293 When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. The PharMerica Medication Regimen Review completed by the CP monthly dated 4/18/14, and two other times after which were signed but undated did not identify R113's physician orders lacked the parameters. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. On 5/7/14, at 1:56 p.m. CP stated he would expect parameters written by the physician to clarify when to give which medication.	{F 428}		
{F 431} SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 294 The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 431}	Continued From page 295	{F 431}		

medication and treatment carts had the internal drawers kept clean; the facility failed to ensure medications were dated when opening; eye medications, suppositories, topical medications were observed to be stored together for 11 of 67 residents (R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88). In addition, the white refrigerator in the medication room (used to store refrigerated medications) was observed to have a heavy buildup of frost in the freezer compartment. These practices had the potential to affect all 67 residents residing in the facility. In addition, the facility failed to lock a medication cart which held biologicals and medications (anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication). This had the potential to affect 4 of 7 residents (R73, R37, R83, R115) who were near the medication cart. The four residents were able to access to the cart according to staff.

Findings include:

WEST MEDICATION CART
On 5/7/14, at 7:52 a.m. first (top) drawer was observed to have the following:
R13 had an open Advair Diskus inhaler (used for breathing) without an open date.

R13's Minimum Data Set (MDS) dated 3/25/14, noted R134 had breathing problems and was cognitively intact.

According to the package insert by GalxoKlineSmith dated 2008, staff were to "Take ADVAIR DISKUS out of the box and foil pouch. Write the 'Pouch opened' and 'Use by' dates on the label on top of the DISKUS. The 'Use by' date is 1 month from date of opening the pouch."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 431}	Continued From page 296	{F 431}		

R92 had an opened and expired bottle of Travatan Z 0.004% (reduce the elevated pressure inside your eye) eye drops for R92. The label indicated to "Order After 3/27/14." A sticker affixed to the bottle indicated the medication was opened on 3/3/14. The bottle was observed to be stored loosely with oral medications. A second bottle of the same eye drop with date opened of 4/19 (no year) written on the label, had no open date documented on the Date Opened sticker. A third bottle of the same eye drop was also observed to be stored loosely (no zip lock bag) in and with oral medications for various other residents and had no open date. All three Travatan Z bottles for R92 were opened and had remaining doses in each bottle.

R92's MDS dated 1/15/14, indicated R92 had adequate vision and no vision problems.

According to the package insert by Alcon Laboratories (SA) (Pty) Ltd, Revised 11/02, directed staff, "STORAGE INSTRUCTIONS: Store below 25°C., DO NOT USE MORE THAN 30 DAYS AFTER OPENING. KEEP OUT OF REACH OF CHILDREN."

R9's Insulin Aspart pen (Novolog- used to control blood sugar) had no open date and had a sticker on the pen which indicated "EXP [expires]: 04/11/14." A second pen of the same medication for R9 lacked the protective cover for the end of the pen (where the needle affixes) and lacked an open date. Both pens were stored in and with eye drops for other residents.

R9's MDS dated 3/24/14, indicated R9 was cognitively intact and had diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 297	{F 431}		

According to the package insert by Novo Nordisk INC, dated 2002 through 2008, staff were to store as follows: " Recommended Storage: Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated. Unpunctured vials can be used until the expiration date printed on the label if they are stored in a refrigerator. Keep unused vials in the carton so they will stay clean and protected from light.

R54 had a bottle latanoprost 0.005% (used to reduce the intraocular pressure) eye drops was observed to be stored loosely with other oral medications.

R54's MDS dated 1/15/14, indicated R54 had adequate vision and no vision problems.

- A 3 milliliter (ml) vial of 2.5 mg albuterol was observed to be stored loosely in the top drawer. The vial had no label to identify which resident the Albuterol was ordered for.
- The first drawer was observed to have a light brown and crumb like consistency buildup of debris in the upper right corner of the drawer. A heavy buildup of sand colored debris was observed in the upper left corner of the first draw. The debris was observed to be with and under the stored inhalers.
- The second drawer had a heavy buildup of brownish colored debris in the corners and bottom of the drawer. The debris appeared to be from pulverized/crushed medication tablets.

On 5/7/14, at 8:15 a.m. the licensed practical nurse (LPN)-C verified the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 431}	Continued From page 298 SOUTH TREATMENT CART On 5/7/14, at 8:39 a.m. the registered nurse (RN)-B verified he worked out of the cart and opened the cart. The following was observed: R29's Levemir insulin flexpen (used to control blood sugar) had no open date on the sticker. R29 's MDS dated 1/29/14, indicated R29 was cognitively intact and was a diabetic. According to the package insert by Novo Nordisk INC, dated 2005 through 20012, staff were to store as follows: "Recommended Storage: 3 mL LEVEMIR FlexPen: Not in-use (unopened) Room Temperature (below 30°C) for 42 days. In-use (opened) was to be stored for 42 days at room temperature." R25's Lantus insulin had an open date of 4/4 (no year) and expiration date of 5/3 (no year). The insulin was open, partially used and expired. R25's MDS dated 4/8/14, indicated R25 was a diabetic and was moderately cognitively impaired. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " R66's Lantus Solostar insulin had no open date.	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 431}	Continued From page 299	{F 431}		

R66's MDS dated 3/25/14, indicated R66 was cognitively intact. The MDS did not indicate R66 was a diabetic. However, the MDS did indicate R66 received insulin injections in the past seven days.

According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. "

RN-B verified the findings at the time of the observation and stated the medications should have open dates. RN-B verified the expired medication was used "today."

The second drawer of the south treatment cart was observed to have a buildup of potential pulverized medication debris in the corners of the drawer.

The third drawer was observed to contain a plastic bin containing various tubes of topical medications for different residents. Some tubes were observed to be stored in zip lock bags with labels. All topical medication tubes in the bin had been used. Topical medications in the bin not in zip lock bags were observed to be in contact with each other. The topical medications not stored separately included a tube of unlabeled Dimethicone Skin no label (barrier ointment).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 431}	Continued From page 300	{F 431}		

R22's tube of Capsaicin 0.25% Cream (used to control pain from arthritis) directed staff to apply the medication to the left hip and right rib.

R22's MDS dated 1/9/14, indicated no musculoskeletal problems, no indications of pain, and also revealed R22 was moderately cognitively impaired.

R95's Hydrocortisone 1% Cream (used to treat skin inflammation and itching) identified to apply the medication to R95's stomach and back;

R95's MDS dated 2/28/14, indicated no rashes were present and revealed R95 was cognitively intact.

- An unlabeled tube of Aquaphor healing ointment (barrier ointment) was approximately 90% used.

R86 had a tube of Fluocinononide 0.05% solution (used to treat the itching, redness, dryness, crusting, scaling scalp) which directed to apply the medication to scalp; R86's tube of Desonide 0.05% (used to treat the redness, swelling, itching, and discomfort of various skin conditions) directed to apply the medication to axilla, groin and abdomen folds; a bottle of Deep Sea Premium Nasal Moisturizing Spray (moisturizes the nasal passages). The bottle of nasal spray was observed to be in contact with other topical medications in the bin. RN-B stated the spray, "Should be in other cart."

R86's MDS dated 3/23/14, indicated no skin problems and was cognitively intact. R86's Treatment Administration Record (TARs) dated May 2014 indciated the R86 received topical cream to the face, skin folds, groin, and axilla

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 431}	Continued From page 301 once or twice a day for psoriasis bulgaris. R29's Nystatin - Triamcinolone Cream (used for yeast infections) directed to apply the medication to R29's labia. R29's MDS dated 1/29/14, indicated R29 was cognitively intact, received creams and ointment to other areas other than feet, and noted R29 was a diabetic. R29's Physician's Order sheet undated indicated Nystatin was to be applied to the labia three times daily for itching. - The drawer was observed to have a heavy buildup of crumbs, pulverized pill fragments and paper, foil and plastic pieces debris in all drawers. The corners and sides of the drawers had the highest build up. RN-B verified the findings at the time of the observation and confirmed the topical medications should be stored separate from nasal medications. RN-B verified the tubes of topical medications for different residents, should not be stored together. SOUTH MEDICATION CART At 9:06 a.m. the South Medication Cart second drawer was observed to have one white and one yellow medication tablet loose in the bottom of left section of the drawer, and one yellow tablet, one white tablet, one pink tablet and one beige tablet loose on the bottom of the right section of the drawer. A buildup of foil debris was observed in all corners. - The third drawer had one bright yellow tablet and a buildup of pulverized pills and foil debris in all corners. - Fourth drawer was observed to have a opened and partially used box of Bisac-Evac 10 mg Bisacodyl suppositories used for constipation)	{F 431}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 431}	Continued From page 302	{F 431}		

stored with nebulizer medications (breathing medications).
- The first small left side drawer was observed to have one unlabeled vial of Albuterol neb solution (breathing medication) stored loosely in the drawer.
- The third left side drawer was observed to have a sticky red colored substance spilled on the bottom of the drawer. The substance appeared to be smeared on the bottom of the drawer, was wet to the touch and easily removed with a finger.
RN-B verified the above findings and was unclear on when the medication carts were cleaned.

MEDICATION ROOM
At 9:21 a.m. the white medication refrigerator was observed to have a heavy buildup of frost approximately two to three inches thick which completely encased an ice pack in the frost of the freezer.

NORTH MEDICATION CART
At 9:24 a.m. the following was observed:

R88's Novolog insulin (used to control blood sugar) was observed to have an open dated of 3/22 (no year) and an expiration date of 4/20 (no year). R88's MDS dated 2/7/14, indicated the resident had expired.

- The second drawer was observed to have a white half tablet, a red gel cap loose in the bottom of the drawer; foil, paper and pulverized medication debris was observed to have built up in edges and corners of the drawer.
- The third drawer was observed to have built up foil, paper and pulverized medication debris in the corners, a red, sticky, circular shaped spill on the bottom of the drawer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 431}	Continued From page 303	{F 431}		

LPN-F verified the findings at the time of the observation. LPN-F was unclear on medication cart cleaning and stated she, does "not have time to get her medication pass done" due to it being "too heavy." LPN-F explained she had too many other responsibilities such as taking blood sugars, administering insulin verified she did not clean the medication cart. Although LPN-F stated she worked for the agency, LPN-F stated she usually worked on the North Medication cart and had worked in the facility for several weeks.

EAST MEDICATION CART
At 9:39 a.m. the second drawer was observed to have two white half tablets loose in the bottom of the drawer.

On 5/7/14, at 11:45 a.m. LPN-E verified she was in charge of the North Unit and stated the medication carts were "a mess" and stated she believed all the carts were newer and cleaned by "the pharmacy" last week. LPN-E was unclear on the cleaning schedule of the medication carts. LPN-E stated before there was trained medication aide (TMA) responsible for the cart and a nurse responsible for the treatment cart. Explained there were "fifteen different hands" in each cart and they were not being kept clean.
-At 12:00 p.m. LPN-E observed the medication carts with surveyor and verified the findings. LPN-E stated it was a new medication cart. LPN-C was present at the time of the observation and stated the medication cart was "not new." LPN-E verified eye drops, Advair Diskus inhalers, and insulin required open dates.

On 5/7/14, at 1:26 p.m. LPN-A verified she was in charge of the West and East units. LPN-A stated she had not completed any cleaning audits for the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 431}	Continued From page 304	{F 431}		

medication carts and did not know if audits were completed. LPN-A stated she did not know the audit or cleaning schedules for the carts. LPN-A was unclear what the facility system was to ensure the medication carts were kept clean. LPN-A further stated she was unclear who was responsible for cleaning the medication carts and was unclear on the policy for medication cart cleaning.

On 5/8/14, at 4:21 p.m. the consulting administrator stated the facility did not have a policy or a procedure for medication cart cleaning and verified the carts should have been cleaned. The consulting administrator stated the facility was "not allowed to write policies," but could write a "procedure."

A PharMerica 3.7 Medications and Medication Labels policy dated 9/2010, directed multi-dose vials "shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)" The policy further identified all medications should have a pharmacy affixed label.

The PharMerica 4.1 Storage of Medication policy dated 9/2010, directed to store eye, internally administered, oral inhalation, nasal, oral and topical medications separately.

Medications carts were left unlock and un-supervised.
South Hallway Medication cart
On 5/5/14, at 1:39 p.m. observed the key lock to the nursing medication cart to be fully extended in the unlocked position on the South unit. Two residents were observed to wheel by the cart and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 431}	Continued From page 305	{F 431}		

no staff was in the hallway. RN-B, was observed to follow the surveyor from the nursing station onto the South unit and approach the medication cart and open the top drawer.

East Hallway Medication Cart
On 5/8/14, at 3:50 p.m. surveyor observed the unlocked medication cart across the nursing station in the East Hall Way.
-At 3:53 p.m. observed the administrator walk past the unlocked cart.
-At 3:55 p.m. observed the director of nursing walk past the cart then walk right past the cart back to the nursing station.
-At 3:54 p.m. nursing assistant (NA)-F came stood approximately 6 feet beside the surveyor on the counter typing then walked away.
-At 3:56 p.m. observed resident with a cane walk past the cart to his room.
-At 3:57 p.m. observed NA-G standing on the opposite side of the hallway approximately 2 foot steps from the cart still unlocked.
-At 3:58 p.m. director of nursing (DON) walked past the cart again and went down the hallway.
-At 3:59 p.m. observed receptionist (O)-D walked past the medication cart approximately 1 step from the cart still unlocked.
-At 4:00 p.m. DON walked past the medication cart still unlocked back to the nursing station. Went into the nursing station stood at the inside of the counter looking down the hallway where the unlocked cart was stationed.
-At 4:01 p.m. observed NA-I walked past the medication cart to the South hallway.
-At 4:02 p.m. O-D again went past the unlocked cart approximately one foot step went to the human resource office and came right out and returned to the front desk.
-At 4:04 p.m. observed NA-I walked past the cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 431}	Continued From page 306 again and turned right and walked past the cart to the South Hallway. When interviewed on 5/8/14, at 4:06 p.m. LPN-D if the medication cart was supposed to left open stated, "No." LPN-D walked over to unlocked medication cart and locked it. When interviewed on 5/9/14, at 10:05 a.m. LPN-E stated, "All the medication carts are not supposed to left open." When interviewed on 5/9/14, at 1:32 p.m. RN-B stated the medication cart should be locked when staff was not around and when nurses walked away from the carts. RN-B further stated the nurse that had left the cart unlocked had acknowledged she had left the cart unlocked on 5/8/14. The facility Storage of Medication dated 9/10, directed "In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.	{F 431}		
{F 465} SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 465}	Continued From page 307 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident room carpets for 3 of 3 residents (R22, R56, R33) and an E-Z stand (a mechanical stand used for transfers) were kept in good repair, clean and in a sanitary manner. Findings include: A tour of the facility was conducted on 5/9/14, at 8:59 a.m. through 10:05 a.m. with the director of facility operations (DFO) and the following concerns were identified: Carpets: On 5/9/14, R22's portion of the room was observed. The carpet had large dark brown stain/spots from the bed to the dresser. DFO verified the carpet was not clean and stated, "I think it is filthy and trashed." R22's annual Minimum Data Set (MDS) dated 4/10/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs. R22 used both the walker and wheelchair (w/c) for mobility in his room. On 5/7/14, at 7:59 a.m. R22's carpet was observed to have dark brown spots/stain on the carpet around the bed area and to the entrance of the room. On 5/9/14, at 9:34 a.m. DFO verified R22's carpet was not clean stated "Again this is one of the rooms that I would like to have a deep cleaning and was hoping the cleaning of the carpet would have been done after pest control was here	{F 465}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 465}	Continued From page 308 yesterday." R56 was bedfast in the room. When R56's room was observed on 5/9/14, at 8:59 a.m. the carpet had several dark, black ground-in spots and stained red around the bed. R56's annual MDS dated 2/25/14, indicated R56 required extensive to total assistance with activities of daily living (ADLs) including transfers, was bed bound, used a w/c for mobility and had intact cognition. On 5/9/14, at 9:30 a.m. DFO verified the carpet in R56's room was not clean and stated, "It needs to be deep cleaned." R33 On 5/6/14, at 9:00 a.m. surveyor noticed a strong malodorous urine smell coming out of R33's room and the carpet observed to have dark brown large stain/spots from the bed to the radiator and on the area between the foot of bed and dresser (walk area). During observation a housekeeping staff was observed standing outside R33's room but was cleaning the next room. On 5/9/14, at 9:38 a.m. DFO verified the smell stated, "It's very strong and this is another room that needs to have the carpet cleaned or replaced." DFO stated, "We were supposed to get the air freshener's from Ameri-Pride today but they were supposed to be delivered on Friday." DFO further stated the carpet cleaning company had been to the facility recently and cleaned the common areas. The DFO knew the contract was expired and directed questions to the	{F 465}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 465}	Continued From page 309	{F 465}		

administrator.

R33's quarterly MDS 2/20/14, indicated intact cognition, required limited assistance with ADLs, had impairment to both lower extremities and used a walker and w/c for mobility. R33's also received a diuretic.

Mechanical lift:
E-Z stand handle did not have a cleanable surface.

On 5/9/14, at 9:05 a.m. the E-Z stand was observed stored on the alcove on the West Hall and the left bar was observed to have vinyl peeling off exposing the foam underneath. The cracked vinyl was covered with gray duct tape and at the end the tape was exposing the sticky side of the tape making it not a cleanable surface.

When interviewed on 5/9/14, at 9:07 a.m. DFO verified stated, "I was told by the vice president to put the duct tape over for now and I have a bid for cushions and guard and am waiting."

When interviewed on 5/9/14, at 8:38 a.m. the administrator stated there is a carpet cleaning plan with a contractor who would be coming in to clean a couple rooms at a time. Administrator further stated, "We are going to order replacement parts for the E-Z stand, we had been told that the duct tape was sufficient."

Review of the w/c cleaning schedule for Maintenance dated May 2014 indicated R36's w/c had not been cleaned. The Wheelchairs To Pull For Night Washing sheets dated 5/1/14, through 5/9/14, also indicated R36's w/c had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 465}	Continued From page 310 cleaned. The facility Maintenance Request Log Policy and Procedure revised April/2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs ..." The policy lacked information on how often residents carpets would be cleaned.	{F 465}		
F 469 SS=D	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a pest control program effective in the control of ants in 1 of 1 resident room (R56). Findings include: During observation on 5/7/14, at 7:42 a.m. 12 winged insects were noted on R56's bed and on the wall at the head of the bed. During observation on 5/7/14, at 7:59 a.m. R56's room was noted to have open food items, The carpeting next to the bed was heavily soiled with brown and red material, and a foul odor was noted in the room. On 5/7/14, at 8:41 a.m. an ant mound and three ants were noted in the corner of R56's room by	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 469	Continued From page 311	F 469		

the window. Multiple ants were noted crawling on and inside the heater under the window.

When interviewed on 5/7/14, at 7:50 a.m. the director of facility operations stated the facility used Xtreme Pest Solutions for pest control. He stated staff identify any concerns with pests by documenting in the maintenance log kept behind the nursing station.

When interviewed on 5/7/14, at 8:05 a.m. housekeeper-B verified there were bugs in R56's room and stated he had not seen them the prior Thursday when he'd cleaned the room. Housekeeper-B stated R56, "Has lots of sweets in her room and that may be why."

On 5/7/14, at 8:09 a.m. the director of facility operations was asked to come to R56's room and stated, "We have to get her out of the room right away!" and call the pest company. He stated he was not sure what the bugs were but thought they were ants or wasps.

The pest control contractor was interviewed on 5/7/14, at 12:52 p.m. and stated the bugs were a form of pavement ants and he had treated the room and the surrounding areas. He reported the ants were drawn into the room for food and the facility would need to maintain treatment to the affected areas.

Review of the Service Report dated 2/13/14, included treatment for mice and rats. Review of the Service Report dated 4/3/14, included treatment for multiple targeted pests including ants.

The Service Report dated 5/7/14, at 12:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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F 469	Continued From page 312 included treatment for multiple targeted pests including ants and indicated four rooms on the south hall were treated as well as the exterior of the south wing. A policy regarding pest control was requested and the director of facility operations stated the facility did not have a policy.	F 469		
{F 490} SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 observation, interview and document review, the administrator failed to provide adequate supervision and oversight for residents who had known drug and alcohol (ETOH) use for 2 of 11 residents (R37, R129). In addition, the administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues being identified at F490. In addition to the IJ issues, the facility was not administered in a manner to maintain compliance with other regulations specific to meet the needs of residents for 15 of 40 residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; 3 of 5 employees (E1, E2, E3) reviewed whose annual evaluations were not	{F 490}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

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{F 490}	Continued From page 313	{F 490}		

completed; 1 of 5 nursing assistants (NA-Z) did not meet the required inservice hours; 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) did not have current license verification. These administrative failures had the potential to affect all residents of the facility.

The IJ began on 5/10/14, when R37 was admitted to the hospital for acute alcohol intoxication requiring medical treatment including intubation to assist with breathing. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/12/14, at 3:15 p.m. The IJ was not removed by the exit date of the survey.

Findings include:

On 5/9/14, the facility had been informed of serious and immediate safety and supervision issues related to a lack of adequate supervision for residents, specifically related to resident's with known drug and alcohol use issues, and elopements. The facility had been informed these issues constituted an immediate jeopardy situation. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and/or alcohol intoxication. In addition, on 5/11/14, a vulnerable resident was able to elope from the facility on three separate occasions without staff present even though the facility had implemented a WanderGuard device.

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 490}	Continued From page 314	{F 490}		

Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an IJ situation for R37, R129 and R116.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q).

Refer to F250: the facility failed to aggressively identify, assess, develop and implement interventions for medically-related social services, for residents known to provide and/or use illegal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 490}	Continued From page 315	{F 490}		

drugs and ETOH in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9).

Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.

Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to ETOH abuse.

Refer to F323: the facility failed to ensure systems were in place to support patient care, and supervise staff. An IJ was identified on 5/9/14, for lack of supervision related to drug and ETOH use for R37, R129, R41, R117, and for the lack of supervision for residents who were at risk for elopements, R13. On 5/9/14 the administrator, On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).

Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14.

Refer to F492: the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 490}	Continued From page 316	{F 490}		

Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work.

Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months.

Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility.

Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility.

A letter was provided to surveyors on 5/19/14 by an employee who wished to remain anonymous. The letter indicated that as of that date, the President and CEO of Videll Healthcare was informing employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 490}	Continued From page 317 a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had also been posted at the employee time clock. The IJ that began on 5/12/14, was not removed at the time of the exit from the survey because the facility failed to have developed a plan to avoid any future delay in notification of staff if serious and immediate issues were identified for any residents; failed to have developed and/or revised policies related to obtaining a drug and alcohol free facility; failed to have reviewed and/or revised their elopement policies; had not yet made arrangements to ensure all staff had received training; had not yet convened an interdisciplinary team meeting to discuss and determine how to monitor resident safety, care needs and how to prevent any future occurrence of such serious and immediate concerns.	{F 490}		
F 492 SS=E	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure nurses and nursing	F 492		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 318	F 492		

assistants (NAs) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance to ensure freedome from tuberculosis (TB) before they were assigned to work. This had the potential to affect all 67 residents residing in the facility.

Findings include:

The facility did not comply with the Minnesota Statute 144A.72 REGISTRATION REQUIREMENTS; PENALTIES. Subdivision 1.Minimum criteria. The commissioner shall require that, as a condition of registration: (2) the supplemental nursing services agency shall comply with all pertinent requirements relating to the health and other qualifications of personnel employed in health care facilities.

A review of the supplemental staff files revealed the following:

NA-T had a negative tuberculin skin test (TST) administered on 8/26/11. There was no record to show a second TST was done.

Licensed practical nurse (LPN)-C had a chest x-ray result dated 10/17/07. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor.

LPN-F's TB screening test result dated 4/10/14, read "Negative. M. tuberculosis infection not likely, but cannot be excluded in cases of immunosupression." There was no screening for symptoms of active TB and there was no examination done by a medical doctor after the TB screening test.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 492	Continued From page 319	F 492		

LPN-I had a first TST administered on 3/29/11. There was no evidence of a second TST having been done.

LPN-J had a negative CXR results done on 12/7/09. There was no screening for symptoms of active TB completed and there was no examination done by a medical doctor.

LPN-K CXR results done on 1/19/09, was read as "Unremarkable exam." There was no screening for symptoms of active tuberculosis and there was no examination done by a medical doctor.

On 5/13/14, at 9:33 a.m. during a telephone interview, O-I from Soul Care staffing agency verified the above-named supplemental staff are employed by Soul Care and that the same staff had been reporting for work at the facility. He further verified all of the findings pertaining to TB screening dates and procedures for the employees named.

On 5/13/24, 10:27 a.m. LPN-A, nurse manager, stated the staffing agency would provide to the facility the TB screening records of staff coming to work. LPN-A stated that it was human resources (HR's) responsibility to keep track of the records and to keep the files for the facility.

On 5/13/14, at 10:55 a.m., the consultant administrator verified the list of supplemental staff provided to surveyors was current, and the staff had been working at the facility. The consultant administrator stated that supplemental staff was not treated any differently from regular facility staff with regard to TB screening. She stated Soul Care provided the TB screening records of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 492	Continued From page 320 supplemental staff, and if staff were found positive for the TST results, they should have been required to undergo assessments for current TB symptoms, should have had CXR and physician's visit indicating employees were clear from tuberculosis. The consultant administrator stated HR was responsible to keep track of pool staff records and to report to the director of nursing and the administrator if issues were identified. The Clinical and Operations Manual dated 5/2012, directed the facility to administer a 2-step PPD (purified protein derivative used to do a TST) to all employees and that documented copies were to be kept in the employees' file records.	F 492		
{F 493} SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility for 15 of 44	{F 493}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 321	{F 493}		

residents (R34, R129, R37, R116, R41, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; facility failed to ensure 3 of 5 employees (E1, E2, E3) reviewed during the initial survey for annual evaluations were completed; In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed; the facility failed to ensure 5 of 11 employees (RN-C, RN-D, LPN-A, NA-U, NA-Q) had current license verification. In addition, the facility's governing body failed ensure vendors were paid in a timely manner. This had the potential to affect all 67 residents in the facility.

Findings Include:

Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse.

Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 322	{F 493}		

administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly.

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q).

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9).

Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 323	{F 493}		

Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse.

Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).

Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13.

Refer to F412: the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status.

Refer to F490: the administrator failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 324	{F 493}		

(R37, R129, R117). In addition, administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement.

Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work.

Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months.

Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility.

Refer to F500: the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because they had not paid the bill to the agency.

Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 325 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice on Monday, May 5th, Tuesday, May 6th, and Wednesday, May 7th. The facility had social workers scheduled, but due to not paying their bill, the social workers were not provided." For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social	{F 493}		

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	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 493}	Continued From page 326 worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 493}		
{F 497} SS=C	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of	{F 497}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 497}	Continued From page 327 nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed. This had the ability to impact all 67 residents in the facility as the facility was a one story facility and the staff could work on all of the units. Findings include: Evaluations: On 5/12/14, at 10:00 a.m. employee performance evaluations for E1, E2 and E3 were requested of the administrator. He said he would get them; however, no evaluations were provided. On 5/13/14, at 12:41 p.m. performance evaluations for E1 through E3, from previous March 2014 survey and evaluations for all employees due for annual performance review in March 2014 and April 2014 was requested of the administrator. He said he would get the information.	{F 497}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 497}	Continued From page 328 On 5/13/14, at 3:30 p.m. unable to interview the director of nursing (DON) as the DON had resigned. On 5/13/14, at 3:35 p.m. although the evaluations had been requested, no employee performance evaluations had been provided by facility as of that time. At the time of exit on 5/13/14, at 4:30 p.m. the evaluations still had not been provided. In-service: NA-Z was hired on 4/10/11. The employee file was reviewed for continuing education and noted NA-Z had only 3.5 hours of the 12.0 required hours from 1/1/13 through 5/12/14.	{F 497}		
F 499 SS=D	483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements. Professional staff must be licensed, certified, or registered in accordance with applicable State laws. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification of licensure for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C). These had the potential to affect all 67 residents residing in the facility. Findings include:	F 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 499	Continued From page 329 Licensure verification: LPN-A's employee file folder lacked verification of the LPN license. The administrator verified on 5/12/14, at 12:45 p.m. there was no proof of nursing licensure obtained from the Minnesota Board of Nursing for LPN-A. RN-C was hired on 4/8/14, indicated no licensure verification (copy of license dated 10/4/13) had been completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge for doing license verifications for new employees. The administrator further stated the HR person was terminated two weeks ago. The administrator added the facility did not ensure tracking for new employees' license verification. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, then she started full time work on her own since 4/16/14. The facility's Clinical Manual, Operational Manual dated 5/2012, directed the facility to obtain verification of nursing licensure from the State licensing board upon employment and to keep a completed "License Verification Form" in the employee's personnel file.	F 499		
{F 500} SS=D	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a	{F 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 500}	Continued From page 330 person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because the facility had an outstanding debt to the agency. Findings include: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. At 2:30 p.m. the administrator stated the contracted social work agency was Circle of Life Aging Services. The owner of Circle of Life, Aging Services (contracted social service), interviewed On 5/12/14, 1:18 p.m.c stated, "The reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th,	{F 500}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 500}	Continued From page 331 Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 4 of 11 residents (R129, R86, R41, R37) who sustained harm due to lack of social services interventions; for 5 of 11 residents (R14, R56, R117, R62, R9) who needed social services interventions for alleged substance abuse and did not receive the services; and for 2 of 11 residents (R13, R103) who were alleged to have eloped and did not receive the medically needed social services.	{F 500}		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 502	Continued From page 332	F 502		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.

Findings include:

A Progress Notes dated 5/6/14, noted as a late entry for 5/5/14, indicated R37 was found outside of the facility and reported to staff he had gotten heroin and cocaine from another resident and had been injecting the drugs. R37 was noted to have several scattered purple bruises on his forearms.

A Physician's Orders dated 5/6/14, directed urine toxicology screen.

A Progress Notes dated 5/6/14, indicated the nurse went to R37's room to obtain a urine specimen for toxicology screen. R37 refused to provide a urine sample to the nurse. The note indicated a urine sample cup and supplies were left in R37's room with instructions to obtain a sample when R37 had the urge to void even though a urine specimen for toxicology needed to be witnessed by staff.

Review of the medical record lacked evidence of any further attempts made to obtain the urine toxicology screen or lab results.

When interviewed on 5/12/14, at 11:53 a.m. the health unit coordinator stated there was not a urine toxicology screen completed as ordered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 502	Continued From page 333 and the only lab work completed for R37 in May 2014 was done in the hospital. A facility policy regarding lab work was requested and not provided.	F 502		
{F 514} SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete medical records, the charts lacked nursing notes, laboratory results, behavior monitoring. and assessment and plans for initial physician assessments for 20 of 40 residents (R103, R116, R86, R71, R9, R34, R51, R129, R13, R117, R41, R62, R37, R56, R36, R123, R1, R113, R29, R91). This had the potential to affect all 67 residents. Findings include: R103 was admitted to the facility on 7/29/13, with	{F 514}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 514}	Continued From page 334	{F 514}		

diagnoses of multiple right sided fractures of arm, leg, rib and pelvis related to a motor vehicle accident.

Last progress note on 1/5/14, at 5:30 a.m., "Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility, and currently uses Foley catheter."

An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter. R103 was now assessed as independent in all functional activities of daily living. The chart lacked documentation of when the Foley catheter was removed.

The chart lacked a significant change MDS for improvement in more than two areas of functional status.

The care plan dated 8/9/13, and revised 3/29/14, and 4/26/14, indicated, "English as a second language, required short term placement for rehab and was expected to discharge to the community within the next 3 months. R103 had impaired mobility care plan related to MVA, multiple fractures and weakness, and was to use a cane. A potential for self-care performance deficit. A potential for alteration in bowel and bladder related to disease process, unsteady gait, and cultural differences."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 514}	Continued From page 335	{F 514}		

The medical record was reviewed on 5/11/14, and lacked documentation of LOA (leave of absence) or discharge.

Orders dated 4/16/14 state may LOA unsupervised with medications.

On 4/20/14 at 9:48 p.m. Pt went on LOA. The chart lacked documentation of return to the facility.

On 5/10/14 at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA.

On 5/11/14, at 10:00 a.m. the facility was asked if the resident had been discharged, or was on LOA and had returned to the facility. HUC checked to see and resident was in room. He had signed in at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility.

On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had notes for R103, but knew he had been working with a relocation worker.

R71 was admitted to the facility on 5/17/10, with admission diagnosis of CVA (stoke) with hemiplegia (loss of all or part of one side of the body), chronic pain syndrome, depression, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 514}	Continued From page 336	{F 514}		

diabetes.

R71 was seen by the physician on 4/16/14, labs were ordered, and new medication orders dated 4/16/14, included: bendadryl 25 mg (milligrams) give 1-2, every 4-6 hours as needed for itching, and to increase gabapentin to 300 mg, give 2 every bedtime (for persistent left sided pain).

On 4/18/14, a physician order to increase atorvastatin (a cholesterol-lowering medication) to 80 mg daily, and Metformin ER (used to treat type 2 diabetes) 1000 mg daily with supper.

An initial primary care physician (PCP) to establish primary care on 4/16/14: noted a history of CVA (stroke), left hemiplegia (loss of use of part or all of the left side), hypertension, dyslipidemia, Major Depressive disorder, diabetes type II, tobacco abuse, and neuropathic pain. A review of medication list, and laboratory tests were ordered Hbg A1c (a indicator of diabetic compliance over a three month period), lipid panel (cholesterol testing) alt (liver test), lytes and BUN (kidney function tests).

On 5/6/14, a review of the medical record revealed no results for the lab tests that had been ordered on 4/16/14.

On 5/7/14, at 3:14 p.m. the health unit coordinator (HUC) verified the medical record lacked results of the 4/16/14, ordered labs, and also lacked the new PCP initial visit notes, assessment, or plan for patient treatment.

R9's medical record lacked laboratory results since 7/30/13.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 514}	Continued From page 337	{F 514}		

On 5/13/14, at 9:30 a.m. during review of R9's medical reviewed it was revealed R9 had been to the primary physician's office several times for routine visit since 7/30/13, but lacked laboratory results for all the tests completed during the office visits.

When interviewed on 5/13/14, at 10:58 a.m. the HUC verified there were no labs in the resident chart since 7/30/13. The HUC stated the particular clinic the resident went to "always" had given her a hard time getting the notes and labs. The HUC indicated she had been told in the past that she had to call the day of the appointment to request for the information or write a note in the facility referral sheet but still nothing was being sent back with resident.

Copies of R34's care plan were requested from the record. The vulnerable adult care plan for R51 was provided that had been in R34's chart. R34 and R51 have the same last name with different first names.

Refer to 223: the facility failed to ensure R34 was free from verbal abuse from R36 and review of the medical records for R34 and R36, lacked documentation regarding the incident which was reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, R9).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 514}	Continued From page 338	{F 514}		

That resulted in harm for R129, R117, R41, R37.

Refer to F274: the facility failed to complete a significant change assessment (SCSA) for 2 of 3 residents (R56, R116) with a decline in functional status.

Refer to F275: the facility did not comprehensively assess 1 of 1 resident (R36) who required a comprehensive assessment at 366 days.

Refer to F280: the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter for 1 of 3 residents (R36); and for 1 of 1 resident (R116) on Hospice who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who allegedly had substance abuse.

Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.

Refer to F329: the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R36, R1, R89, R113, R29, R37, R91).

Refer to F412: the facility failed to ensure residents were provided dental services for 1 of 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 514}	Continued From page 339 residents (R36). In addition, the facility failed to ensure residents received recommended dental follow-ups for 1 of 3 residents (R9). Refer to F502: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Refer to F520: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.	{F 514}		
{F 520} SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify	{F 520}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 520}	Continued From page 340	{F 520}		

and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 44 (R34, R37, R129, R116, R41,R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1, E2, E3) reviewed during the initial survey; the facility failed to ensure nursing assistants (NA) received the required continuing education for 1 of 5 (NA-Z); and 5 of 11 employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility.

Findings include:

Refer to F223: the facility failed to ensure one of one resident (R34) was free of abuse.

Refer to F224: an Immediate Jeopardy (IJ) was identified at F224 for neglect of care for R37 and R129, when residents were able to access drugs and alcohol and required hospitalization after the Immediate Jeopardy at F323 had been identified on 5/9/14.

Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 520}	Continued From page 341	{F 520}		

residents (R129, R37, R116, R41, R10, R70, and R13).

Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (RN-C, RN-D, LPN-A, NA-U, NA-Q).

Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 11 of 11 residents (R129, R13, R117, R41, R62, R37, and R9).

Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.

Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 520}	Continued From page 342	{F 520}		

Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).

Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14.

Refer to F490: an IJ was issued at F490 for administration failure to fully implement the March POC, and to act upon the IJ identified at F323 on 5/9/14, to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14.

Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work.

Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 520}	Continued From page 343	{F 520}		

in the facility for greater than 12 months.

Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C. These had the potential to affect all 67 residents residing in the facility.

The facility failed to pay vendors in a timely manner:

On 5/8/14, at 2:00 p.m. facility staff stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services.

On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. "For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{F 520}	Continued From page 344 equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." On 5/19/14, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the Limited Liability Company (LLC) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{F 520}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite resurvey was conducted on May 5, 6, 7, 8, 9, 10, 11, 12, and 13, 2014, to determine compliance with State deficiencies issued during a recertification survey exited on March 18th, 2014. During the onsite visit it was determined that the	{2 000}		

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{2 000}	Continued From page 1 following corrections order(s) # 130, 135, 165, 255, 265, 530, 540, 545, 565, 570, 625, 800, 830, 900, 1325, 1426, 1475, 1530, 1535, 1610, 1665, 1695, 1730, 1830, 1850 and 2000 were NOT corrected. These uncorrected order(s) will remain in effect and will be reviewed at the next onsite visit. Also uncorrected order(s) will be reviewed for possible penalty assessment(s). In addition new state correction orders were issued at 285 and 820.	{2 000}		
{2 130}	MN Rule 4658.0050 Subp. 1 Licensee;General duties Subpart 1. General duties. The licensee of a nursing home is responsible for its management, control, and operation. A nursing home must be managed, controlled, and operated in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to pay vendors in a timely manner, failed to ensure policies and procedures were in place, or implemented to ensure highest practicable well being of the residents. This had the potential to affect all 67 residents and staff(ing) in the facility. Findings include: A letter provided to surveyors on 5/19/14 identified that as of that date, the President and	{2 130}		

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{2 130}	Continued From page 2 CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous. On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. At 2:30 p.m. the administrator stated the contracted social work agency was Circle of Life Aging Services. The owner of Circle of Life, Aging Services (contracted social service), interviewed On 5/12/14, 1:18 p.m.c stated, "The reason you did not see social workers at the facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has	{2 130}		

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{2 130}	Continued From page 3 been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents."	{2 130}		
{2 135}	MN Rule 4658.0050 Subp. 2 Licensee;Specific duties Subp. 2. Specific duties. The licensee must develop written bylaws or policies for the management and operation of the nursing home and for the provision of resident care, which must be available to all members of the governing body, and must assume legal responsibility for matters under its control, for the quality of care rendered and for compliance with laws and rules relating to the safety and sanitation of nursing homes, or which otherwise relate directly to the health, welfare, and care of residents. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility for 16 of 67 residents (R34, R129, R37, R116, R41, R10, R70, R13, R117, R62, R56, R123, R22, R1, R36, R9) reviewed for various deficient practices; facility failed to ensure 3 of 5 employees (E1, E2, E3) reviewed during the initial survey for annual evaluations were completed; and the facility failed to ensure 5 of 11 employees (RN-C, RN-D,	{2 135}		

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{2 135}	Continued From page 4 LPN-A, NA-U, NA-Q) had current license verification. In addition, the facility's governing body failed ensure vendors were paid in a timely manner. This had the potential to affect all 67 residents in the facility. Findings Include: Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse. Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an immediate jeopardy situation for R37, R129 and R116. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly	{2 135}		

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{2 135}	Continued From page 5 investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and alcohol use/alleged black	{2 135}		

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{2 135}	Continued From page 6	{2 135}		

market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the IJ at elopement (F323).

Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13.

Refer to F412: the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status.

Refer to F490: the administrator failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, administrator failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). These administrative failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement.

Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a supplemental nursing services agency (Soul Care) had the necessary screening and

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{2 135}	Continued From page 7 clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F500: the facility failed to have contracted social services available on 5/5/14, 5/6/14, and 5/7/14, because they had not paid the bill to the agency. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. the health unit coordinator (HUC) and licensed practical nurse (LPN)-E stated that the contracted social workers were not onsite yet that week at Camden Videll Health	{2 135}		

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{2 135}	Continued From page 8	{2 135}		

Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services.

On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated, "I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated "the reason you did not see social workers at the facility last week was because they did not pay their invoice on Monday, May 5th, Tuesday, May 6th, and Wednesday, May 7th. The facility had social workers scheduled, but due to not paying their bill, the social workers were not provided." For a few days getting ready for your return increased amount of social workers to facility to three FTE's [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents."

A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the

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{2 135}	Continued From page 9 employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{2 135}		
{2 165}	MN Rule 4658.0050 Subp. 3.F Licensee;provision of adequate financing Subp. 3. Responsibilities. A licensee is responsible for: F. Provision of evidence of adequate financing, proper administration of funds, and the maintenance of required statistics. A nursing home must have financial resources at the time of initial licensure to permit full service operation of the nursing home for six months without regard to income from resident fees. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the administrator failed to provide adequate supervision to residents that had alleged drug and alcohol (ETOH) use for 2 of 11 residents (R37, R129). In addition, the administrator failed to provide adequate supervision to residents to prevent elopement	{2 165}		

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{2 165}	Continued From page 10 from the facility for 1 of 3 residents (R116). Findings include: On 5/9/14, the facility had been informed of serious and immediate safety and supervision issues related to a lack of adequate supervision for residents, specifically related to resident's with known drug and alcohol use issues, and elopements. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and/or alcohol intoxication. In addition, on 5/11/14, a vulnerable resident was able to elope from the facility on three seperate occassions without staff present even though the facility had implemented a WanderGuard device. Refer to F223: the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse. Refer to F224: the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who eloped from the facility with a WanderGuard (a system to alert staff when a resident leaves the facility) in place. This lack of supervision caused an IJ situation for R37, R129 and R116. On 5/9/14, the facility had been informed of serious and immediate safety of the residents	{2 165}		

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{2 165}	Continued From page 11 related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and/or State agency (SA) for 8 of 9 residents (R129, R37, R116, R41, R70, R13, R14, R66) who had allegations of abuse, mistreatment, or neglect of care; in addition, the facility failed to ensure the allegations were investigated thoroughly. Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, and NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use	{2 165}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 165}	Continued From page 12 illegal drugs and ETOH in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, and R9). Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to ETOH abuse. Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An IJ was identified on 5/9/14, at 2:03 p.m. for lack of supervision, drug and ETOH use/alleged black market for R37, R129, R41, R117, and lack of supervision - elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified that R116 was added. Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. Refer to F492: the facility failed to ensure nurses and nursing assistants (NAs) from a supplemental nursing services agency (Soul	{2 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 165}	Continued From page 13 Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C and background check was completed for 1 of 3 nursing assistants (NA)-U before they were allowed to work. These had the potential to affect all 67 residents residing in the facility. Refer to F520: the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial survey and 5 of 11 employees RN-C, RN-D, LPN-A, NA-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. A letter provided to surveyors on 5/19/14 identified that as of that date, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the LLC (limited liability company) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the the	{2 165}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 165}	Continued From page 14 healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{2 165}		
{2 255}	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not ensure the quality committee met as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 13 of 67 (R34, R37, R129, R116, R41, R10, R70, R13, R117, R62, R9, R56, R123) residents residing in the facility and 3 of 5 employees (E1,E2,E3) reviewed during the initial	{2 255}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 255}	Continued From page 15 survey and 5 of 11 employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q) reviewed during the revisit. This had the potential to affect all 67 residents in the facility. Findings include: Refer to F223: the facility failed to ensure one of one resident (R34) was free of abuse. Refer to F224: an Immediate Jeopardy (IJ) was identified at F224 for neglect of care for R37 and R129, when residents were able to access drugs and alcohol and required hospitalization. Refer to F225: the facility failed to ensure incidents of potential abuse, neglect and mistreatment were immediately reported to the administrator and State agency (SA) for 7 of 7 residents (R129, R37, R116, R41, R10, R70, and R13). Refer to F226: the facility failed to ensure the facility reported allegations of potential abuse/neglect immediately to the administrator and State agency (SA) and to thoroughly investigate potential situations of abuse/neglect/elopement for 4 of 5 residents (R37, R129, R13, and R116); the facility failed to screen new employees for reference checks, back ground studies and license/certification verification for 5 of 5 newly hired employees (RN-C, RN-D, LPN-A, NA-U, NA-Q). Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use	{2 255}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 255}	Continued From page 16	{2 255}		

illegal drugs and alcohol in the facility for 11 of 11 residents (R129, R13, R117, R41, R62, R37, and R9).

Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.

Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers.

Refer to F319: the facility did not ensure treatment and services were provided for chemical dependency for 1 of 1 resident (R37) identified as having concerns related to alcohol abuse.

Refer to F323: the facility failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14.

Refer to F353: the facility failed to provide adequate staff to prevent harm from occurring. In addition the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14.

Refer to F490: an IJ was issued at F490 for administration failure to fully implement the March POC. The administrator failed to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14.

Refer to F492: the facility failed to ensure nurses and nursing assistants (NA's) from a

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{2 255}	Continued From page 17 supplemental nursing services agency (Soul Care) had the necessary screening and clearance for tuberculosis (TB) before they were assigned to work. Refer to F497: the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. Refer to F499: the facility failed to ensure license was verified for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C. These had the potential to affect all 67 residents residing in the facility. The facility failed to pay vendors in a timely manner: On 5/8/14, at 2:00 p.m. facility staff stated that the contracted social workers were not onsite yet that week at Camden Videll Health Care, because the bill had not been paid. The administrator stated the social work agency was Circle of Life Aging Services. On 5/12/14, 1:18 p.m. Circle of Life, Aging Services (contracted social service) an interview with owner who stated,"I get paid every two weeks, two out of three invoices have been paid, and one invoice was paid late. I have a 3rd day clause in my contact; the facility gets 30 days after 3rd day. I received one payment four days late. The first invoice dated April 4th, and they paid on May 8th, and the second invoice dated April 17th, which they paid that one on time. They paid those two invoices and one outstanding invoice $9,048, not due yet. The owner stated"the reason you did not see social workers at the	{2 255}		

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{2 255}	Continued From page 18 facility last week was because they did not pay their invoice. Monday, May 5th, Tuesday, May 6th, Wednesday, May 7th, had social workers scheduled for here, but due to not paying their bill, received payment late. " For a few days getting ready for your return increased amount of social workers to facility to three FTE' s [full time equivalents] three social worker's in a day for a few days, but otherwise approved for two FTE. I have three covering for two FTE equivalents, two were part time and job share. And approval has been given for some overtime to be utilized. The contract is open ended to have social workers here, contract states to have a two week notice when wanting to end services. Going forward would have to check with Videll Health Care corporate executive vice president [EVP]; I would assume they would continue with two full time equivalents." On 5/19/14, the President and CEO of Videll Healthcare sent a letter to the employees that their healthcare benefits had ended on March 17, 2014. The letter stated that the Limited Liability Company (LLC) would make an accounting of the monies deducted from individual checks and put together a plan to return the money as soon as possible. The letter encouraged staff to go the healthcare.gov/marketplace to register for insurance. The letter further stated Videll continues to work with the insurer to put an alternative solution together. This letter had been placed at the employee time clock and was provided by an employee who wished to remain anonymous.	{2 255}		
{2 265}	MN Rule 4658.0085 Notification of Chg in Resident Health Status	{2 265}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 265}	Continued From page 19 A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the physician and family member(s) was promptly notified for 1 of 1 resident (R13) observed to elope from the	{2 265}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 265}	Continued From page 20 building during the survey on 5/6/14. Findings include: On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 exited the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half lap tray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently. - At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking. - At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her. - At approximately 11:00 a.m. R13 was randomly	{2 265}		

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{2 265}	Continued From page 21 observed to be smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to finish smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building. -At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair using her feet to propel the wheelchair towards 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 made a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly (posted speed limit was 30 miles per hour). The smoking monitor was observed to be behind a pillar with his back to the street and R13. - At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor that R13 had been observed on the city sidewalks. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, assisted her to wheel back to the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility. R13's Diagnosis Report dated 2/4/09, identified diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.	{2 265}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 265}	Continued From page 22 The Vulnerable Adult Assessment dated 6/24/13, identified R13 had a history of wandering into other resident's rooms, history of unsafe smoking and taking other peoples' belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgment. In addition, the assessment indicated R13 was required to have supervised LOAs (Leave of Absences) only, and that R13 had a past history of drug abuse. A LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and that the resident was unable to leave the facility unsupervised. A Camden Care Center Care Conference form dated 10/1/13, included; "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection." The Nursing Assessment Packet Review for the reference period 3/19 through 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of	{2 265}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 265}	Continued From page 23 daily living (ADLs). A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13. The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, indicated R13 had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "WanderGuard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision." An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the	{2 265}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 265}	Continued From page 24	{2 265}		

incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. The receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident." Although the note indicated a message had been left for the NP, the NP and family member(s) were not called until three days after the incident.

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 265}	Continued From page 25 WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At no time during the observation, did O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. registered nurse (RN)-C stated she was in the room when O-C had reported R13 had eloped. RN-C stated the announcement was made and RN-C, licensed practical nurse (LPN)-E, LPN-A and dietary manager (DM) was present for the announcement. RN-C stated she had not reported the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; and would be responsible to notify the family and physician regarding the elopement.	{2 265}		
2 285	MN Rule 4658.0100 Subp. 2 Employee Orientation and In-Service Education Subp. 2. In-service education. A nursing home must provide in-service education. The in-service education must be sufficient to ensure the continuing competence of employees, must address areas identified by the quality assessment and assurance committee, and must address the special needs of residents as determined by the nursing home staff. A nursing home must provide an in-service training program in rehabilitation for all nursing personnel to promote ambulation; aid in activities of daily	2 285		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 285	Continued From page 26	2 285		

living; assist in activities, self-help, maintenance of range of motion, and proper chair and bed positioning; and in the prevention or reduction of incontinence.

This MN Requirement is not met as evidenced by:
Based on interview and document review, the facility failed to provide annual performance evaluations for 3 of 3 employees (E1, E2, E3) reviewed for staff that have worked in the facility for greater than 12 months. In addition, the facility failed to ensure the nursing assistants (NAs) met the required 12 hours per year continuing education for 1 of 5 NAs (NA-Z) reviewed. This had the ability to impact all 67 residents in the facility as the facility was a one story facility and the staff could work on all of the units.

Findings include:

Evaluations:
On 5/12/14, at 10:00 a.m. employee performance evaluations for E1, E2 and E3 were requested of the administrator. He said he would get them; however, no evaluations were provided.

On 5/13/14, at 12:41 p.m. performance evaluations for E1 through E3, from previous March 2014 survey and evaluations for all employees due for annual performance review in March 2014 and April 2014 was requested of the administrator. He said he would get the information.

On 5/13/14, at 3:30 p.m. unable to interview the director of nursing (DON) as the DON had resigned.

On 5/13/14, at 3:35 p.m. although the evaluations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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2 285	Continued From page 27 had been requested, no employee performance evaluations had been provided by facility as of that time. At the time of exit on 5/13/14, at 4:30 p.m. the evaluations still had not been provided. In-service: NA-Z was hired on 4/10/11. The employee file was reviewed for continuing education and noted NA-Z had only 3.5 hours of the 12.0 required hours from 1/1/13 through 5/12/14. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise policies and procedures for evaluating staff performance reviews. The Director of Nursing could perform monthly audits to ensure annual performance reviews are being performed. TIME PERIOD FOR CORRECTIONS: Fourteen (14) days.	2 285		
{2 530}	MN Rule 4658.0300 Subp. 4 Use of Restraints Subp. 4. Decision to apply restraint. The decision to apply a restraint must be based on the comprehensive resident assessment. The least restrictive restraint must be used and incorporated into the comprehensive plan of care. The comprehensive plan of care must allow for progressive removal or the progressive use of less restrictive means. A nursing home must obtain an informed consent for a resident placed in a physical or chemical restraint. A physician's order must be obtained for a physical or chemical restraint which specifies the duration and circumstances under which the restraint is to be used, including the monitoring interval. Nothing in this part requires a resident to be awakened during the resident's normal sleeping hours	{2 530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 530}	Continued From page 28 strictly for the purpose of releasing restraints. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) reviewed for restraint, was free of physical restraints while directly supervised by staff during meals. Findings include: On 5/7/14, at 8:28 a.m. R89 was observed to be at a meal in her wheelchair (W/C) with the right break locked. Anti-rollbacks (devices which engage and keep wheelchair from rolling back when a resident stands) were observed to be applied to the back of the W/C. A nursing assistant (NA)-V was observed to be sitting directly to R89's left and assisted R89 to eat. When asked why the W/C brake was locked, NA-V stated "we lock one brake," and verified the left brake was unlocked. NA-V explained "brakes" needed to be locked "to protect her [R89]." NA-V further explained R89 needed to protect from "falling." NA-V was unclear why the left brake was left unlocked. The right side of the W/C was observed to be flush to the table. During the observation, R89 was observed to stand repeatedly, had worried expression on her face and repeated in an anxious voice, "I gotta go!" On 5/8/14, at approximately 8:30 a.m. R89 was observed to be at the dining room table in the same location. R89 was observed to have both W/C brakes locked; the anti-rollback device remained appropriately applied to the W/C. R89 attempted to stand multiple times, appeared worried when standing, then immediately sat back down.	{2 530}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 530}	Continued From page 29 - From 8:30 a.m. until 9:40 a.m. R89 remained at the breakfast meal. NA-V was observed to provide R89 her breakfast, set up the breakfast and sit directly next to R89 and assist her to eat. At no time were W/C brakes unlocked. R89 was observed to stand repeatedly throughout the meal, pushing back slightly with her legs as she stood. The W/C was flush to the top of the table, preventing R89 from leaving the table. The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a W/C and had "N/A [non-applicable]" written by hand in the section. Review of the clinical record lacked evidence R89 was assessed for restraints. R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint. The Care Area Assessment (CAA) for activities of daily living (ADLs) Function/Rehabilitation	{2 530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 530}	Continued From page 30 Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease. The clinical record lacked evidence R89 had been assessed for restraint use, including locked W/C brakes and having the W/C pushed flush to the table. R89's care plan dated as last reviewed on 3/28/14, identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and did not include direction to place R89 against a desk or table. The care plan was updated on 4/30/14, to include, "Anti-roll back brakes installed onto wheelchair to prohibit wheelchair from rolling backwards when resident offloads independently. Least restrictive safety device while in wheelchair." On 5/12/14, at 9:24 a.m. the licensed practical	{2 530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 530}	Continued From page 31	{2 530}		

nurse (LPN)-E stated R89 "was not restrained" and stated "anti-rollback brakes were placed on the wheelchair." LPN-E stated R89's W/C was "looked at by therapies" and therapies had assessed R89 for the use of the anti-rollbacks on the W/C. LPN-E was unclear whether the locking of R89's W/C brakes had been assessed as a form of restraint.
- At 9:28 a.m. LPN-E stated the therapy department had only made a "recommendation" and since R89 was not on the therapy case load, they "didn't document the evaluation." LPN stated direct care staff had been "educated" not to lock R89's brakes or restrain her against a desk or table. LPN-E verified if R89 was directly supervised by a staff person, the W/C brakes should not have been locked.

On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of anti-rollbacks and the use of potential restraints, such as having both brakes locked and the W/C pushed flush to a table. DON repeatedly stated he thought "physical therapy assessed the use of the anti-rollbacks" but was unclear if R89 was assessed for restraints. DON verified therapy assessments should have been documented in R89's clinical record.

On 5/12/14, at 12:28 p.m. the physical therapy assistant and rehab manager (PTA), occupational therapist (OT), and physical therapist (PT) were interviewed together in the therapy gym. All denied having assessed R89 for the use of the anti-rollbacks, W/C brake locking, or restraints. PTA stated the anti-rollbacks had been an idea that had been "brought up" in the morning meeting as "a way to keep her [R89] safe without locking the brakes." The OT stated therapy staff had "helped maintenance order the device," and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 530}	Continued From page 32	{2 530}		

stated since maintenance had not seen the device before, therapy staff had assisted him to "apply it." The PT stated no therapy staff had actually assessed R89 because there was no "physician's order" and because R89 "was not on case load." All therapists verified they would not "assess" a resident without a physician's order and stated they were unclear when they should "get involved." All verified they were employees of Videll Healthcare Limited Liability Company (LLC), but then stated, "The facility doesn't have polices to let us know our responsibilities."

On 5/12/14, at 12:23 p.m. R89 was observed to be in her W/C at the lunch meal. NA-V was observed seated directly to the left of R89. NA-V was interacting with R89 before the meal. R89 was observed to have the W/C pushed up flush against the table and both W/C brakes were observed to be locked which caused R89 to be restrained. The left anti-rollback arm was observed to be twisted off R89's left W/C tire (rendering the anti-rollback ineffective). The surveyor alerted NA-V to the anti-rollback being ineffective.
- At 12:26 p.m. R89 was observed to be provided her meal. NA-V setup the meal and remained with R89. R89 was observed to remain in the dining room throughout the meal with the brakes locked. NA-V sat next to R89 until approximately 1:20 p.m. NA-V then unlocked both brakes and wheeled R89 away from the table and into the activity room on the South unit.

On 5/13/14, at 9:03 a.m. LPN-E verified R89 should not have been restrained at the table while supervised during the meal.

The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 530}	Continued From page 33 residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lap buddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking a resident's W/C brakes, seating a resident up against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DON or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each shift and released according to physician's orders. The policy did not address the release of restraint devices, such as releasing the restraint every two hours, during supervised activities, or while the resident was supervised at a meal.	{2 530}		
{2 540}	MN Rule 4658.0400 Subp. 1 & 2 Comprehensive Resident Assessment Subpart 1. Assessment. A nursing home must conduct a comprehensive assessment of each resident's needs, which describes the resident's capability to perform daily life functions and significant impairments in functional capacity. A nursing assessment conducted according to Minnesota Statutes, section 148.171, subdivision 15, may be used as part of the comprehensive resident assessment. The results of the comprehensive resident assessment must be used to develop, review, and revise the resident's comprehensive plan of care as defined in part 4658.0405. Subp. 2. Information gathered. The comprehensive resident assessment must	{2 540}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 540}	Continued From page 34 include at least the following information: A. medically defined conditions and prior medical history; B. medical status measurement; C. physical and mental functional status; D. sensory and physical impairments; E. nutritional status and requirements; F. special treatments or procedures; G. mental and psychosocial status; H. discharge potential; I. dental condition; J. activities potential; K. rehabilitation potential; L. cognitive status; M. drug therapy; and N. resident preferences. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete a significant change in status assessment (SCSA) for 2 of 3 residents (R56, R116) who had sustained a decline in functional status; and for 1 of 3 residents (R103) who had experienced a significant improvement in activities of daily living (ADLs). Findings include: R56's record was reviewed. A SCSA minimum data set (MDS) assessment was initiated with an assessment reference date (ARD) of 4/26/14, and when reviewed on 5/7/14, at 9:00 a.m. the MDS was noted as in progress with an expected completion date of 5/12/14, twenty-two days after the change in status had been identified. When interviewed on 5/7/14, at 10:40 a.m. registered nurse (RN)-C stated the SCSA MDS	{2 540}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 540}	Continued From page 35 was scheduled to be completed on 5/12/14, and the care plan would be completed seven days later on 5/19/14. When interviewed on 5/13/14, at 9:53 a.m. RN-C stated she had never done MDSs before and had only received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS policy was requested and was not received. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The admission MDS dated 1/26/14, indicated a Brief Interview for Mental Status (BIMS) score of 15/15, which showed no cognitive deficit, and a Patient Health Questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. According to the admission MDS, R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. On 4/15/14, at 10:49 p.m. a nursing Progress Note indicated, "Pt is declining. He is very weak and needs a lot of assistance." The quarterly MDS dated 4/24/14, depicted R116 as needing assist of one person for bed mobility, ambulation	{2 540}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 540}	Continued From page 36	{2 540}		

in and out of room, dressing toilet use and hygiene. R116 had also deteriorated and required supervision for eating and transfers.

On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that "a significant change MDS should have been done when it had been determined his condition declined in two areas of functional status." Although the resident had declined in bed mobility, transfers, toileting, dressing, ambulation and personal hygiene, no significant change MDS had been conducted. The quarterly MDS (ready to export, but not exported) did show the extensive assist that R116 now required but interim MDS coordinator verified "it should have been a significant change MDS."

R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures or arm, leg, rib and pelvis related to a motor vehicle accident.

The progress note dated 1/5/14, at 5:30 a.m. indicated R103 was oriented X 3, able to communicate needs and wants. In addition, the notes indicated R103 was independent with movement and bed mobility, and currently utilized a Foley catheter.

An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting.

An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter was in use. R103 was assessed as independent in all functional

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 540}	Continued From page 37 activities of daily living. Although R103 had improved in more than two functional areas, no significant change MDS had been completed as a result of the improved status. According to MDS manual 3.0 dated April 2012, a significant change has to be completed when, "There is a determination that a significant change (either improvement or decline) in a resident's condition from his/her baseline has occurred as indicated by comparison of the resident's current status to the most recent comprehensive assessment and any subsequent Quarterly assessments; and The resident 's condition is not expected to return to baseline within two weeks."	{2 540}		
{2 545}	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 3 residents (R36) who required an annual comprehensive assessment. Findings include:	{2 545}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 545}	Continued From page 38 The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12. On 5/13/14, at 9:52 a.m. the electronic record (Point Click Care) was reviewed and revealed R36 had an admission Minimum Data Set (MDS) completed on 5/29/13. The Quarterly MDS's were completed on 8/29/13, 11/21/13, and 2/18/14. A fourth quarterly MDS had been initiated with an assessment reference date of 5/14/14. An annual comprehensive MDS was not initiated as required. When interviewed on 5/13/14, at 9:53 a.m. registered nurse (RN)-C verified she had initiated a quarterly MDS instead of the required annual MDS and confirmed that an annual MDS should have been implemented. RN-C stated she had never done MDSs before and received online training and telephone support. RN-C stated she used a paper list to track what MDS was due for each resident. A MDS scheduling and completion policy was requested and was not received.	{2 545}		
{2 565}	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document	{2 565}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 39	{2 565}		

review, the facility failed to ensure the care plan was followed and target behaviors were monitored for the use of Zyprexa (olanzapine-an antipsychotic medication) for 1 of 1 resident (R89), and failed to ensure smoking interventions were followed in accordance with the care plan for 3 of 3 residents (R36, R1, R9, R22), and failed to ensure the care plan was followed for 1 of 3 residents (R9) who required dental services.

Findings include:

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 as having a physician order for Zyprexa (an antidepressant) related to "potential injury to self or others, dementia, agitation and pick [sic] disease." The care plan directed the staff to administer the medication as ordered, monitor/document for side effects and effectiveness of the medication. The care plan further directed the staff to "discuss with MD [physician], family regarding ongoing use of the medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of target behaviors such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa.

Review of the clinical record indicated R89 was not monitored for target behaviors.

Review of the Consultant Pharmacist Recommendations dated 4/17/14, identified

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{2 565}	Continued From page 40 olanzapine (Zyprexa) 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist (CP) review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. R36: Observations of R36 on 5/6/14, at 11:32 a.m. the resident was observed retrieving a cigarette from the inside of his coat and lit it with a lighter from his right pocket. The smoking monitor personal was directed away from the resident and approximately 20 feet away. Observations of R36 on 5/7/14, at 7:07 a.m. the resident was observed smoking a cigarette without a smoking apron on. The smoking monitor personal was approximately ten feet away from the resident. Observations of R36 on 5/7/14, at 7:41 a.m. the resident was observed to have multiple burn holes in his gloves. Observation of R36 on 5/7/14, at 8:18 a.m. the resident obtained a cigarette from inside his coat	{2 565}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 565}	Continued From page 41 and a lighter from his right pocket and lit the cigarette. R36 did not have a smoking apron on. The smoking monitor personal did not offer R36 a smoking apron. Observations of R36 on 5/7/14, at 9:21 a.m. the resident was observed smoking without a smoking apron on and the smoking monitor personal was approximately 20 feet from R36 and was focused on the street and not the resident. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed in his room with a pack of eight cigarettes in his shirt. Observations of R36 on 5/7/14, at 1:40 p.m. the resident was observed smoking without a smoking apron. The smoking monitor personal was approximately 15 feet from R36. Observations of R36 on 5/7/14, at 3:15 p.m. the resident was observed smoking without a smoking apron and the smoking monitor personal was not within arm's reach. Observations of R36 on 5/8/14, at 9:29 a.m. the resident was observed smoking a cigarette; the smoking monitor personal offered a smoking apron to R36 but the resident refused. The staff did not encourage the resident to wear. Observations of R36 on 5/8/14, at 2:08 p.m. the resident was observed smoking without a smoking apron on. The smoking monitor personal was approximately 15 feet away and was looking in the opposite direction. Observations of R36 on 5/9/14, at 7:15 a.m. the resident was approached by facility staff to wear a smoking apron. R36 stated he wouldn't wear one	{2 565}		

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{2 565}	Continued From page 42 after what happened yesterday. R36 stated when staff put a "bib" on R34, R34 took it off and threw it on the ground. R36 stated if she (R34) did not have to wear one, he did not either. R36 wheeled to the smoking patio and smoked a cigarette without an apron on. Observations of R36 on 5/12/14, at 11:38 a.m. the resident wheeled by the smoking monitor personal and lit a cigarette and smoked without an apron on. The smoking monitor personal did not offer R36 a smoking apron. Review of R36 ' s care plan dated 6/14/13, identified R36 as having impaired cognitive function/dementia, alteration in decision making, and/or impaired thought processes. The care plan further indicated R36 required supervision when smoking, and that the resident was to smoke only in designated areas utilizing adaptive equipment apron for safety. An undated list of facility smokers indicated R36 was a supervised smoker and indicated staff keeps smoking material with directions to wear a smoking apron and stay within arm's reach. When interviewed on 5/7/14, at 7:33 a.m. nursing assistant (NA)-B stated she offers to lock the cigarettes in the facility locked box for residents who are unsafe to keep them on their person. NA-B stated if a resident refuses to follow the smoking rules, such as refusing to turn in their smoking materials, refusing to wear aprons, or smoking in non-smoking areas, she makes a note in the smoking monitor log.	{2 565}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 43 R1 was observed on 5/5/14, and consecutive days 5/6/14, 5/7/14 and 5/8/14, smoking without wearing an apron, keeping her smoking material's on her and not smoking in the facility designated areas. When interviewed on 5/8/14, at 10:03 a.m. NA-E stated R1 had a pack of cigarettes and a lighter when she got off the transportation van. NA-E stated "She is very stubborn". When interviewed on 5/8/14, at 11:32 a.m. R1 indicated she had left to the appointment with five cigarettes and her lighter because it was going to be a long time without smoking and when she returned to the facility she had handed the cigarettes back to the smoking monitor. Review of R1's smoking evaluation dated 3/17/14, identified R1 as having a history of unsafe smoking practices when heavily medicated and or tired and falls asleep while smoking. R1 cannot safely utilize lighter/matches and cannot safely handle lit smoking materials and was a supervised smoker. The smoking care plan dated 3/12/14, identified R1 was a smoker. The goals were "Will follow all guidelines regarding smoking at Camden Care Center and will remain safe while smoking." The care plan directed R1 will smoke only in designated smoking areas, was a supervised smoker and had refused Cigarettes and lighter to be kept at nursing station for safety. When interviewed on 5/9/14, at 1:59 p.m. the director of nursing (DON) stated R1 had been educated about leaving her smoking materials in the cart and had been asked to take the cigarettes one at a time. The DON confirmed the plan of care had not been followed.	{2 565}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 44 On 5/6/14, at 7:40 a.m. R9 was observed smoking on the front smoking designated patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area then retrieved cigarettes and lighter from her right sock and placed them on the table next to a covered ash tray. During observation NA-B noticed R9 smoking and covered her with a smoking apron at that time. Observation at 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked. On 5/6/14, at 2:45 p.m. when interviewing R9, surveyor observed a cigarette box in each of her socks. When R9 was asked why she was storing the cigarettes in her socks she stated "You can leave now, go now". The smoking care plan dated 10/20/11, identified R9 as a smoker. Goal "R9 will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker. When interviewed on 5/6/14, at 3:06 p.m. the DON verified R9 was a supervised smoker which meant she should relinquish her cigarette and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. . When interviewed on 5/6/14, at 3:12 p.m. NA-I	{2 565}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 45	{2 565}		

(smoking monitor) verified R9 did not have cigarettes in the facility locked box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box.

Observation on 5/6/14 at 8:05 a.m., staff was observed assisting R22 to the smoking area, applied a smoking apron and placed a blanket around his shoulders. Staff remained near but not within an arms-length as R22 held a handful of Kleenex while smoking.

Observation on 5/7/14, at 9:27 a.m. R22 was observed outside in the designated smoking area sitting in his w/c next to the building pillar. R22 was holding a cigarette on the right hand and the other hand holding a the self-extinguishing ash tray. R22 was not wearing a smoking apron and had a blanket across his lap. R22 dropped his cigarette on to his shirt/blanket, was able to pick it up himself. The smoke monitor personal was not at arms-length and did not observe this happen. NA-B was standing approximately six feet away from the resident. At 9:31 a.m. R22 continued to smoke with no smoking apron, he dropped his cigarette for the second time on to his lap and was able to pick it up himself. NA-B was observed standing by the smoking cart approximately 5 feet away from the resident and was not at arms-length to quickly assist the resident.

Review of R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "(R22) will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was wear smoking apron while smoking. Staff to intervene is resident displays unsafe smoking

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 46 behaviors or refuses safety interventions, and R22 was a supervised smoker. Review of R22's Smoking Evaluation dated 4/22/14, indicated R22 had a history of smoking in inappropriate places, burn holes in his clothing , was a supervised smoker and smoking materials were secured by staff. When interviewed on 5/7/14, at 9:33 a.m. NA-B stated she had not witnessed R22 drop his cigarette at 9:27 a.m. and again at 9:31 a.m. even though she was standing near the smoking cart and designated to monitor resident during smoking. When interviewed on 5/9/14, at 1:59 p.m. the DON confirmed the plan of care had not been implemented related to R22 smoking privileges and safety. Review of the annual Minimum Data Set (MDS) dated 10/11/13, did not identify R9 dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene. R9's care plan reviewed 4/9/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." R9 had diagnoses which included Schizophrenia, diabetes mellitus, and orofacial dyskinesia.	{2 565}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 565}	Continued From page 47 Review of In House Senior Services, LLC Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and 12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful." On 5/6/14, at 2:45 p.m. R9 was observed to have missing teeth during an interview in her room. On 5/7/14, at 3:28 p.m. LPN-A was interviewed and stated "I went thru the progress notes and I don't see anything that addresses the dental exam. " During an interview on 5/7/14, at 3:30 p.m. household unit coordinator (HUC) stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this."	{2 565}		
{2 570}	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 570}	Continued From page 48 the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter use for 1 of 3 residents (R36) and for 1 of 1 resident (R116) who had a decline in activities of daily living (ADLs) and for 1 of 6 residents (R62) who was identified by the facility who allegedly had substance abuse. Findings include: Review of R36's quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 did not have a Foley catheter in use. Review of the care plan for R36 dated 3/18/14, identified a focus topic; " alteration in elimination". The care plan further indicated R36 had a temporary indwelling Foley catheter in place due to diuretic use. Interventions listed; change R36 catheter as needed per Physician's Orders and to irrigate the catheter as needed. When interviewing R36 on 5/7/14, at 7:41 a.m. he stated he did not have a catheter and used the toilet independently. During interview on 5/7/14, at 1:45 p.m. with registered nurse (RN)-A, she confirmed R36 did not have an indwelling Foley catheter. During interview on 5/13/14, at 11:41 a.m. with RN-B, she indicated R36 previously had an indwelling Foley catheter but no longer used one.	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 570}	Continued From page 49 RN-B confirmed the care plan should have been updated to reflect R36's current status. A care plan policy was requested and was not provided. R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. R116 was receiving hospice care since 1/21/14, the resident was independent in self-cares, transfers, and mobility. The admission MDS dated 1/26/14, identified a brief interview for mental status (BIMS) score of 15/15, which showed no cognitive deficit, and a patient health questionnaire (PHQ-9 is a multipurpose instrument for screening, diagnosing, monitoring and measuring the severity of depression) score of 4, which indicated minimal depression. The MDS further indicated R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. Review of the quarterly MDS dated 4/24/14, indicated R116 as requiring 1assistance with bed mobility, ambulation in and out of room, dressing, toileting and hygiene. The MDS further indicated R116 required supervision for eating and transfers.	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 570}	Continued From page 50 Review of the progress notes for R116 on 4/15/14, at 10:49 p.m. indicated R116 condition was declining and requiring more assistance with ADL's. Review of R116's care plan with a revision date of 5/2/14, indicated,"Cognition intact and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis."The care plan had not been revised to depict the changes in ADLs. On 5/13/14, at 9:11 a.m. the admission nurse and interim MDS coordinator verified that R116 care plan was not current to reflect R116 decline in health status that required assistance with ADL's updated with the needed assistance with ADLs. R62 was admitted to the facility on 8/31/13, with diagnoses that included; memory loss, dementia and cerebrovascular accident (CVA) per the Admission Record. Review of the quarterly MDS dated 2/25/14, indicated R62 had moderate cognitive impairment. The MDS did not address R62's substance abuse. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, verified that she had smoked marijuana, denied having more marijuana and verbalized understanding regarding discharge if she continued this behavior. Review of the most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the residents health status Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 as having"past/recent substance abuse"and a history of risky behaviors	{2 570}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 570}	Continued From page 51 and being in an abusive relationship. R62 required supervised LOA (leave of absence) except for appointments with scheduled transport. Review of facility progress notes dated 1/24/14, indicated R62 was observed smoking marijuana on the outside smoking patio, R62 denied she was smoking marijuana Review of R62's care plan with a revision date of 4/26/14, identified R62 having a history of being in an abusive relationship, and as having impaired cognitive function/dementia. Interventions included"approach resident in a calm manner, assess and report any change in mood/behavior and provide the resident with resources as needed. R62 has been assessed and may not leave the facility without supervision." The care plan had never been revised to include R62's known alcohol and/or drug abuse even though it was identified in the Vulnerable Adult Assessment dated 3/18/14, and documented in the nursing progress notes on 1/24/14. During an interview with the facility contracted licensed social worker (CLSW)-A and CLSW-B confirmed the plan of care had not been revised to reflect R62's substance abuse.	{2 570}		
{2 625}	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission;	{2 625}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 625}	Continued From page 52 B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520, subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.	{2 625}		

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{2 625}	Continued From page 53 This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to complete medical records, the charts lacked nursing notes, laboratory results, behavior monitoring. and assessment and plans for initial physician assessments for 20 of 67 residents (R103, R116, R86, R71, R9, R34, R51, R129, R13, R117, R41, R62, R37, R56, R36, R123, R1, R113, R29, R91). Findings include: R103 was admitted to the facility on 7/29/13, with diagnoses of multiple right sided fractures of arm, leg, rib and pelvis related to a motor vehicle accident. Last progress note on 1/5/14, at 5:30 a.m.: Resident is oriented X 3, able to communicate needs and wants. Resident was independent with movement and bed mobility, and currently uses Foley catheter An MDS quarterly assessment dated 1/31/14, indicated a Foley catheter (a tube used to continuously drain the bladder) was still in place. R103 required supervision and assist of one for bed mobility, transfers, locomotion on and off the unit, dressing and toileting. An MDS quarterly assessment dated 5/1/14, indicated no Foley catheter. R103 was now assessed as independent in all functional activities of daily living. The chart lacked documentation of when the Foley catheter was removed.	{2 625}		

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{2 625}	Continued From page 54 The chart lacked a significant change MDS for improvement in more than two areas of functional status. The care plan dated 8/9/2013, and revised 3/29/14, and 4/26/14, indicated: English as a second language, required short term placement for rehab and was expected to discharge to the community within the next 3 months. R103 had impaired mobility care plan related to MVA, multiple fractures and weakness, and was to use a cane. A potential for self-care performance deficit. A potential for alteration in bowel and bladder related to disease process, unsteady gait, and cultural differences. The medical record was reviewed on 5/11/14, and lacked documentation of LOA (leave of absence) or discharge. Orders dated 4/16/14 state may LOA unsupervised with medications. On 4/20/14 at 9:48 p.m. Pt went on LOA. The chart lacked documentation of return to the facility. On 5/10/14 at 1:57 p.m. R103 was observed to put two plastic bags of belongings in a car got in and was driven away. The chart lacked documentation of why the resident left the facility, the resident was ready for discharge and awaiting placement. It was not clear in the medical record if the resident had been discharged, or was on LOA. On 5/11/14, at 10:00 a.m. the facility was asked if the resident had been discharged, or was on LOA and had returned to the facility. HUC checked to	{2 625}		

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{2 625}	Continued From page 55 see and resident was in room. He had signed in at 11:00 p.m. The administrator stated he would expect to have medical record documentation when residents left on LOA and returned to the facility. On 5/12/14, at 1:37 p.m. neither CLSW-A or CLSW-B had notes for R103, but knew he had been working with a relocation worker. R71 was admitted to the facility on 5/17/10, with admission diagnosis of CVA (stoke) with hemiplegia (loss of all or part of one side of the body), chronic pain syndrome, depression, and diabetes. R71 was seen by the physician on 4/16/14, labs were ordered, and new medication orders dated 4/16/14, included: Benadryl 25 mg (milligrams) give 1-2, every 4-6 hours as needed for itching, and to increase gabapentin to 300 mg, give 2 every bedtime (for persistent left sided pain). On 4/18/14, a physician order to increase atorvastatin (a cholesterol-lowering medication) to 80 mg daily, and Metformin ER (used to treat type 2 diabetes) 1000 mg daily with supper. An initial primary care physician (PCP) to establish primary care on 4/16/14: noted a history of CVA (stroke), left hemiplegia (loss of use of part or all of the left side), hypertension, dyslipidemia, Major Depressive disorder, diabetes type II, tobacco abuse, and neuropathic pain. A review of medication list, and laboratory tests were ordered Hbg A1c (an indicator of diabetic compliance over a three month period), lipid	{2 625}		

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{2 625}	Continued From page 56 panel (cholesterol testing) alt (liver test), lytes and BUN (kidney function tests). On 5/6/14, a review of the medical record revealed no results for the lab tests that had been ordered on 4/16/14. On 5/7/14, at 3:14 p.m. the health unit coordinator (HUC) verified the medical record lacked results of the 4/16/14, ordered labs, and also lacked the new PCP initial visit notes, assessment, or plan for patient treatment. R9's medical record lacked laboratory results since 7/30/13. On 5/13/14, at 9:30 a.m. during review of R9's medical reviewed it was revealed R9 had been to the primary physician's office several times for routine visit since 7/30/13, but lacked laboratory results for all the tests completed during the office visits. When interviewed on 5/13/14, at 10:58 a.m. the HUC verified there were no labs in the resident chart since 7/30/13. The HUC stated the particular clinic the resident went to "always"had given her a hard time getting the notes and labs. The HUC indicated she had been told in the past that she had to call the day of the appointment to request for the information or write a note in the facility referral sheet but still nothing was being sent back with resident. Copies of R34's care plan were requested from the record. The vulnerable adult care plan for R51 was provided that had been in R34's chart. R34 and R51 have the same last name with different first names.	{2 625}		

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{2 625}	Continued From page 57 Refer to 223: the facility failed to ensure R34 was free from verbal abuse from R36 and review of the medical records for R34 and R36, lacked documentation regarding the incident which was reported on 5/5/14, and lacked indication of how R34 would be protected from R36. Refer to F250: the facility failed to aggressively identify, assess, determine interventions and implement the interventions for medically-related social services, and pursue the provision of these services for residents known to provide and use illegal drugs and alcohol in the facility for 6 of 6 residents (R129, R13, R117, R41, R62, R37, R9). That resulted in harm for R129, R117, R41, R37. Refer to F274: the facility failed to complete a significant change assessment (SCSA) for 2 of 3 residents (R56, R116) with a decline in functional status. Refer to F275: the facility did not comprehensively assess 1 of 1 resident (R36) who required a comprehensive assessment at 366 days. Refer to F280: the facility failed to ensure resident care plans were revised when appropriate, related to Foley catheter for 1 of 3 residents (R36); and for 1 of 1 resident (R116) on Hospice who had a decline in activities of daily living (ADLs); and for 1 of 6 residents (R62) who was identified by the facility who allegedly had substance abuse. Refer to F309: the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice.	{2 625}		

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{2 625}	Continued From page 58 Refer to F314: the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Refer to F329: the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R36, R1, R89, R113, R29, R37, R91). Refer to F412: the facility failed to ensure residents were provided dental services for 1 of 3 residents (R36). In addition, the facility failed to ensure residents received recommended dental follow-ups for 1 of 3 residents (R9). Refer to F502: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work. Refer to F520: the facility failed to obtain a urine toxicology screen according to physician's orders for 1 of 1 resident (R37) who had physician ordered lab work.	{2 625}		
{2 800}	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is	{2 800}		

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{2 800}	Continued From page 59 involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate staff to prevent harm from occurring. In addition, the facility did not retain the required staff schedule and was not able to provide documentation of staff schedules from 3/18/14 through 4/5/14. This had the potential to affect all of the 67 residents who resided at the facility which include R22, R129, R1, R41, R37, R13, R86, R116, R1, R36, R117, R9, R14, R62. Findings include: The facility has started using agency staff, licensed nursing and nursing assistants (NA) from Soul Care LLC 1521 Como Ave Southeast Minneapolis, 55414. On 5/6/14, orientation was requested for any agency staff that has worked since the last survey. A review of the orientation files verified that the facility did not ensure staff had background checks, and had received the required tuberculin skin testing (TST). A review of the facility schedules dated from 4/5/14 through 5/17/14, indicated the facility staffing plan called for on the day shift: two licensed nurses with 13 nursing assistant (NA's); on the evening shift: two licensed nurses with 13 NA's and on the night shift: two licensed nurses with 6 NA's. Open nursing and NA shifts in the two week block of time from 5/4/14 through 5/17/14, included nine nursing day shifts and 53 NA's open day	{2 800}		

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{2 800}	Continued From page 60 shifts, 17 open evening shifts, and 30 open night shifts. Two additional staff was being used for 1:1's for R1 who was alleged by the facility to both ingest and provide illicit substances to residents within the facility and R129 after she had obtained and ingested cocaine within the facility and required hospitalization. An undated facility typed document titled 1:1 Observation Staff Responsibilities indicated: only one staff person performs the 1:1 observation with only one resident during the assigned time, and follows the resident wherever he/she goes and maintains a distance no further than arm's length at tall times. When the resident is in the room, staff will be either sitting outside or inside his/her room and make sure that they maintain residents visual at all times. Notify nurse/supervisor with any suspicious activity observed on resident. Will accompany resident if he desires to go out and smoke and make sure that appropriate clothing is worn, and oxygen is removed 5 minutes before going out to smoke. Nursing was to oversee the 1:1 observations and respond to concerns reported. One additional staff per shift was used as a smoke monitor. The Smoking Monitor Responsibilities (undated document) directed the monitor to ensure the smoking areas are monitored at all times, carry a list of smokers, and the smoking assessment results at all times. The monitors were to use the list to determine which residents require close supervision or other interventions and ensure the interventions are in place. "Supervised smokers must be within direct line of sight at all times. Those requiring assistance with smoking materials must be within reach of the smoking monitor.... Direct all	{2 800}		

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{2 800}	Continued From page 61 smokers to the designated smoking areas only... No smoking will be allowed in front of the building. Notify supervisor immediately if: a resident not on the list is smoking. A resident refused indicated interventions, such as wearing a smoking apron or staying within the designated smoking area." On 5/7/14, at 9:27 a.m. and again at 9:31 a.m. R22 (a resident identified by the facility as a supervised smoker required to wear a smoking apron) was observed by surveyors to drop a lit cigarette onto his shirt, both times the resident was able to pick it back up. When interviewed at 9:32 a.m. the smoke monitor NA-B stated she had not observed R22 dropping the cigarette at 9:27 a.m. or 9:31 a.m. and verified that she had been more than an arm ' s length away from the smoker. R22's clothing was checked and no burn holes were noted in his shirt, or in the blanket that had been covering his lap. NA-B stated that R22 was supposed to be a supervised smoker with a smoking apron, but the resident had refused to wear the smoking apron. NA-B verified she had given R22 a cigarette to smoke, even though she knew he was assessed to require a smoking apron. NA-B stated when R22 or any resident refused to wear the smoking apron, or follow the rules; they would record it in the smoke monitor notes. The smoke monitor notes were reviewed and revealed that notes started on 3/15/14, and were present for March 16th through 21st, 24th through 27th, 28th was blank, 29th and 30th, and the 31st was blank. On April 28th and 30th and May 2nd-3rd, and 4th were left blank. On all of the days listed residents had refused to wear smoking aprons, and/or relinquish the smoking materials. The administrator stated he thought the other logs had been collected, but stated he had not reviewed them for compliance with the	{2 800}		

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{2 800}	Continued From page 62 smoking policy. Residents within the facility were able to obtain, ingest and allegedly sell alcohol and drug substances within the facility while the smoking monitor, safety monitor and 1:1 staff were in place for R129 and R1. Immediate Jeopardy (IJ) was identified at F323 for lack of supervision to prevent alcohol and drug use that lead to hospitalization for (R41, R129, and R37) and elopement by R13, a resident with a WanderGuard (an alert system that lets the facility know a resident has left the building) who was let outside to smoke and went from there to the public sidewalk, the facility had to be notified by surveyors of the elopement) Refer to F323 on 5/9/14. After the IJ was identified on 5/9/14, two Residents (R129 and R37) who both had one to one (1:1) staff (defined by the facility administrator as being within arm's length of the resident to prevent incidents from occurring) were able to obtain and ingest alcohol and drug substances on 5/10/14. On 5/10/14 at 1:07 p.m. R37 was taken to North Memorial Medical Center for intoxication. R37 was animated and chatting with the medics as he was taken, and the health unit coordinator (HUC) stated that is how you know he is intoxicated, he was friendly and chatting, when not intoxicated he was usually very quiet. It was reported from the hospital that the resident had alcohol and methadone (a drug he had not been prescribed) in his system. The administrator stated the 1:1 staff assigned to R37 should have been able to prevent him from obtaining and consuming alcohol and methadone.	{2 800}		

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{2 800}	Continued From page 63 On 5/11/14, at 10:55 a.m. the administrator notified surveyors he had not been notified that R129 was sent to emergency room, at 4:00 a.m., after she had reported to a staff member that she was intoxicated. A blood alcohol level was determined to be .323 (more than three times the legal limit) and R129 was in the intensive care unit, intubated and assisted to breath by a mechanical ventilator. The administrator stated the 1:1 staff assigned to R129 should have been able to prevent her from obtaining and consuming alcohol. After investigation it was noted by contracted licensed social work (CLSW)-A that R1 accelerated away from her 1:1 staff at a high rate of speed in her electric w/c and was able to make an exchange with R117 (a former resident), R1 and R129 were noted to make an exchange later in R129's room, both had 1:1 staff who did not report the exchange, and failed to protect the residents on 1:1 observation. A special Staffing - One to One Assignment policy dated May 2012 and revised May 2013 included: one to one staffing assignments are in place based on an assessed need until appropriate permanent alternative arrangements can be made reasons may include, but are not limited to: treat of suicide by a resident, altered mentation that may dislodge treatment lines or devices, escalating exit seeking behavior, altered cognition in an agitated state that is not easily redirected., or not respected the boundaries of other residents. The procedure stated "to keep the one to one within arm's reach at all times. (if not suicidal may have visual privacy for toileting). Alternatives to one to one assignment are investigated as timely as possible. (alternative care setting, medical evaluation), family or responsible party are notified to see if they are available to provide this heightened level of	{2 800}		

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{2 800}	Continued From page 64	{2 800}		

supervision. Documentation of the one to one assignment is made in the clinical record; appropriate care plan/review/revision is made during the one to one assignment. IDT [interdisciplinary team] will meet to determine the appropriateness of removing a one to one and under what circumstances it may be reinitiated."

The one to one staff, and safety monitor were not effective in preventing residents from obtaining and consuming drugs and alcohol within the facility, the facility lacked an analysis of that staffing failure and lacked additional interventions to safe guard residents.

Refer to F224: the facility failed to provide adequate supervision to residents for that had alleged drug and alcohol use for 3 of 11 residents (R37, R129, R117). In addition, the facility failed to provide adequate supervision to residents to prevent elopement from the facility for 1 of 3 residents (R116). In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent elopement for 1 of 3 residents (R13). These facility failures resulted in Immediate Jeopardy (IJ) issues at F323 related to the failure of the facility to supervise the residents for the alleged drug and alcohol use and elopement. This had the potential to affect all 67 residents in the facility.

F323: the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in Immediate Jeopardy (IJ) on 5/9/14, at 2:03 p.m. Also a second IJ was identified for 2 of 3 residents (R37, R129) on 5/12/14, at 2:51 p.m. In addition, the facility failed to ensure residents with WanderGuard were supervised when leaving

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 800}	Continued From page 65 the facility for 2 of 3 residents (R13, R116) observed to elope from the facility. R13 was observed on 5/6/14, to leave the facility with a WanderGuard attached. This resulted in IJ on 5/9/14, at 2:03 p.m. R116 was observed to leave the facility on 5/11/14, at 9:30 a.m. This resulted in IJ on 5/12/14, at 2:51 p.m. In addition, to the resident(s) in IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113). Also, the facility failed to ensure residents were smoking safely according to the plan of care for 3 of 3 residents (R1, R36, R22).	{2 800}		
2 820	MN Rule 4658.0510 Subp. 5 Nursing Personnel; Assignment of duties Subp. 5. Assignment of duties. Nursing personnel must not perform duties for which they have not had proper and sufficient training. Duties assigned to nursing personnel must be consistent with their training, experience, competence, and credentialing. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure verification of licensure for 2 of 3 licensed nurses (licensed practical nurse (LPN)-A and registered nurse (RN)-C). These had the potential to affect all 67 residents residing in the facility. Findings include: Licensure verification: LPN-A's employee file folder lacked verification of	2 820		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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2 820	Continued From page 66 the LPN license. The administrator verified on 5/12/14, at 12:45 p.m. there was no proof of nursing licensure obtained from the Minnesota Board of Nursing for LPN-A. RN-C was hired on 4/8/14, indicated no licensure verification (copy of license dated 10/4/13) had been completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge for doing license verifications for new employees. The administrator further stated the HR person was terminated two weeks ago. The administrator added the facility did not ensure tracking for new employees' license verification. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, then she started full time work on her own since 4/16/14. The facility's Clinical Manual, Operational Manual dated 5/2012, directed the facility to obtain verification of nursing licensure from the State licensing board upon employment and to keep a completed "License Verification Form" in the employee's personnel file. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a monitoring system to ensure ongoing compliance and to ensure agency staff used are trained, certified, competent and experienced. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 820		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 67	{2 830}		
{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to coordinate hospice services for 1 of 1 resident (R56) reviewed for hospice. Findings include: R56's annual Minimum Data Set (MDS) dated 2/24/14, included a Brief Interview of Mental Status Score (BIMS) of 15 (cognitively intact). A physician's order dated 4/18/14, gave approval for hospice to evaluate and treat and for in-house psychiatry services to be provided. A Provider Orders for Life Sustaining Treatment (POLST) dated 4/21/14, indicated R56's cardiopulmonary resuscitation status (CPR) status was DNR/Do Not Attempt Resuscitation (Allow Natural Death) and goals of treatment were noted as Comfort Care. The POLST dated	{2 830}		

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{2 830}	Continued From page 68 4/21/14, was signed by R56's husband. Review of the facility care plan dated 4/23/14, indicated R56 was DNR/Do Not Intubate (DNI), comfort cares and was receiving hospice services, medical directives would be honored with an intervention to coordinate care with hospice. A POLST dated 4/26/14, indicated R56's CPR status was CPR/Attempt to Resuscitate, directed to Limit Interventions and Treat Reversible Conditions and included interventions and treatments of IV/IM antibiotic treatment and IV fluid administration. The POLST dated 4/26/14, was signed by R56. A nurse practitioner (NP) progress note dated 4/30/14, noted a diagnosis of end stage liver disease, now on hospice secondary to decline in condition. Review of the hospice Team Care Plan dated 5/7/14, indicated R56 signed onto hospice on 4/21/14, with a diagnosis of chronic liver disease with a prognosis of less than six months to live. Review of the hospice care plan dated 5/7/14, indicated R56 was DNR with an intervention of "DO NOT RESUSCITATE." A Residential Communication Note from hospice dated 5/12/14, indicated a message was left with the hospice social worker to call the facility social worker regarding POLST. A Progress Note dated 5/12/14, indicated contracted licensed social worker (CLSW)-B spoke with R56 about her POLST. R56 reported to SW-B she wanted to be DNR/comfort cares	{2 830}		

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{2 830}	Continued From page 69 and that was also what her husband wanted. SW-B indicated she placed the correct POLST information in the advanced directives section of the medical record. A Progress Notes dated 5/12/14, indicated CLSW-B spoke with R56's husband regarding the POLST and hospice. R56's husband stated to CLSW-B the POLST should be DNR/comfort cares. On 5/13/14, at 8:41 a.m. a review of the physician's orders signed 4/9/14, continued to direct "Full Code." On 5/7/14, at 9:31 a.m. registered nurse (RN)-A reported he would go to the POLST in the front of the chart to determine what to do if R56 was found without a pulse and not breathing. The POLST in the front of the chart was the one dated 4/26/14, directing CPR. When interviewed on 5/7/14, at 10:43 a.m. licensed practical nurse (LPN)-A stated the POLST dated 4/26/14 would be the current one and would be the one the nurses would refer. On 5/7/14, at 10:45 a.m. the NP stated her plan of care for R56 was DNR and comfort care only. The NP stated she did not feel the resident was capable of making a decision for her POLST and the decision should be made by R56's husband. Upon interview on 5/7/14, at 10:55 a.m. the hospice RN-E stated she was unaware the POLST for R56 was changed on 4/26/14. RN-E stated CLSW-D completed the POLST dated 4/21/14, with R56's husband. When interviewed on 5/7/14, at 12:04 p.m.	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 70 CLSW-D stated the reason why the POLST dated 4/21/14, was signed by R56's husband was R56 "was really confused and uncooperative" and directed all questions to her husband. SW-D stated she was unaware the POLST was changed on 4/26/14, and would expect the facility to notify hospice with any changes because full code and the treatments requested would not be a hospice focus of care. On 5/7/14, at 12:14 p.m. the health unit coordinator (HUC) verified the facility did not have a hospice care plan for R56. On 5/7/14, at 1:08 p.m. the HUC provided a hospice care plan and stated the care plan was faxed to the facility on 5/7/14. When interviewed on 5/7/14, at 12:26 p.m. nursing assistant (NA)-D stated he does not know what hospice does for R56, he sees them come in but that's it. Upon interview on 5/7/14, at 2:01 p.m. RN-F stated the POLST dated 4/21/14, was signed by the hospice medical director on 5/7/14, with the original effective date of 4/21/14. RN-F stated she expected the hospice care plan to be in the chart within two weeks of enrollment. When interviewed on 5/9/14, at 9:22 a.m. R56's husband stated he recalled signing the POLST dated 4/21/14, and verified his expectations were R56 was DNR and comfort care only. On 5/12/14, at 1:50 p.m. SW-B stated she had followed up with hospice and the intent is for R56 to be DNR and SW-B would make sure that was in place. RN-B was interviewed on 5/13/14, at 11:41 a.m.	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 71 and stated she was not aware of the code status discrepancy. RN-B stated she or the nurse would be responsible for communicating with the physician regarding code status. RN-B verified the physician's orders for Full Code did not match the POLST dated 4/21/14, and the nurses would have mixed guidance for what to do in case of emergency. On 5/13/14, at 1:50 p.m. RN-B provided a copy of the POLST signed by the hospice physician and stated the NP was aware of the code status because she had given orders for hospice. The facility Social Services/Social Work policy (undated) directed "Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident." A hospice policy was requested and was not provided. Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol (ETOH) and drug use for 4 of 11 residents (R37, R129, R41, R117). This resulted in an Immediate Jeopardy (IJ) for these four residents. A second IJ component was identified for 2 of 3 vulnerable residents at risk for elopement (R13, R116), due to the facility's failure to ensure adequate supervision and protection to prevent elopement from the facility. In addition to the resident(s) identified in the IJ, the facility failed to ensure adequate supervision was provided to prevent potential injury from ETOH and drug use for 5 of 11 residents (R9, R14, R62, R86, R113) and failed to ensure 3 of 3 residents (R1, R36 and R22) who smoked cigarettes did so in a safe manner as determined by their plans of care.	{2 830}		

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{2 830}	Continued From page 72 The IJ began on 5/1/14, when R41 drove an electric wheelchair off the sidewalk at the facility while intoxicated, requiring medical treatment with hospitalization. The administrator, consulting administrator, and director of nursing (DON) were notified of the IJ on 5/9/14, at 2:14 p.m. The administrator, consulting administrator and DON were informed of the additional immediate jeopardy concerns related to R13 and R116's elopement behaviors, at 3:15 p.m. on 5/12/14. Findings include: Alleged substance abuse: R37's progress notes indicated the resident had required hospitalizations 2/22/14, 4/23/14 and 5/10/14, related to ETOH/drug use. The Admission Record dated 1/14/14, indicated R37 had been admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and a history of alcoholism. Progress note documentation indicated R37 had been found with ETOH/vodka while in the facility on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. Observations of R37 revealed the following: - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. This surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket. - On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any	{2 830}		

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{2 830}	Continued From page 73	{2 830}		

coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident's wheelchair down the West hallway and was observed outside R9's room. There was no staff with R37 when during the observation. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and the HUC asked him where his partner was. Nursing assistant (NA)-L approached at that time and told the HUC she was the 1:1 for R37 today.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance.

Additional review of R37's record revealed these Progress Notes:
- On 11/26/13, the notes indicated chemical dependency (CD) treatment/Alcoholics Anonymous (AA) was discussed. R37 had stated he'd participated in AA services in the past and he'd had success including three years of sobriety before a recent relapse. The note indicated nursing had reported two episodes of ETOH intoxication while in the nursing home since the last visit and R37 had acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no ETOH use with nursing to monitor. The NP indicated there were "clear dependency concerns."
- On 1/8/14, the notes indicated the resident had a history of ETOH abuse which had also occurred since living at the facility.
- On 2/21/14, the notes indicated R37 had been drinking vodka and that an empty bottle had been found. The notes also indicated R37 had been observed to be distributing money to staff and residents. When R37 had noticed he had no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 74	{2 830}		

money to buy vodka, he had gone to the automatic teller machine (ATM) machine to get money. The notes indicated staff were concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. a note had been documented which indicated R37 was handing out his money to "anyone who would listen" and staff had taken $116.00 dollars from him to lock up.
- On 2/22/14, at 10:14 p.m. the notes indicated R37 had called 911 to send himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift had taken a bottle of vodka from him. The notes indicated R37 had asked the p.m. shift to return the vodka or pay him $25.00.
- On 2/27/14, at 1:13 p.m. the notes indicated R37 wanted to leave on a leave of absence (LOA), was advised he could not go on an unsupervised LOA, but had left the facility.
- On 2/27/14, at 10:07 p.m. indicated R37 was "drunk" and had a blood pressure of 147/105.
- On 3/2/14, indicated R37 was "drunk" and was noted to have a blood pressure of 176/98 and a pulse of 99.
- On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital.
- On 4/13/14, the notes indicated R37"seemed intoxicated" and one full bottle of vodka and one quarter full bottle were removed from the room.
- On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37's room. At 12:04 p.m. staff checked R37's room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink ETOH at the facility. R37 was offered a transfer to a facility that

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 75	{2 830}		

allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of ETOH. R37 stated he would like to get help to have ETOH removed from his body. Staff called 911 and police escorted R37 to detox.
- On 4/24/14, at 9:30 a.m. the notes indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of ETOH. At 12:01 p.m. on that day, the notes indicated R37 approached staff and "again was clearly intoxicated." The notes indicated the contracted licensed social worker (CLSW)-A and a police officer had entered R37's room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assaultive in any way.
A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 had been observed earlier walking into and out of R117's room and "seemed to be like an exchange of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for ETOH consumption. Further the note indicated, "A few hours later" R37 was shouting and appeared "intoxicated" and a 75% emptied bottle of vodka was found in R37's room.
- On 4/25/14, at 9:58 a.m. notes indicated R37 was "clearly inebriated", had slurred speech and could barely wake up. R37 refused to provide the source where he continued to get ETOH.
- On 4/25/14, at 3:24 p.m. notes indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and still smelled like he had ETOH on his breath.
- On 5/2/14, notes indicated R37 had removed a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 76 wander guard and refused a new one to be placed. - On 5/3/14, notes indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room. - On 5/5/14, at 3:53 p.m. the notes indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of ETOH and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and had said he was going to Las Vegas. - On 5/5/14, at 4:56 p.m. the notes indicated R37 had slurred speech, smelled of ETOH and had a staggering gait. - On 5/5/14, at 10:25 p.m. the notes indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka. - On 5/6/14, a note, which indicated it was a late entry for 5/5/14 at 6:00 p.m., indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 had stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff.	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 77 Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. the progress notes indicated R37 had been placed on 1:1 observation related to incidences of getting intoxicated. - On 5/9/14, notes indicated R37 "was clearly intoxicated" and that an empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time. - On 5/10/14, notes indicated R37 had been observed giving his credit card to R117 on 5/9/14. A second note indicated R37 had returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, the progress notes indicated R37 had a drug screen positive for methadone at the	{2 830}		

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{2 830}	Continued From page 78 hospital. R37 did not have a prescription for Methadone. The Physician (MD) and Nurse Practitioner (NP) orders indicated they were aware of R37's alcohol use. Notes included: - On 1/8/14, included a diagnosis of ETOH abuse and a note the resident continued to have problems while living in the facility. - On 2/5/14, indicated R37 had recently been found with a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH. - On 2/28/14, an order directed staff to discharge R37 to another facility (that allowed drinking). - On 3/5/14, an order directed; "do not call on-call MD or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, notes indicated R37 had been hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement. the notes indicated R37 had been treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's use of alcohol, to encourage R37 not to use, and that even if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, an order directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as	{2 830}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 79	{2 830}		

needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, an order directed "no LOA-supervised or other". In addition, the NP included an order for a WanderGuard, and to check placement every shift for elopement even though R37 had cut off the WanderGuard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and ETOH counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The Depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 80 fewer episodes of ETOH abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA. - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had a history of significant ETOH use when out on unsupervised LOA.	{2 830}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 81 The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions. Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of ETOH intoxication and ETOH withdrawal noted 9/23/13, and substance abuse noted 2/23/14. A Care Conference Summary dated 4/1/14, indicated a discharge plan of "discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37 had a history of drinking and bringing ETOH in the building or going on unsupervised LOA and R37 had stayed in the building with no ETOH use since 3/3/14. A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing ETOH and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 82	{2 830}		

been drinking, room checks were being completed and staff was finding ETOH bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase ETOH and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 got ETOH from.

The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or ETOH and stated he has heard about exchanges but could not remember who he had heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 83 when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever." On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for Delirium tremens (DTs-significant withdrawal symptoms). During interview on 5/12/14, at 8:59 a.m., registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check. The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy (stated name) a friend of R1" went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware of who R1's friend was. The DON stated the 1:1 had refused to go to the bank with R37 and that the friend of R1 had signed R37 out. The DON stated the consultant administrator was going to go with R37 and R1's friend to the bank until it was decided the facility was not comfortable with her (the consultant administrator) going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA, but stated the administrator, consultant administrator and the social worker had decided R37 could go anyway. The DON stated he had no idea where	{2 830}		

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{2 830}	Continued From page 84 R37 had gotten methadone from. When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH had been found in R37's room and 3 plastic containers with the labels removed which nursing indicated were methadone containers. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on a LOA, and stated R37 had returned with a card from Walgreens so they knew he hadn't followed his agreement to only go to the bank. The administrator stated the friend of R1 would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOA and that he had believed CLSW-A and had not checked the chart himself. The administrator stated he was also not aware of R1's relationship with the friend and that the DON had not told him about the order for no LOA or the relationship between R1 and the friend. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 leaving on LOA she had been informed by nursing (she could not remember who) that R37 could leave the facility with supervision. CLSW-A reported she'd made it clear to the person taking R37 out, R1's friend, that R37 could only go to the bank and nowhere else. She stated she'd told R1's friend that R37 would try and talk him into going to the liquor store but that R37 could not go there. CLSW-A said R1's friend had reassured her he had been sober for ten years and would never take R37 to a liquor store. CLSW-A stated it was not until after R37 had left, that nursing (did not remember	{2 830}		

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{2 830}	Continued From page 85 who) told her R37 had orders for "no LOA" and that R1's friend was a drug dealer. CLSW-A said it would have been nice to have known that information before she'd allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she'd trusted nursing to know the correct information. She also stated she was aware R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing hadn't been finding the ETOH when they made the bed. When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs or aware that R1's friend was her drug dealer prior to having allowed R37 to leave with R1's friend on an LOA. R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times). R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed ETOH on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation (mechanical ventilator assisted breathing) for a blood ETOH level of .323. The admission MDS dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's CAA	{2 830}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 86 for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with ADLs. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering CD treatment. The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms. R129's Smoking Evaluation dated 3/18/14, identified to "monitor for ETOH use or oversedation." The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is	{2 830}		

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{2 830}	Continued From page 87	{2 830}		

aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is ona 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the DON on 5/5/14.

An Emergency Department Chart [a form from the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked

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{2 830}	Continued From page 88	{2 830}		

by the ER, but lacked a toxicity screening for cocaine, drug or ETOH use. R129 was given two doses of Dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency (SA) were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1.

A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD."

On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, ETOH and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 89 The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and procedures in place." R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 90 ADLs and "1:1" in larger bold print. Nursing Progress Notes: - On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 mg [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use." - On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money." - On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment. - On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 91	{2 830}		

order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
- On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility

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{2 830}	Continued From page 92 to R129's current PCP. - On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction." - On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest." - On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms." - On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 93	{2 830}		

toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal drugs was identified, reported to the administrator immediately, reported to the SA or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.
- On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of Dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 830}	Continued From page 94 signed by the writer]. On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms." On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arm's length from R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M. - At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern. - At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129. - At 8:38 a.m. R129 stood up and walked to the	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 830}	Continued From page 95	{2 830}		

front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway.
- At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129.
- At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of

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{2 830}	Continued From page 96	{2 830}		

R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking beside (to the left) of R129.
- At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14.
- At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor.
- At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk.

On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 97 R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and ETOH treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{2 830}	Continued From page 98	{2 830}		

use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of ETOH or drugs being exchanged on "my shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse.

On 5/8/14, at 11:40 a.m. NA-S stated they had seen ETOH bottles in residents rooms and smelled ETOH on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January 2104 or February 2014. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 99	{2 830}		

NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."

On 5/8/14, at 11:55 a.m. a housekeeper (H)-A was asked if they were aware of any residents drinking ETOH in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any ETOH bottles found in the facility "and has." H-A was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the ETOH bottles came from, H-A stated she was unclear, but thought they may have been provided by family.

On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated ETOH from R37. LPN-H verified ETOH was provided to R37 and suspected to other residents of the facility, but was unclear how the ETOH was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility.

On 5/8/14, at 12:10 p.m. the HUC stated she was aware of resident drug and ETOH use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 100 "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming ETOH in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the ETOH was coming from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine. On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and ETOH use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129. Further review of the nursing progress notes indicated the following: - On 5/9/14, at 7:31 p.m. the pharmacy was	{2 830}		

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{2 830}	Continued From page 101	{2 830}		

contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
- On 5/11/14, at 10:09 a.m. a note written by the HUC indicated NMMC called the facility "requesting" R129's medication administration records (MARs). The note indicated the RN from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough ETOH to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the ETOH and/or if the assigned 1:1 was interviewed at the time.
- On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two LPNs were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of ETOH. She also

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 102 reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving R129 ETOH, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her ETOH. - On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMC was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine." - On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of ETOH was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m. On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 103 - Was asked regarding R129 obtaining ETOH or drugs while on a 1:1, DON verified the information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and ETOH while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained ETOH, but verified R129 was harmed by the incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." CLSW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for CD treatment and verified was last noted to be offered to R129 on 4/4/14.	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 104 Both verified they should have revisited CD treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for ETOH toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. CLSW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, "I cannot imagine how a resident who was on 1:1 would get that much ETOH in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home." R41: The facility failed to provide supervision to prevent ingestion of alocholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium. R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m. , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 105	{2 830}		

the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily function problems).

The admission MDS dated 2/17/14, indicated R41 had a BIMS score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detected depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The CAAs dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. "Resident is OK to go on unsupervised LOA." A Smoking Evaluation dated 2/10/14, indicated independent with smoking and

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{2 830}	Continued From page 106 smoking materials. The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with ADLs, and was safe for unsupervised LOA. A Physician's Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41's request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician's recommendations were scheduled and that R41 went to the consults. A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. "He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain." The physician was notified and 9-1-1 was called. R41 was transferred to NMMC for further evaluation. He was admitted to ICU with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41's LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but	{2 830}		

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{2 830}	Continued From page 107 lacked mention of the causative factor of intoxication. On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician's Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's." A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA. On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c. Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41's medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as AA or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41's medical record lacked any evidence R41 had seen the house psychologist. R117: R117 was identified by the facility as questionably buying cigarettes and drugs, and selling within the	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 108	{2 830}		

facility. The facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents.

R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression.

The admission MDS dated 2/3/14, indicated R117 had a BIMS score of 15/15, which depicted no cognitive impairment. R117 was independent with all activities of daily living and mobility.

R117's LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised; a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.

The care plan revised 4/27/14, indicated R117 did exhibit verbal abuse/aggression towards staff. "Staff has reasonable cause to believe that Resident has brought alcohol & drugs into the facility for other Residents." R117 had displayed

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{2 830}	Continued From page 109 actual physical behaviors/physical fight with roommate. R117 would play music very loud and would not turn the music down which disrupted other residents. R117 often left the facility and did not return at said time. The interventions were R117 would cease bringing any type of alcoholic beverages or illegal drugs into the facility and would not exhibit threatening behavior toward staff or other residents. R117 would follow the facility policies and procedures R117 would return to facility at designated time or will call facility to report he would be late. "If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called." The progress notes were reviewed and noted: - On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: "resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator." - On 2/13/14 at 6:39 a.m. a progress note indicated, "Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility." - On 2/16/14, 9:06 a.m. a progress note indicated, "resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware."	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 110 - On 3/27/14 at 4:01 p.m. a progress note indicated, "Resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern about resident's behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP [common entry point] should aggressive behaviors towards others occur. Resident is calm at this time." - On 3/31/14, at 4:43 a.m. a progress note indicated, "AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. Writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours." - On 3/31/14, at 1:40 p.m. resident had still not returned from LOA on 3/30/14. "No phone numbers on file to try to reach resident." - On 3/31/14, at 2:58 p.m. R117 just returned from LOA at 2:30 p.m. "Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here.	{2 830}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 111 Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding." - On 4/11/14, at 3:18 p.m. "Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH [group residential housing] housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID [identification] and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning." - On 4/25/14, at 10:11 a.m. a progress note indicated, "Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations [DFO] met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks." - On 4/26/14, (no time) a progress note indicated,	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 112	{2 830}		

officer from the Minneapolis Police department (MPD) came regarding the seven credit cards that were found in R117's room that were not his name. "Officer took the cards and will check to see if any of them had had any activity or been reported stolen."
- On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t [due to] length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated.
- On 5/2/14, at 2:00 p.m. a progress note indicated, "Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated 'no' Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 113	{2 830}		

decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded 'no.' Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes."
- On 5/5/14, at 3:55 p.m. a progress note indicated, "Writer was updated by NAR [nursing assistant registered] that this resident received money from another resident [#02445] to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident [#02445], he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up. "
- On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 114	{2 830}		

and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (unable to determine if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), and she then reached down and put the wallet into his lower left leg pants pocket.
- On 5/7/14, at 8:43 a.m. R1 stated "there were no smoking problems here until this thing started [referring to 1:1 for unsafe smoking and not following facility rules], I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that "[R117] was also known to charge for getting drugs and alcohol." R1 turned to R9 (roommate) and stated, "Isn't that right!" R9 verified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.
- On 5/7/14, at 1:15 p.m. a call was made to the MPD-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 115 - On 5/8/14, at 2:38 a.m. a progress note indicated, "Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on." - On 5/8/14, at 6:30 a.m. "Resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility." - On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only. - On 5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility. - On 5/9/13, at 10:38 a.m. (was added to the progress notes) "Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic." - On 5/9/14, at 11:50 a.m. "Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 116 office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office." - On 5/9/14, at 12:00 p.m. "writer spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph's office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph's hospital." - On 5/9/14, at 12:23 p.m. two police cruisers (three officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that "R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox [drug toxicity] screen here (urine drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating." - On 5/9/14, at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident's condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and congestive heart failure (CHF) condition. All	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 117	{2 830}		

medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph's ER and gave report and updated on status, along with requesting toxicology screen.
- On 5/9/14, at 1:04 p.m. a social work progress note indicated, "Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached, resident yelled 'Are you LSW-C?' Writer responded affirmatively, resident then yelled 'Why did you tell [R81], I was threatening him? He's my friend and I have the right to see him.' Writer informed resident that writer was not aware of what he was talking about, writer asked who [R81] was. [R117] walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled 'no' and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox-screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" Resident stated "yes." Police and emergecnt medical technician (EMT) then stated that his doctor gave an order for him to be

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 118	{2 830}		

admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated 'yes' in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell 'I am leaving AMA' Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 119	{2 830}		

will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time."
- On 5/9/14, at 2:34 p.m. a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated, 'It is not nobodies damn business.' Resident is going to be discharged from St. Joseph's. IDT team notified."
- On 5/9/14, at 15:47 p.m. a progress note indicated, "writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information."
- On 5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. "[R117] was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on [R117]. [R117] had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As [R117] chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised [R117] that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present."
- On 5/10/14, at 12:25 p.m. R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 120	{2 830}		

road.
- On 5/10/14, at 12:58 p.m. the administrator stated R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. R117 was supposed to call the police that morning and be escorted to the facility to pick up his belongings. "But he had not yet called."

On 5/12/14, at 1:37 p.m. interview with contracted social workers CLSW-A and CLSW-B Verified they had not been in the facility on Monday May 5th through Wednesday May 7th, because Videll Health Care was late with the payment to the agency Circle of Life (social work temporary agency). Their agency had been contracted to get the facility up to date with assessments and plans, and they had been trying to meet the residents and get the assessments completed.

When interviewed on 5/12/14, at 2:43 p.m. CLSW-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. CLSW-A stated, "I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 121 Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home." Although the care plan had been updated on 4/11/14, by CLSW-C and on 4/27/14 by CLSW-A, R117 had not been offered services for his repeated aggressive and confrontational behaviors, or chemical dependency. ELOPEMENT: On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a WanderGuard applied, the WanderGuard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor. Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently. On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 122	{2 830}		

the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly The speed limit was 30 miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards on the sidewalk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 123 facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility. R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease. The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug abuse. LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised. A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a WanderGuard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 124 The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a WanderGuard. R13's quarterly MDS dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with ADLs. A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a WanderGuard or elopement risk. R13's Physician's Order Sheet dated 4/16/14, directed to check R13's WanderGuard every shift beginning 9/19/13. The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year). R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision. An undated Group 5 assignment sheet (a form	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 125 carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a WanderGuard. The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident. On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then.	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 126 The SA form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk." On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The WanderGuard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the WanderGuard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area. - At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the WanderGuard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the WanderGuard alarm for residents who wanted to smoke in the designated smoking area. At not time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building. On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and DM were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{2 830}	Continued From page 127	{2 830}		

elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or SA would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if that occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with WanderGuards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a WanderGuard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 128	{2 830}		

component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement.

Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance."

A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 129	{2 830}		

placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor."

Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 130 indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks.	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 131 Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 132 resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA). R9 was not supervised during smoking, was keeping smoking materials and was an alleged "Pot smoker." On 5/6/14, at 7:40 a.m. R9 was observed smoking cigarettes out front on the designated smoking patio with no staff in attendance. On 5/6/14, at 8:56 a.m. R9 was observed wheeling herself to the front designated smoking area, she retrieved cigarettes and a lighter from her right sock and placed them on the table next to a covered ash tray. R9 then leaned to the table with her right elbow as she lit her cigarette and	{2 830}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 133	{2 830}		

started to smoke. During observation, NA-B went over to the smoking cart to get a smoking apron, applied the apron on R9, and sat directly across from R9.
-At 9:05 a.m. NA-B continued to watch R9 as she smoked.
-At 9:08 a.m. R9 was observed wheeling herself into the building. No burn holes noted on the front of her shirt or clothing.

On 5/6/14, at 10:05 a.m. R9 was observed wheeling herself out of the building as staff monitoring the smoking area was observed applying a smoking apron, wheeled herself to the smoking area retrieved her cigarette and lighter from her socks as she was leaning far forward and continued to lit the cigarette and began to smoke.
-At 10:11 a.m. R9 was still observed sitting on her w/c at the smoking area.
At 10:14 a.m. R9 lit another cigarette leaned very far forward to retrieve and replace cigarettes in her socks and continued to lean forward multiple times as she smoked.
-At 10:19 a.m. R9 returned back to the building.

On 5/6/14, at 2:45 p.m. when interviewing R9 surveyor observed a cigarette box in each white sock on each inner leg. When R9 was asked why she was storing the cigarettes in the socks she stated "You can leave now, go now". Surveyor left the room as requested.

When interviewed on 5/6/14, at 3:06 p.m., the DON stated he was not sure if R9 was supposed to be supervised during smoking, and indicated he had been given a list of smokers who required supervision just that day. Upon review of the list, the DON stated R9 was a supervised smoker which meant she should relinquish her cigarettes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 830}	Continued From page 134	{2 830}		

and lighter. DON stated R9 should not have had any tobacco products on her person, but did not have to wear an apron. Following the interview, the DON was observed to approach R9 at the smoking area and speak to her, and to return to tell the surveyor R9 had refused to give him the cigarettes she had in her socks.

When interviewed on 5/6/14, at 3:12 p.m. NA-I (smoking monitor) verified after looking through the locked cigarette box on the cart R9 did not have cigarettes in box. NA-I stated he had been working at the facility for a month and R9 had never had cigarettes in the locked box.

When interviewed on 5/6/14, at 3:20 p.m. the administrator, DON and LPN-A (the resident care manager for R9) all stated if a resident was a supervised smoker they were supposed to relinquish all smoking materials but many refused. They said they couldn't force them to do it as the residents were part of the supervised program. LPN-A further stated "They have been told that they have to do this and we had a meeting with all smokers last week. They were given a copy of the smoking policy by social services and were supposed to sign it, but some refused. We have told them the rules and when they are or aren't allowed to keep them [their cigarettes], but they don't care. [R9] should be in there, but she won't give them to us."

When interviewed on 5/6/14, at 3:25 p.m. the DON stated, "We have a smoking policy updated and it does include that they should relinquish, are still supervised, the smoking monitor makes sure they are safe with their usage, that is why they are out there and we are still keeping them safe, we have tried to get her lighter and cigarettes on repeated effort but have not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{2 830}	Continued From page 135 able to do so." When interviewed on 5/6/14, at 3:43 p.m. LPN-A stated "Problem is if I took her cigarette and lighter, she would just get the cigarettes from somewhere else probably gives someone money to go buy a pack of cigarettes. We tried this morning to take them from her and she stated "I'm not giving them to you because you will sell them to another resident". LPN-A stated the policy had been explained and R9 had asked what would happen if they did not abide and LPN-A had stated they were consequences. LPN-A further stated the NA who was monitoring the smoking had a book on the cart and documented when a resident refused or when they are not safe. When asked by surveyor if the smoking monitor had reported off to her LPN-A stated she was not sure maybe the social worker had been reported to. When interviewed on 5/12/14, at 2:26 p.m. CLSW-A stated when R9's room had been searched on 4/23/14, R9's cigarette roller had been found on the roommate's side and had been taken out of the room and kept in the social service room and family had been called to get it but R9's family had been very upset about staff removing the roller from the room. Both CLSW-A and CLSW-B stated they were un-aware R9 was an alleged "Pot smoker" or had history of using per the Resident List Report dated 5/8/2014, provided by the administrator. Both indicated they had not received the list of all the residents who had been thought to have substance abuse issues. When R9 was interviewed on 5/13/14, at 8:36 a.m., and asked whether she smoked "pot', R9 stated "It's a lie that I am using any pot" and kept	{2 830}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{2 830}	Continued From page 136 repeating same statement to the surveyor. R9's MDS dated 3/24/14, identified R9's diagnoses included schizophrenia, diabetes mellitus, orofacial dyskinesia, psychotic disorder, manic depression and chronic obstructive pulmonary disease. The MDS indicated R9 had no behaviors and had a BIMS score of 15 indicating intact cognition. In addition, the MDS indicated R9 received one person assist with transfers, dressing, hygiene, and R9 was did not use any mobility devices yet R9 used a w/c during the course of the survey around and off the unit for mobility. The nutritional status Care Area Assessment dated 3/25/14,, had identified R9 had history of tobacco abuse. The smoking care plan dated 10/20/11, identified R9 was a smoker. Goal "[R9] will follow all guidelines regarding smoking at Camden Care Center, will remain safe while smoking." Care plan directed cigarettes and lighter will be kept at nursing station, and R9 was a supervised Smoker. Smoking Evaluation dated 10/7/13, indicated R9 was independent with smoking and smoking materials. After concern was brought to the facility attention on 5/6/14, another Smoking Safety Assessment was completed which indicated R9 was to remain as a supervised smoker, facility was to store tobacco products but may choose to wear apron or not. Progress Note dated 4/30/14, indicated the director of facility operations and two social workers had been to R9's room and a bottle of "Shout", raw tobacco and other materials (for the tobacco to be rolled) had been removed from the room and placed in the Administrator's office for	{2 830}		

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{2 830}	Continued From page 137 the family to pick up when they visited. The undated and untitled list of Unsupervised and Supervised Smokers, revealed R9 was identified as a supervised smoker,did not need to wear a smoking apron, but was supposed to be within an arms distance from the smoking monitor. R14 was observed to ingest an unknown substance, was sent to the hospital and tested positive for THC (the active substance in marijuana) on 5/3/14, R14 was not evaluated for substance abuse, assessed for safety or provided supervision to prevent potential future access to illegal drugs. R14's admission record dated 1/14/14, indicated diagnoses to include depressive disorder, epilepsy and below the knew amputation. R14's significant change MDS dated 12/31/13, identified R14 had moderately impaired cognition, no mood problems and physical behavior symptoms towards others 1-3 days in the assessment period. The MDS indicated R14 required extensive assistance with most ADLs but was independent with locomotion on and off the unit and eating. The CAA were all dated 1/9/14; CAA for cognitive loss/dementia indicated R14 was able to understand and be understood. CAA for ADL function and rehab potential identified R14 had "alcohol abuse" and "alcohol induced dementia. CAAs did not identify any history of drug use. R14's Vulnerable Adult care plan dated as revised on 4/26/14, indicated R14 had a "History of chemical abuse, including marijuana and heroin. The care plan goal indicated R14 would "remain safe and free from abuse/neglect." The care plan interventions indicated R14 refused all in-house	{2 830}		

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{2 830}	Continued From page 138 and outside psychiatric services. The care plan identified R14 required supervision for LOA from the facility. A nursing Progress Note dated 5/3/14, at 8:35 p.m. indicated a nursing assistant (NA) had reported to a nurse they saw R14 "put something" in a small plastic bag "possibly drug" at 8:30 p.m. The note indicated a nurse approached R14, noted he had something in his mouth and asked the resident to "spit out" what was in his mouth. R14 refused to open his mouth, swallowed the content and then opened his mouth for the nurse. The note indicated R14 was "non-cooperative" and "attempted to hit the nurse with his fist." The note indicated the physician had been notified and R14 had been sent to the ER for evaluation. A North Memorial Robbinsdale HUC Transfer Packet indicated the results of toxicology screen identified R14 was positive for "THC Metabolites [the active drug components of marijuana]" from the past 24 hours. The report identified the laboratory report had been obtained for R14 due to "drug ingestion." Although the specific incident was documented on 5/3/14, the clinical record lacked documentation including, investigation of the incident to determine potential source(s) R14 may have obtained the illegal drug from, notification of law enforcement, any follow up assessment of R14's safety, an evaluation of R14's access to leave the facility, such as to smoke; documentation of how to prevent potential future instances of R14's illegal drug access and ingestion, monitoring of R14 and interdisciplinary involvement, such as medically related social services.	{2 830}		

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{2 830}	Continued From page 139 On 5/8/14, at 11:32 a.m. R14 was interviewed. R14 stated he did not recall the incident on 5/3/14. R14 stated his memory was poor due to being an "eplileptic." R14 denied awareness of illegal drug and ETOH activity in the facility. When asked what R14 would do if she observed illegal drug or ETOH activity in the facility, R14 stated he would "tell the resident not to do it," but would not notifiy staff. When asked why he would not notify staff, R14 stated, "'Cause we all have enough troubles, if someone wants a little activity on the side, go for it!" On 5/12/14, at 10:26 a.m. the DON was interviewed, and verified there was no current system in place for monitoring staff to ensure facility policies were followed. DON was unclear on the specifics of R14's incident. On 5/12/14, at approximately 2:00 p.m. CLSW-A and CLSW-B both verified they were not aware or informed of R14 obtaining and ingesting an illegal drug. Both verified they were not notified R14 was sent to the hospital and had a positive toxicity screen for marijuana. Both CLSW's explained they would have assessed R14 and reviewed potential CD treatment options with R14. Both CLSWs expressed R14 may require increased supervision due to accessing an illegal drug and his history of chemical dependency. Both verified they had access to the computer clinical record, CLSW-A stated the facility lacked consistent documentation of incidents, interventions, assessments and follow up. R62 was identified by the facility to have past/recent substance abuse. R62 had diagnoses that included memory loss, dementia and cerebrovascular accident (CVA).	{2 830}		

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{2 830}	Continued From page 140 The MDS did not address R62's substance abuse. The most recent cognitive loss/dementia CAA dated 9/11/13, lacked a comprehensive summary of the resident. Review of the quarterly MDS, dated 2/25/14, indicated R62 had moderate cognitive impairment. Review of facility progress note dated 1/24/14, at 17:03, indicated "a resident approached writer alerting us that another resident (res) is sitting outfront smoking marijuana. Writer went and found R62 smoking a joint. Writer told res that she'd have to put it out, and to consider this a warning. She was informed that the next time she will be discharged. Writer also asked res if she had anymore marijuana and she denied having any". Review of facility progress note dated 1/24/14, at 17:17, indicated "this writer with the Administrator approached this resident in her room to talk to her about her smoking weed-as per another resident who is a smoker too. Res agreed that she was smoking "weed" this afternoon at the smoking designated area. Writer told resident that the next time she is found smoking "weed" she will be discharged. Res verbalized understanding, and denied having anymore "weed" with her. Nursing will continue to monitor". Review of a Vulnerable Adult Assessment dated 3/18/14, identified R62 had "past/recent substance abuse" and a history of risky behaviors and being in an abusive relationship. R62 was identified to need supervised LOA except for appointments with scheduled transport. R62's care plan with revision date of 4/26/14, identified that R62 had no indications for displaying inappropriate behaviors, had a history	{2 830}		

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{2 830}	Continued From page 141 of being in an abusive relationship, and had impaired cognitive function/dementia, evidenced by varying mental function, judgment deficit, dementia, 'ETOH" abuse and impaired decision making skills. The care plan did not address ETOH and/or drug abuse even though it was identified in the Vulnerable Adult Assessment and progress notes. Review of a facility provided list of residents with questionable or known ETOH and drug use dated 5/8/14, at 8:02 a.m. identified R62 for drugs. During an interview on 5/13/14, at 10:18 a.m., the DM stated "I did what the 1/24/14 progress note says and reported it to the social worker, director of nursing and the interdisciplinary team...I did not search her room that I remember." During an interview on 5/13/14, at 10:33 a.m. CLSW-A and CLSW-B stated that they were unaware until now of the incident with R62 smoking marijuana in the outside smoking area even though it was documented in the progress notes and the vulnerable adult assessment dated 3/18/14 identified recent and history of substance abuse. CLSW-A stated she has been at the facility for "about a month". SW-B stated she has been at the facility since 3/19/14. During an interview on 5/13/14, at 12:57 p.m. RN-B stated on 1/24/14, R62 had verified she'd been smoking 'weed' but had told them she did not have anymore. RN-B stated they did not search R62's room for drugs and "I would assume the administrator would take care of it because she was there." RN-B verified the care plan was not updated and that she "didn't think" R62 had ever been offered any chemical dependency assistance.	{2 830}		

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{2 830}	Continued From page 142 R86 had been committed as mentally ill and chemically dependent on 10/31/12, which was amended on 3/12/13, to include admission to a nursing home for rehabilitation and when completed and/or mentally stable, again participate in chemical dependency treatment. The facility Resident List Report, provided 5/8/14, at 11:00 a.m. identified R86 as a known pot smoker. According to the Admission Record dated 3/16/13, R86 had been admitted to the facility with diagnoses including: hepatic encephalopathy (confusion related to liver failure) and cirrhosis of the liver and hepatomegaly (enlarged and fatty liver) alcoholic liver damage, thrombocytopenia and anemia (blood disorders related to clotting factors not supplied by the damaged liver, psychosis, drug abuse and drunkenness. A care conference dated 1/2/13[sic] (2014), lacked mention of commitment to facility for chemical dependency and mental illness, or need for treatment when stable. A progress note dated 2/24/14, at 4:38 a.m. " Resident had been very confused and having difficulty to settled down in bed. judgement [sic] has been non intact and appearing restless with a lot of tremor. He did attested [sic] to this writer that when he goes LOA he smokes marijuana but never drink ETOH at all. He state "If I drink I will die. " His platelet has been dangerously lower thus posing him at a risk for bleeding. Update DR smiley about resident change in condition, which then mandate this writer to send resident to the emergency for thorough evaluation at this time. Meanwhile, writer had been trying to touch base	{2 830}		

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{2 830}	Continued From page 143 with family members but unable. We will continue to follow up with his condition. " A progress note dated 2/24/14, indicated at 11:00 p.m. "Pt was found smoking 'pot' in his room. His roommate was in the room at that time. The nurse discussed the disadvantages of smoking in the room including fire hazard. The administrator was informed via text messaging and incident report filled out." A progress note dated 3/4/14, at 6:11 a.m. noted, " While executing an initial nursing rounds this shift, this writer smell and noted a medicine bottle fill up with marijuana. Upon conversation, this resident did urge this staff that; he was not going to smoke within this vicinity and he refused to surrender it to this writer, instead he affirmed to this writer that he was going to report it to the police. Added to that, he did want to have an extra oxycodone which had been previously discontinued. He had flexeral [sic]with some benefit noted. He want [sic] another sleeping pills at about 4 am. He had one sleeping pill at bedtime. Refused 50 mg of Trazodone [sic], he wanted 100 mg. Meanwhile we will continue to offer him support and encourage him with care and pain management protocol at this moment. " An annual MDS dated 3/22/14, had a BIMS score of 15/15. R86 required setup for dressing and meals and was independent with all other cares. A vulnerable adult assessment dated 3/18/14, noted past and recent chemical abuse. R86 had fluctuating cognitive deficits related to liver damage, chemical use and needed supervised LOA due to fluctuating cognition and chemical use. A smoking assessment dated 3/18/14, indicated	{2 830}		

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{2 830}	Continued From page 144 reports of smoking marijuana outside, and recent drug use reported by resident. A LOA safety assessment dated 3/18/14 indicated mental illness, fluctuating cognition related to liver disease. R86 needed supervised LOA due to fluctuating cognition and chemical use (no mention of committed to the facility related to substance abuse and mental illness. On 4/13/14, a care conference indicated: long term placement waiting for liver transplant. " Is aware of need to remain sober to stay on the (transplant) list. Does not want to go to treatment. Discussed AA (alcoholics anonymous), stated he has tried in the past. " The care plan dated 3/27/14, indicated: R86 was a vulnerable adult related to cognitive limitations, physical limitations, history of substance abuse past and recent, interventions included: Provide resident with treatment program information as needed and as requested. Resident has been assessed and is appropriate to leave facility for appointment with schedule transport. Resident has been assessed and may not leave this facility without supervision due to fluctuating cognition secondary to liver disease and substance abuse. R86 was committed to prevent exposure to ETOH and chemical substances of abuse. The fa	{2 830}		
{2 900}	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	{2 900}		

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{2 900}	Continued From page 145 provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based interview and document review, the facility failed to develop interventions for 1 of 3 residents (R123) identified with pressure ulcers on admission to the facility reviewed for pressure ulcers. Findings include: R123's Hospital Nursing Progress Note dated 4/11/14, indicated R123 had three pressure ulcers which were connected to continuous wound vacuum (vac) suction and the dressings were intact. The pressure ulcers locations and stages were not identified. R123 was admitted to the facility on 4/18/14, and deceased on 4/21/14. R123's diagnoses included Spastic paralysis due to multiple sclerosis (MS), pressure ulcers, physical deconditioning, generalized weakness, abnormal pain, diabetes, cerebral palsy, and weakness of both legs obtained from the Discharge Orders and Plan dated 4/18/14.	{2 900}		

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{2 900}	Continued From page 146 Admission Nursing Assessment dated 4/18/14, indicated a full skin assessment had been completed and a right hip pressure ulcer area with measurements 6.5 centimeters (cm) length (L) x 3 cm width (W) x 2.2 cm depth (D) and 2.5 cm tunnel at 6 o'clock position, right buttock with measurements 4.6 cm (L) x 2.0 cm (W) X 0.0 cm (D) cm and right heel area measured 1.2 cm (L) x 1.0 cm (W) x 2.0 cm (D) had all been identified. The form did not indicate if the areas were pressure related nor were the areas staged. Progress Notes dated 4/18/14, indicated a full skin assessment had been completed with measurements as noted on the Admission Nursing Assessment dated 4/18/14. On the right hip area a wet to dry dressing had been removed and wound bed consisted of moist yellow, pink, red tissue with moderate amount of yellow, red odorless drainage were observed and the surrounding wound tissue had no redness, warmth, or tenderness noted and wound vac dressing had been applied. On the right buttock foam dressing had been removed from with wound bed consisting of dry pink and red tissue, no drainage, no redness, warmth, or tenderness noted to the tissue surrounding the wound and non-adherent dressing applied. On right heel foam dressing had been removed ulcer observed with wound bed consisting of moist red and yellow tissue with scabbing, large amount of odorless drainage noted, no redness or warmth noted to the tissue surrounding the wound and non-adherent dressing was applied. The Progress Note did not also indicate if the areas neither were pressure related nor were the areas staged. A Physician's Order dated 4/18/14, directed staff to "Apply non-adherent dressings to right ischial	{2 900}		

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{2 900}	Continued From page 147 tuberosity wound and right heel until needed supplies are received." The facility Initial/Temporary Care Plan dated 4/18/14, identified R123 had pressure areas marked and indicated with wound vac. However, the medical record lacked evidence of any other interventions being put into place to prevent and/or minimize potential further skin breakdown such as turning and repositioning, wound care, and pressure relieving mattress. During document review it was revealed a Braden Scale-For Predicting Pressure Sore Risk dated 4/21/14, indicated R123 had a score of 11 which indicated R123 was at high risk and the Comprehensive Evaluation of Skin Risk Factors dated 4/21/14, identified the risk factors but lacked immediate interventions to minimize further potential skin breakdown. R123's admission Minimum Data Set (MDS) dated 4/21/14, indicated R123 required limited to extensive assist of one to two with activities of daily living (ADL's) including bed mobility and transfers; had impairment on one side on the lower extremity with limited range of motion (ROM) and had one Stage 1 (a Stage I pressure ulcer is an observable pressure related alteration of intact skin whose indicators as compared to the adjacent or opposite area on the body may include changes in one or more of the following: skin temperature (warmth or coolness), tissue consistency (firm or boggy feel) and/or sensation (pain, itching) and two Stage 2 pressure ulcers (a Stage 2 is partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The MDS noted R123 was not on a turning and repositioning schedule	{2 900}		

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{2 900}	Continued From page 148 and did not have wound care treatments that were completed in the last seven days. When interviewed on 5/12/14, at 9:58 a.m. registered nurse (RN)-C MDS coordinator verified the temporary care plan had been developed but there without interventions to minimize further potential skin breakdown. RN-C further indicated "I believe there should have been more interventions listed than just the wound vac as resident had already pressure ulcers." On 5/13/14, director of nursing was unavailable for interview. The facility policy entitled Skin Integrity Management, dated 5/12, directed director of nursing services (DNS) or designee and the interdisciplinary team (IDT) were responsible to ensure the development and implementation of a comprehensive plan of care including prevention and wound treatments as indicated. The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin issues, maintain function and improve quality of life.	{2 900}		
{21325}	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services	{21325}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21325}	Continued From page 149 that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 2 residents (R9, R36) received assistance to obtain dentures or coordinate dental care services for dental follow up, and to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed without dentures during the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m. When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s)	{21325}		

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{21325}	Continued From page 150	{21325}		

(edentulous); maintained oral care independently and R36 had reported he had dentures at home not at the facility.

Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him.

Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums.

The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..."

The Camden Care Center Quarterly Care Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet.

R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns.

The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or

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{21325}	Continued From page 151 dentures and is able to chew adequately without his teeth and noted weight as stable. Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested. When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care. When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms. When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him. When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..." On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a	{21325}		

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{21325}	Continued From page 152 while ago and would like new ones if his old ones could not be found. On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones. The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided. The facility plan of correction indicated by 4/28/14, social service and nursing would coordinate getting R36 fitted with dentures and these activities would be clearly documented in the clinical record to include any and all communication with the guardian. Review of R36's record on 5/7/14, at 1:50 p.m. lacked evidence of a dental visit. When interviewed on 5/7/14, at 2:10 p.m. the health unit coordinator (HUC) stated reported she had spoken to R36 and he stated his dentures were in a storage locker and he did not want new ones and stated the information was in the progress notes. The HUC was again interviewed on 5/8/14, at 8:17 a.m. and she stated she was unable to locate any documentation regarding her conversation with R36 regarding his dentures and she verified she had not offered R36 a routine dental exam. At 2:32 p.m. the HUC reported R36 had agreed to a dental visit and would be scheduled for one. When interviewed on 5/13/14, at 2:29 p.m. licensed practical nurse (LPN)-E stated the facility did not have a dental policy and the corporate consultant stated it was on a case by case basis. The facility Medical Services policy dated May	{21325}		

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{21325}	Continued From page 153 2012, indicated the social services director or designee was responsible to arrange dental services to meet the needs of the residents. R9 had a dental exam on 2/27/14, which indicated that more dental treatment was needed, however had not received dental follow up as recommended. The annual MDS dated 10/11/13, did not identify R9 had any dental issues or problems with teeth. The significant MDS dated 3/24/14, indicated R9 had no cognitive impairment and required one person assist of staff with personal hygiene. Review of R9's care plan dated 4/10/12, indicated R9 "has dental needs" and listed interventions of "Resident has natural teeth. Has some missing teeth. Resident will be seen annually or as needed. Nursing to notify dentist of any dental concerns. Resident has been seen by In-House Dental for their dental needs." The careplan indicated R9 had diagnoses that included schizophrenia, diabetes mellitus, and orofacial dyskinesia. Review of In House Senior Services, LLC (limited liability company) Patient Progress Notes dated 2/27/14, outlined a treatment plan that included "Pt [patient] has several retained root tips and a couple fractured crowns. #23 and #25 are quite mobile, but they do not bother pt. These should be extracted when they become symptomatic. #31 and #12 should be restored. #9 should be attempted to be restored, though because gingiva has already grown into the cavity, it may not be successful. Res was cooperative, though has difficult time holding her mouth still, and her tongue is very active."	{21325}		

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{21325}	Continued From page 154 During an interview on 5/6/14, at 2:45 p.m. R9 stated "I can chew. I saw a dentist here. I'm missing some teeth but he said they have to fall out before I can get dentures." During an interview on 5/7/14, at 3:28 p.m. LPN-A stated "I went through the progress notes and I don't see anything that addresses the dental exam." During an interview on 5/7/14, at 3:30 p.m. HUC stated she was not aware of this dental exam and to her knowledge nothing has been set up for her, "I am making a copy to do something about this." Review of the facility Medical Services policy with revision date of May 2013, indicated the facility will ensure each resident has access to dental/vision/hearing/podiatric services to meet their individualized needs, resident needs are identified at the time of admission and additionally through the RAI [resident assessment indicator] process and daily assessment/monitoring of resident condition and change in condition also alerts staff to the need for medical services.	{21325}		
{21426}	MN St. Statute 144A.04 Subd. 4 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis	{21426}		

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{21426}	Continued From page 155 infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to follow State guidelines to ensure Employee Tuberculosis (TB) Screening, Tuberculin Skin Test (TST) and medical evaluations for 6 of 11 employees were completed before providing direct care reviewed during a post survey revisit. Findings include: A review of nursing assistant (NA)-C file revealed a hire date of 10/24/13, the Employee Tuberculosis Screening was completed the very day and NA-C had indicated she had no positive TB skin test but Minnesota Refugee Health Assessment Form dated 10/24/05, indicated NA-C had received TST which measured 13 Millimeters (mm) induration when indicating a positive skin test. During further document review, a chest x-ray examination dated 5/29/09, indicated NA-C had no evidence of pneumothorax or pleural effusion but lacked documentation of a medical evaluation to rule out a diagnosis of infectious TB disease.	{21426}		

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{21426}	Continued From page 156 On 5/7/14, at 2:33 p.m. NA-C's file was reviewed and lacked a medical evaluation but revealed NA-C had had an Urgent Care Discharge Instructions dated 4/28/14, which noted "Patient [Pt] has normal screening chest x-ray [CXR]." When interviewed on 5/7/14, at 3:03 p.m. NA-C indicated she had been to the doctors office and had only done a chest x-ray and not a medical examination. A review of NA-D file revealed a hire date of 4/16/13, the Employee Tuberculosis Screening was completed the same day and NA-D had indicated he had no positive TB skin test. A TST had been applied to the left forearm on 4/17/13, which was not read and NA-D had a chest x-ray examination dated 4/19/13. The chest x-ray indicated NA-D had no acute cardiac or pulmonary pathology and no evidence of active TB. NA-D file lacked documentation of a medical evaluation to rule out a diagnosis of infectious TB disease. A review of licensed practical nurse (LPN)-A revealed a hired date 4/2/14, LPN-A had received both the first step TST on 7/22/13, read 7/24/13, zero millimeters (mm) and a second step TST on 8/2/13, read 8/5/13, zero mm respectively. However the file lacked the Employee Tuberculosis Screening prior to LPN-A starting to provide direct care. A review of NA-A revealed a hire dated 4/2/14, the Employee Tuberculosis Screening completed 4/2/14, and the Preliminary Chest X-ray Report dated and signed 8/20/14, by the physician indicated NA-A had a chest x-ray which was negative. The file for NA-A lacked a medical examination to rule out a diagnosis of TB.	{21426}		

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{21426}	Continued From page 157 A review of registered nurse (RN)-A revealed a hire date 4/25/14, the Employee Tuberculosis Screening completed was 4/23/14, chest x-ray dated 2/28/13, indicated the indication for x-ray was for health maintenance and the conclusion was normal chest. RN-A file also lacked a medical examination to rule out diagnosis of TB. A review of LPN-B revealed a hire date 5/5/14, the Employee Tuberculosis Screening was in the file but was not completed or signed. LPN-B file indicated she had received the first step TST on 4/25/14, read 4/27/14, zero mm and the form indicated LPN-B was due to receive the second TST on 5/7/14. When interviewed on 5/6/14, at 1:54 p.m. the corporate human resource director stated she was under the impression after a chest x-ray was completed that was it. She further stated this was not very clear from the last survey.	{21426}		
{21475}	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by:	{21475}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21530}	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.	{21530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21530}	Continued From page 159 This MN Requirement is not met as evidenced by: Based on interview and document review, the consultant pharmacist failed to identify lack of medication parameters for as needed (PRN) pain medications for 2 of 7 residents (R91, R36), failed to identify a lack of adequate indication for use, resident specific target behaviors and monitoring for antipsychotic medication for 2 of 7 residents (R37, R89) and failed to identify a lack of side effect monitoring and sleep monitoring for antidepressant medications for 1 of 7 residents (R1) reviewed for unnecessary medications. Findings include: R91's Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13, with a diagnosis of osteoporosis. Review of the Medication Regimen Reviews (MRR) for R91 from 10/17/13 through 5/7/14, lacked evidence the missing parameters for PRN pain medications were identified. Review of the Medication Administration Record (MAR) dated 4/1/14 through 4/30/14, revealed R91 did not receive any PRN Tylenol (a mild amalgesic) and Ibuprofen (an anti-inflammatory medication) and received multiple doses of PRN Oxycodone (a narcotic). Review of the Physician's Order Sheet signed 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain. R91 had orders for multiple PRN pain medications which lacked parameters for use.	{21530}		

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{21530}	Continued From page 160 R36's Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12, with diagnoses of femur fracture and alcoholic cirrhosis of the liver. Review of the MRR for R36 from 4/22/13 through 5/6/14, lacked evidence the missing parameters for PRN pain medications were identified. Review of the MAR dated 4/1/14 through 4/30/14, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (TID) as needed and Oxycodone 10 mg TID, both for pain, and lacked parameters for use. R36 had orders for multiple PRN pain medications which lacked parameters for use. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. Review of the MRR for R37 on 11/14/13, indicated R37 was taking Seroquel for psychosis, however lacked direction for target behavior monitoring. Review of the MRRs from 9/25/13-4/18/14, revealed the CP failed to identify the need for a gradual dose reduction or documentation of the clinical contraindication. Physician and Nurse Practitioner (NP) Notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14	{21530}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21530}	Continued From page 161 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. R37 received Seroquel (an antipsychotic medication) daily without adequate indication for use, monitoring or an attempt at a gradual dose reduction. When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist (CP) stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. When interviewed on 5/7/14, at 3:09 p.m. the CP stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received. The consultant pharmacist did not identify the lack of monitoring for resident specific target behaviors and the lack of orthostatic hypotension	{21530}		

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{21530}	Continued From page 162 side effect monitoring for R89's use of Zyprexa (an antipsychotic medication). R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the	{21530}		

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{21530}	Continued From page 163 medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]."	{21530}		

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{21530}	Continued From page 164 Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia. Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident	{21530}		

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{21530}	Continued From page 165 has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective." The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more." The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia. On 5/5/14, at approximately 1:40 p.m. R89 was observed to be lying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89. On 5/12/14, at 9:24 a.m. the licensed practical nurse (LPN)-E verified the target behaviors were diagnoses and were not resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other	{21530}		

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{21530}	Continued From page 166 way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor	{21530}		

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{21530}	Continued From page 167 these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the CP was called and a message left. The consultant pharmacist did not return the call. The consultant pharmacist did not identify monitoring of R1's side effects for Trazodone and Venlafaxine (Effexor-both anti-depressants) and sleep monitoring was lacking. R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness	{21530}		

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{21530}	Continued From page 168 of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the Monthly Medication Regimen (MMR) from 3/18/14 forward, revealed the consultant pharmacist had reviewed R1's medications, both were undated and unsigned. The MMR's failed to identify side effects monitoring, and sleep monitoring were lacking, as indicated in the plan of correction dated 4/28/14. Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. registered nurse (RN)-B stated she was not sure	{21530}		

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{21530}	Continued From page 169 where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the	{21530}		

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{21530}	Continued From page 170 documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. R113 CP failed to identify lack of parameters for as needed pain medication. Physician order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15mg) by mouth every four PRN, Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider. When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis,	{21530}		

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{21530}	Continued From page 171 alcohol dependence obtained from the significant MDS dated 2/14/14. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. The PharMerica Medication Regimen Review completed by the CP monthly dated 4/18/14, and two other times after which were signed but undated did not identify R113's physician orders lacked the parameters. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as ordered. On 5/7/14, at 1:56 p.m. CP stated he would expect parameters written by the physician to clarify when to give which medication.	{21530}		
{21535}	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued.	{21535}		

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{21535}	Continued From page 172 In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure target behavior and side effect monitoring, sleep monitoring, and parameters for use were in place for 7 of 7 residents reviewed for unnecessary medications. (R91, R36, R37, R89, R1, R113, R29). Findings include: R91 had physician orders for PRN Tylenol, Ibuprofen and Oxycodone (pain medications) without identified parameters for when to use which medication. Review of the Admission Record dated 5/9/14, indicated R91 was admitted on 10/9/13 with a diagnosis of osteoporosis. The significant change in status Minimum Data Set (MDS) dated 4/1/14, indicated R91 had frequent pain rated at a six. Review of the Physician's Order Sheet signed	{21535}		

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{21535}	Continued From page 173 4/18/14, included orders for Ibuprofen 600 milligrams (mg) every six hours PRN, Tylenol 650 mg every six hours PRN and Oxycodone 15 mg every six hours PRN all for pain and lacked parameters for use. Review of the Medication Administration Record (MAR) dated 4/1/2014-4/30/2014, revealed R91 did not receive any PRN Tylenol and Ibuprofen and received multiple doses of PRN Oxycodone. R36 had physician orders for PRN Tylenol and Oxycodone without identified parameters for when to use which medication. The Admission Record dated 4/28/14, indicated R36 was admitted to the facility on 5/26/12 with diagnoses of femur fracture and alcoholic cirrhosis of the liver. The quarterly MDS dated 2/18/14, indicated R36 had occasional pain rated at a four. The Physician's Order Sheet dated 5/1/14, included orders for Tylenol 1000 mg three times a day (tid) as needed and Oxycodone 10 mg tid both for pain and lacked parameters for use. Review of the MAR dated 4/1/2014-4/30/2014, revealed R36 received Tylenol three times for pain rated at an eight and Oxycodone two times for pain rated at an eight. When interviewed on 5/7/14, at 1:51 p.m. registered nurse (RN)-A reported he would usually do a pain assessment for PRN pain medications and for a pain level below three he would not give Oxycodone.	{21535}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 174 When interviewed on 5/7/14, at 1:56 p.m. the consultant pharmacist stated he would expect parameters written by the physician to clarify when to give which PRN pain medication. On 5/9/14, at 8:46 a.m. licensed practical nurse (LPN)-B was interviewed and stated when there is multiple PRN pain medications ordered, she would assess pain level and start with the lowest pain medication unless the resident's pain was "really bad" or something else worked for the resident. Upon interview on 5/12/14, at 9:40 a.m. RN-B stated she would start with Tylenol first and see if it works, then would document if it was ineffective and then try Oxycodone unless there was a specific physician order. The facility Pain Management policy revised May 2013, lacked direction regarding parameters for PRN pain medication. R37 had physician orders for Seroquel (an antipsychotic medication) without adequate indications for use, without side effect and symptom monitoring and lacked evidence of a gradual dose reduction (GDR) or documentation of a clinical contraindication. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13. Diagnoses included altered mental status and alcoholism. The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/7/13, indicated R37 was receiving antidepressant and antipsychotic medications; however, lacked a comprehensive	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 175 assessment summary regarding the medications in use. A Psychotropic Medications care plan revised on 3/16/14, included Seroquel was used for psychoses and directed to monitor for side effects and consult with pharmacy and physician to consider dosage reduction when clinically appropriate. The Physician's Order Sheet dated 4/1/14, included orders for Seroquel 25 mg every bedtime and indicated the diagnosis was anxiety. Review of the Physician's Order Sheet dated 5/1/14, lacked a diagnosis for the medication. The Information and Consent for Psychotropic Medications dated 9/19/13 and 2/26/14, indicated the diagnosis to support use were "agitation/sleep." A review of three undated Behavior/Intervention Monthly Flow Record, revealed R37 was monitored for number of hours of sleep and "yelling/striking." The records revealed R37 slept between six and eight hours on all nights recorded and yelling/striking behavior did not occur. Physician and nurse practitioner notes dated 11/15/13, 1/8/14, 1/22/14, 2/5/14, 4/9/14 and 4/10/14, were reviewed and lacked a diagnosis of psychosis or a clinical contraindication to a gradual dose reduction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist (CP) stated side effects were supposed to be monitored as this was required by the regulation. CP further stated all behaviors have to be specific to the resident.	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21535}	Continued From page 176 Upon interview on 5/12/14, at 3:57 p.m. the nurse practitioner (NP) stated R37 received Seroquel for psychosis, verbal outbursts and generalized anxiety which were mainly problematic when R37 was drinking. The NP stated she believed a different medication was used when R37 was in the hospital prior to admit and was unsuccessful because of liver disease. The NP stated she had not reviewed R37's medications because he had been in the hospital frequently and she tries to do dose reductions quarterly. When interviewed on 5/13/14, at 8:46 a.m. LPN-A stated the indication for use for Seroquel was not listed and she would have to check with the physician. LPN-A stated she was not sure what target behaviors were being monitored for Seroquel. LPN-A stated orthostatic blood pressures were recorded in the electronic record. After review of the Weights and Vitals Summary, LPN-A verified there were no orthostatic blood pressures recorded for R37 since December 2013. A call was placed to the CP on 5/13/14, at 10:01 a.m. to clarify adequate indications for use of antipsychotic medications, no return call was received. The facility Psychoactive Medication Management policy revised May 2013, directed the DNS [director of nursing services] or designee was responsible to ensure timely medical consultation when a psychoactive medication requires a medical review. R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic	{21535}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 177	{21535}		

medication). In addition, R89 was not monitored for potential side effect of orthostatic hypotension (a sudden drop in blood pressure with position change, such as standing or sitting up from a lying position).

R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects."

R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 178 others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89	{21535}		

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{21535}	Continued From page 179 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia. Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa. A social service progress note dated 3/26/14, at 3:00 p.m. indicated R89's behaviors were reviewed. "Quarterly Social Service Assessment-Care plan reviewed for changes in mood, behavior, and cognition and updated to reflect Resident's current status. Staff assessment for BIMS [brief interview of mental status, a tool used to measure cognition] and PHQ-9-OV [a tool used to measure potential depression] completed as Resident never or rarely understood questions being asked. Resident has severely impaired cognition r/t [related to] dementia. PHQ-9-OV assessment score of 0 out of 27 indicating no s/sx [signs or symptoms] of depression. Resident continues to receive Zyprexa 7.5 mg [milligrams] daily for dementia/schizophrenia which seems effective. No adverse reactions noted with use of psych med. Will continue to monitor for side	{21535}		

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{21535}	Continued From page 180	{21535}		

effects and effectiveness. [name or R89's guardian], assists with all business and personal needs. Resident has been assessed and cannot leave the facility on an unsupervised LOA [leave of absence]. Resident and guardian have been invited to the upcoming care conference. Social services to continue to be available and assist in meeting the psychosocial needs of Resident." Although the clinical record lacked evidence of target behavior monitoring, the note identified Zyprexa "seems effective."
The Care Conference Summary dated 4/10/14, indicated R89 was "Stable, no mood concerns at this time" and "reviewed medications." The concerns and/or Complaints section indicated, "As agitation increases family notes that her breathing gets heavy. Dislikes walking by family would like to see her walk more."

The Information and Consent for Psychotropic Medications dated 4/29/14, indicated Zyprexa was administrated for diagnosis of Schizophrenia.

On 5/5/14, at approximately 1:40 p.m. R89 was observed to be laying in bed, eyes closed. R89 did not rouse to knock or surveyor announcement at the door. Observations of R89 on 5/7/14, at 8:28 a.m.; 5/8/14, at 8:30 a.m.; and 5/12/14, at 12:23 p.m.

Review of the Behavior Monthly Flowsheet for May 2014 indicated R89 was monitored for restlessness and anxiety, but lacked resident specific target behavior monitoring. The monitoring was initiated on 5/5/14. The clinical record lacked evidence resident specific target behavior monitoring was completed for R89.

On 5/12/14, at 9:24 a.m. the LPN-E verified the target behaviors were diagnoses and were not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21535}	Continued From page 181 resident specific. LPN-E verified target behavior monitoring was only implemented on 5/5/14. LPN-E stated "the other way of monitoring wasn't working" and stated the form was changed. LPN-E verified R89's target behaviors were not assessed or re-evaluated. LPN-E verified no orthostatic blood pressures were checked on R89 since January. On 5/12/14, at 9:44 a.m. the director of nursing (DON) verified R89 should have been assessed for the use of antirollbacks and restraints. DON verified the facility identified target behaviors of agitation and restlessness were not resident specific. DON verified checking the orthostatic blood pressure should have been included in monitoring for side effects of the medication. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data.	{21535}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21535}	Continued From page 182 Consultant Pharmacist Recommendations for dated 4/17/14, identified Olanzapine 7.5 mg daily. The form indicated "also, we need to monitor these behaviors" after a list of potential target behaviors (none were checked). The Modifications as follows section indicated "Behavior monitoring implemented." The form was not signed or dated. The PharMerica Medication Regimen Review form indicated last review was on 5/7/14 and "No New Suggestions" were identified. On 4/17/14, the consultant pharmacist review indicated, "Suggest change Dx [diagnosis] to include supporting behavior patterns & then Monitor." On 5/13/14, at 10:01 a.m. the consultant pharmacist was called and a message left. The consultant pharmacist did not return the call. R1 was not monitored for potential side effects related to use of Trazodone and Venlafaxine (an anti-depressants) and Zolpidem (a hypnotic). Findings include: R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 3/4/14. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 had all the symptoms were nearly every day.	{21535}		

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{21535}	Continued From page 183 The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. Care plan dated 3/12/14, indicated R1 was on antidepressants: Trazodone and Effexor related to diagnoses of depression and insomnia. Goal "[R1] will be free from discomfort or adverse reactions related to antidepressant therapy ..." Care plan directed to administer antidepressant medications as ordered by physician, monitor and document side effects and effectiveness. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 100 Milligrams (mg) by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression - Zolpidem Tartrate 5 mg tablet by mouth at HS as needed for Insomnia "Do not exceed 5 mg dose." Review of the MARs dated 4/28/14, through 5/7/14, revealed R1's side effects monitoring was not be done. In addition review of Blank Flowsheet Report dated 5/5/14, and Behavior Monitoring Documentation dated 3/31/14, through 4/23/14, revealed R1 a sleep log had been initiated but was not being completed as indicated in the plan of correction. When interviewed on 5/7/14, at 1:40 p.m. RN-B stated she was not sure where medication side effects were documentation for anti-depressants and anti-psychotropic but indicated she would find out and get back. She showed the surveyor the "Red 3 ring binder East/West" which the staff	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21535}	Continued From page 184 were supposed to record the number of hours slept and the behaviors for each resident that had behavior monitoring. When interviewed on 5/7/14, at 1:48 p.m. LPN-E stated "We have not done this for all the residents just a few and currently we are going through as we are auditing the psychotropic and including the side effects." Verified R1's MAR's lacked side effects monitoring as indicated in the plan of correction. When interviewed on 5/7/14, at 3:09 p.m. the consultant pharmacist stated side effects were supposed to be monitored and as this was required by the regulation. CP stated he had just not gotten to review R1's medications and record. CP went through R1's physician orders verified and indicated the medications that needed to be monitored for side effects. CP further stated if a resident sleep/Insomnia medications a sleep log or study needed to be completed and consistently. When interviewed on 5/9/14, at 2:03 p.m. DON stated monitoring of side effects should have been standard for residents who were taking antidepressants and anti-psychotropic. DON further stated currently was working on implementing all the interventions and monitoring and was including the night shift to do some of the monitoring such as the amount of hours slept among others. When interviewed on 5/12/14, at 12:52 p.m. LPN-A stated the nurses were supposed to make sure the documentation was completed and the resident care managers (RCM's) like her were supposed to oversee to make sure the documentation was done consistently. LPN stated there was no documentation on the monitoring of sleep hours after 4/28/14, through 5/5/14, because the forms did not have a place to document the number of hours slept and the	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 185 facility had to create a new form which started on the 5/5/14, but was still not being completed consistently. The Psychoactive Medication Management policy dated as reviewed 5/2013, indicated the care plan would identify side effects of the use of any psychoactive medications but lacked monitoring of side effects of anti-depressants and sleep study/logs for resident who were taking medication to aide sleep. R113 lacked parameters for as needed pain medication Oxycodone. R113's diagnoses include neuralgia neuritis and radiculitis, abnormal gait, acute alcohol hepatitis, alcohol dependence obtained from the significant MDS dated 2/14/14. Physician's Order dated 4/21/14, indicated resident had three orders for Oxycodone (Narcotic pain medication) 1-3 tablets (5-15 mg) by mouth every four hours as needed (PRN), Oxycodone 0.5-1 tablets (5-10 mg) by mouth daily as needed for dressing changes only and Oxycodone 1 tablet (5 mg) by mouth daily as needed for physical therapy/occupational therapy (PT/OT) only. R113's Medication Administration Record date 4/1/14, through 5/13/14, indicated R113 had received the medication on multiple occasions and all the orders lacked parameters for administering the different Oxycodone orders. R113's pain care plan dated 3/11/14, identified R113 had acute pain related to postoperative discomfort and had toes amputated secondary to burn from frost bite. Care plan directed to administer analgesia including Oxycodone as	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21535}	Continued From page 186 ordered. Pain Assessment dated 4/25/14, indicated R113 had pain daily and was predictable and the pain did not prevent resident from doing or results in mood or behavior. The assessment indicated the pain was worse and/or breakthrough pain with therapy and dressing change. Summary indicated the pain was from the amputation sites to his both feet toes and was aggravated by therapy and wound care but was relieved by treating with PRN medications prior to treatment and resident reported current pain regime was effective. When interviewed on 5/13/14, agency LPN-G verified when reviewing R113's Medication Administration Record that the orders for Oxycodone did not have parameters for what to give with what pain rate. LPN stated R113 was on LOA but would look in his chart to make sure this was clarified by the provider. When interviewed on 5/13/14, at 9:34 a.m. LPN-E who also was also the resident care manager acknowledged R113 had orders without parameters. LPN-E further stated "We like to clarify and have parameters especially with new admissions. Will call and clarify and ask for parameters thank you." DON was not unavailable to interview on 5/13/14, regarding pain medication parameters. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided. R29 had physician orders for PRN morphine	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21535}	Continued From page 187 (pain medication) with no parameters for use, in addition no pain monitoring was completed. Review of the Admission Record dated 4/28/14, indicated R29 was admitted on 1/15/14, with diagnoses that included chronic pain, diabetic polyneuropathy (nerve damage) and adult failure to thrive. The quarterly MDS dated 4/17/14, indicated R29 had frequent pain rated at a pain level of six. The CAA dated 1/28/14, indicated R29 "has chronic back pain, she gets Neurontin, OxyContin and oxycodone PRN, it has been effective at time". The CAA did not indicate diseases or conditions that may cause the pain, characteristics or frequency of the pain, but indicated it adversely affects mood. During observation on 5/12/14, at 9:10 a.m. R29 was observed to be very thin, awake in a darkened room, in bed and when surveyor asked to enter room, resident stated "no". During observation on 5/12/14, at 2:01 p.m. R29 was in darkened room, in bed sleeping. During observation on 5/13/14, at 850 a.m. R29 was observed lying in bed, dressed in a hospital gown in a darkened room. R29 stated "I am not doing well today, the pain is constant, the meds help for a while, then it starts again". R29 stated she does go to a pain clinic. Review of the physician's order sheet dated 5/9/14 included an order for morphine 30 mg four times daily as needed. Review of the MAR dated 4/1/14 to 5/31/14, revealed R29 received multiple doses of PRN morphine.	{21535}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21535}	Continued From page 188 Review of the pain evaluation and management plan dated 4/17/14, indicated R29 had occasional pain in back and feet, current pain regimen was effective and nursing would continue to monitor and update MD/NP as needed. R29's care plan with revision date of 4/12/2014, identified R29 was on pain medication therapy due to foot surgery and chronic back pain. Interventions included: pain assessment per facility policy, administer medication as ordered and to frequently review for pain medication efficacy. During an interview on 5/12/14 at 3:29 a.m., LPN-E stated that for R29, "some days are good, some days are bad, she is on quite a bit of meds for pain" and that on 5/9/14 R29's primary physician increased some meds, "that may be why she is sleepy". LPN-E stated R29 was not on her caseload, but she would have put short term implementations of pain monitoring in place when there is a change in meds. LPN-E verified that it looks like every three to four hours the morphine is given and that the order should be more specific "like every 4 or 6 hours [hrs]". LPN-E verified there was no pain monitoring being completed, "it must have fallen thru the cracks when we went from paper to the computer". During an interview on 5/13/14, at 10:58 a.m. LPN-G stated he had not given any morphine yet today and would ask the resident if she has any pain. LPN-G further stated he would expect the order to be more specific such as "every 4 or 6 hrs" in addition to PRN, but would ask the nurse manager for more clarification. Review of Medication Administration General Guidelines, section 7.1, page 3 of the facility	{21535}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21535}	Continued From page 189 Nursing Care Center Pharmacy Policy & Procedure Manual date 2007, indicated that medications are administered in accordance with written orders of the prescriber. If a dose seems excessive....or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. The DON was not available to interview on 5/13/14, regarding pain medication parameters and monitoring. The facility pain management policy was requested on 5/13/14, at 11:30 a.m. but was not provided.	{21535}		
{21610}	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 5 medication and treatment carts had the internal drawers kept clean; the facility failed to ensure medications were dated when opening; eye medications, suppositories, topical medications were observed to be stored together for 11 of 67 residents (R13, R92, R9, R54, R29, R25, R66, R22, R95, R86, R88). In addition, the white	{21610}		

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{21610}	Continued From page 190 refrigerator in the medication room (used to store refrigerated medications) was observed to have a heavy buildup of frost in the freezer compartment. These practices had the potential to affect all 67 residents residing in the facility. In addition, the facility failed to lock a medication cart which held biologicals and medications (anti-depressants, anti-psychotropic, blood pressure medication, supplements/vitamins among other prescribed medication). This had the potential to affect 4 of 7 residents (R73, R37, R83, R115) who were near the medication cart. The four residents were able to access to the cart according to staff. Findings include: WEST MEDICATION CART On 5/7/14, at 7:52 a.m. first (top) drawer was observed to have the following: R13 had an open Advair Diskus inhaler (used for breathing) without an open date. R13's Minimum Data Set (MDS) dated 3/25/14, noted R134 had breathing problems and was cognitively intact. According to the package insert by GalxoKlineSmith dated 2008, staff were to "Take ADVAIR DISKUS out of the box and foil pouch. Write the 'Pouch opened' and 'Use by' dates on the label on top of the DISKUS. The 'Use by' date is 1 month from date of opening the pouch." R92 had an opened and expired bottle of Travatan Z 0.004% (reduce the elevated pressure inside your eye) eye drops for R92. The label indicated to "Order After 3/27/14." A sticker affixed to the bottle indicated the medication was opened on 3/3/14. The bottle was observed to be stored loosely with oral medications. A second	{21610}		

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{21610}	Continued From page 191 bottle of the same eye drop with date opened of 4/19 (no year) written on the label, had no open date documented on the Date Opened sticker. A third bottle of the same eye drop was also observed to be stored loosely (no zip lock bag) in and with oral medications for various other residents and had no open date. All three Travatan Z bottles for R92 were opened and had remaining doses in each bottle. R92's MDS dated 1/15/14, indicated R92 had adequate vision and no vision problems. According to the package insert by Alcon Laboratories (SA) (Pty) Ltd, Revised 11/02, directed staff, "STORAGE INSTRUCTIONS: Store below 25°C., DO NOT USE MORE THAN 30 DAYS AFTER OPENING. KEEP OUT OF REACH OF CHILDREN." R9's Insulin Aspart pen (Novolog- used to control blood sugar) had no open date and had a sticker on the pen which indicated "EXP [expires]: 04/11/14." A second pen of the same medication for R9 lacked the protective cover for the end of the pen (where the needle affixes) and lacked an open date. Both pens were stored in and with eye drops for other residents. R9's MDS dated 3/24/14, indicated R9 was cognitively intact and had diabetes. According to the package insert by Novo Nordisk INC, dated 2002 through 2008, staff were to store as follows: " Recommended Storage: Vials: After initial use a vial may be kept at temperatures below 30°C (86°F) for up to 28 days, but should not be exposed to excessive heat or sunlight. Opened vials may be refrigerated. Unpunctured vials can be used until the expiration date printed on the label if they are stored in a refrigerator.	{21610}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21610}	Continued From page 192 Keep unused vials in the carton so they will stay clean and protected from light. R54 had a bottle latanoprost 0.005% (used to reduce the intraocular pressure) eye drops was observed to be stored loosely with other oral medications. R54's MDS dated 1/15/14, indicated R54 had adequate vision and no vision problems. - A 3 milliliter (ml) vial of 2.5 mg albuterol was observed to be stored loosely in the top drawer. The vial had no label to identify which resident the Albuterol was ordered for. - The first drawer was observed to have a light brown and crumb like consistency buildup of debris in the upper right corner of the drawer. A heavy buildup of sand colored debris was observed in the upper left corner of the first draw. The debris was observed to be with and under the stored inhalers. - The second drawer had a heavy buildup of brownish colored debris in the corners and bottom of the drawer. The debris appeared to be from pulverized/crushed medication tablets. On 5/7/14, at 8:15 a.m. the licensed practical nurse (LPN)-C verified the findings. SOUTH TREATMENT CART On 5/7/14, at 8:39 a.m. the registered nurse (RN)-B verified he worked out of the cart and opened the cart. The following was observed: R29's Levemir insulin flexpen (used to control blood sugar) had no open date on the sticker. R29 's MDS dated 1/29/14, indicated R29 was cognitively intact and was a diabetic.	{21610}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21610}	Continued From page 193 According to the package insert by Novo Nordisk INC, dated 2005 through 20012, staff were to store as follows: "Recommended Storage: 3 mL LEVEMIR FlexPen: Not in-use (unopened) Room Temperature (below 30°C) for 42 days. In-use (opened) was to be stored for 42 days at room temperature." R25's Lantus insulin had an open date of 4/4 (no year) and expiration date of 5/3 (no year). The insulin was open, partially used and expired. R25's MDS dated 4/8/14, indicated R25 was a diabetic and was moderately cognitively impaired. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " R66's Lantus Solostar insulin had no open date. R66's MDS dated 3/25/14, indicated R66 was cognitively intact. The MDS did not indicate R66 was a diabetic. However, the MDS did indicate R66 received insulin injections in the past seven days. According to the drug package insert by Dispensing Solutions, Inc. last revised: 9/20/11, "Once you take your SoloStar® out of cool storage, for use or as a spare, you can use it for	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21610}	Continued From page 194 up to 28 days. During this time it can be safely kept at room temperature up to 86°F (30°C). Do not use it after this time. SoloStar® in use must not be stored in a refrigerator. Do not use SoloStar® after the expiration date printed on the label of the pen or on the carton. " RN-B verified the findings at the time of the observation and stated the medications should have open dates. RN-B verified the expired medication was used "today." The second drawer of the south treatment cart was observed to have a buildup of potential pulverized medication debris in the corners of the drawer. The third drawer was observed to contain a plastic bin containing various tubes of topical medications for different residents. Some tubes were observed to be stored in zip lock bags with labels. All topical medication tubes in the bin had been used. Topical medications in the bin not in zip lock bags were observed to be in contact with each other. The topical medications not stored separately included a tube of unlabeled Dimethicone Skin no label (barrier ointment). R22's tube of Capsaicin 0.25% Cream (used to control pain from arthritis) directed staff to apply the medication to the left hip and right rib. R22's MDS dated 1/9/14, indicated no musculoskeletal problems, no indications of pain, and also revealed R22 was moderately cognitively impaired. R95's Hydrocortisone 1% Cream (used to treat skin inflammation and itching) identified to apply the medication to R95's stomach and back;	{21610}		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21610}	Continued From page 195 R95's MDS dated 2/28/14, indicated no rashes were present and revealed R95 was cognitively intact. - An unlabeled tube of Aquaphor healing ointment (barrier ointment) was approximately 90% used. R86 had a tube of Fluocinononide 0.05% solution (used to treat the itching, redness, dryness, crusting, scaling scalp) which directed to apply the medication to scalp; R86's tube of Desonide 0.05% (used to treat the redness, swelling, itching, and discomfort of various skin conditions) directed to apply the medication to axilla, groin and abdomen folds; a bottle of Deep Sea Premium Nasal Moisturizing Spray (moisturizes the nasal passages). The bottle of nasal spray was observed to be in contact with other topical medications in the bin. RN-B stated the spray, "Should be in other cart." R86's MDS dated 3/23/14, indicated no skin problems and was cognitively intact. R86's Treatment Administration Record (TARs) dated May 2014 indciated the R86 received topical cream to the face, skin folds, groin, and axilla once or twice a day for psoriasis bulgaris. R29's Nystatin - Triamcinolone Cream (used for yeast infections) directed to apply the medication to R29's labia. R29's MDS dated 1/29/14, indicated R29 was cognitively intact, received creams and ointment to other areas other than feet, and noted R29 was a diabetic. R29's Physician's Order sheet undated indicated Nystatin was to be applied to the labia three times daily for itching.	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21610}	Continued From page 196 - The drawer was observed to have a heavy buildup of crumbs, pulverized pill fragments and paper, foil and plastic pieces debris in all drawers. The corners and sides of the drawers had the highest build up. RN-B verified the findings at the time of the observation and confirmed the topical medications should be stored separate from nasal medications. RN-B verified the tubes of topical medications for different residents, should not be stored together. SOUTH MEDICATION CART At 9:06 a.m. the South Medication Cart second drawer was observed to have one white and one yellow medication tablet loose in the bottom of left section of the drawer, and one yellow tablet, one white tablet, one pink tablet and one beige tablet loose on the bottom of the right section of the drawer. A buildup of foil debris was observed in all corners. - The third drawer had one bright yellow tablet and a buildup of pulverized pills and foil debris in all corners. - Fourth drawer was observed to have a opened and partially used box of Bisac-Evac 10 mg Bisacodyl suppositories used for constipation) stored with nebulizer medications (breathing medications). - The first small left side drawer was observed to have one unlabeled vial of Albuterol neb solution (breathing medication) stored loosely in the drawer. - The third left side drawer was observed to have a sticky red colored substance spilled on the bottom of the drawer. The substance appeared to be smeared on the bottom of the drawer, was wet to the touch and easily removed with a finger. RN-B verified the above findings and was unclear on when the medication carts were cleaned.	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21610}	Continued From page 197 MEDICATION ROOM At 9:21 a.m. the white medication refrigerator was observed to have a heavy buildup of frost approximately two to three inches thick which completely encased an ice pack in the frost of the freezer. NORTH MEDICATION CART At 9:24 a.m. the following was observed: R88's Novolog insulin (used to control blood sugar) was observed to have an open dated of 3/22 (no year) and an expiration date of 4/20 (no year). R88's MDS dated 2/7/14, indicated the resident had expired. - The second drawer was observed to have a white half tablet, a red gel cap loose in the bottom of the drawer; foil, paper and pulverized medication debris was observed to have built up in edges and corners of the drawer. - The third drawer was observed to have built up foil, paper and pulverized medication debris in the corners, a red, sticky, circular shaped spill on the bottom of the drawer. LPN-F verified the findings at the time of the observation. LPN-F was unclear on medication cart cleaning and stated she, does "not have time to get her medication pass done" due to it being "too heavy." LPN-F explained she had too many other responsibilities such as taking blood sugars, administering insulin verified she did not clean the medication cart. Although LPN-F stated she worked for the agency, LPN-F stated she usually worked on the North Medication cart and had worked in the facility for several weeks. EAST MEDICATION CART At 9:39 a.m. the second drawer was observed to have two white half tablets loose in the bottom of	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21610}	Continued From page 198 the drawer. On 5/7/14, at 11:45 a.m. LPN-E verified she was in charge of the North Unit and stated the medication carts were "a mess" and stated she believed all the carts were newer and cleaned by "the pharmacy" last week. LPN-E was unclear on the cleaning schedule of the medication carts. LPN-E stated before there was trained medication aide (TMA) responsible for the cart and a nurse responsible for the treatment cart. Explained there were "fifteen different hands" in each cart and they were not being kept clean. -At 12:00 p.m. LPN-E observed the medication carts with surveyor and verified the findings. LPN-E stated it was a new medication cart. LPN-C was present at the time of the observation and stated the medication cart was "not new." LPN-E verified eye drops, Advair Diskus inhalers, and insulin required open dates. On 5/7/14, at 1:26 p.m. LPN-A verified she was in charge of the West and East units. LPN-A stated she had not completed any cleaning audits for the medication carts and did not know if audits were completed. LPN-A stated she did not know the audit or cleaning schedules for the carts. LPN-A was unclear what the facility system was to ensure the medication carts were kept clean. LPN-A further stated she was unclear who was responsible for cleaning the medication carts and was unclear on the policy for medication cart cleaning. On 5/8/14, at 4:21 p.m. the consulting administrator stated the facility did not have a policy or a procedure for medication cart cleaning and verified the carts should have been cleaned. The consulting administrator stated the facility was "not allowed to write policies," but could write	{21610}		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21610}	Continued From page 199 a "procedure." A PharMerica 3.7 Medications and Medication Labels policy dated 9/2010, directed multi-dose vials "shall be labeled to assure product integrity, considering the manufacturers' specifications. (Example: Modified expiration dates upon opening the multi-dose vial.)" The policy further identified all medications should have a pharmacy affixed label. The PharMerica 4.1 Storage of Medication policy dated 9/2010, directed to store eye, internally administered, oral inhalation, nasal, oral and topical medications separately. Medications carts were left unlock and un-supervised. South Hallway Medication cart On 5/5/14, at 1:39 p.m. observed the key lock to the nursing medication cart to be fully extended in the unlocked position on the South unit. Two residents were observed to wheel by the cart and no staff was in the hallway. RN-B, was observed to follow the surveyor from the nursing station onto the South unit and approach the medication cart and open the top drawer. East Hallway Medication Cart On 5/8/14, at 3:50 p.m. surveyor observed the unlocked medication cart across the nursing station in the East Hall Way. -At 3:53 p.m. observed the administrator walk past the unlocked cart. -At 3:55 p.m. observed the director of nursing walk past the cart then walk right past the cart back to the nursing station. -At 3:54 p.m. nursing assistant (NA)-F came	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21610}	Continued From page 200 stood approximately 6 feet beside the surveyor on the counter typing then walked away. -At 3:56 p.m. observed resident with a cane walk past the cart to his room. -At 3:57 p.m. observed NA-G standing on the opposite side of the hallway approximately 2 foot steps from the cart still unlocked. -At 3:58 p.m. director of nursing (DON) walked past the cart again and went down the hallway. -At 3:59 p.m. observed receptionist (O)-D walked past the medication cart approximately 1 step from the cart still unlocked. -At 4:00 p.m. DON walked past the medication cart still unlocked back to the nursing station. Went into the nursing station stood at the inside of the counter looking down the hallway where the unlocked cart was stationed. -At 4:01 p.m. observed NA-I walked past the medication cart to the South hallway. -At 4:02 p.m. O-D again went past the unlocked cart approximately one foot step went to the human resource office and came right out and returned to the front desk. -At 4:04 p.m. observed NA-I walked past the cart again and turned right and walked past the cart to the South Hallway. When interviewed on 5/8/14, at 4:06 p.m. LPN-D if the medication cart was supposed to left open stated, "No." LPN-D walked over to unlocked medication cart and locked it. When interviewed on 5/9/14, at 10:05 a.m. LPN-E stated, "All the medication carts are not supposed to left open." When interviewed on 5/9/14, at 1:32 p.m. RN-B stated the medication cart should be locked when staff was not around and when nurses walked away from the carts. RN-B further stated the	{21610}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21610}	Continued From page 201 nurse that had left the cart unlocked had acknowledged she had left the cart unlocked on 5/8/14. The facility Storage of Medication dated 9/10, directed "In order to limit access to prescription medication, only licensed nurses, pharmacy staff, and those lawfully authorized to administer medications (such as medication aides) are allowed access to medication carts. Medication rooms, cabinets and medication supplies should remain locked when not in use or attended by persons with authorized access.	{21610}		
{21665}	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident room carpets for 3 of 3 residents (R22, R56, R33) and an E-Z stand (a mechanical stand used for transfers) were kept in good repair, clean and in a sanitary manner. Findings include: A tour of the facility was conducted on 5/9/14, at 8:59 a.m. through 10:05 a.m. with the director of facility operations (DFO) and the following concerns were identified: Carpets: On 5/9/14, R22's portion of the room was	{21665}		

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{21665}	Continued From page 202 observed. The carpet had large dark brown stain/spots from the bed to the dresser. DFO verified the carpet was not clean and stated, "I think it is filthy and trashed." R22's annual Minimum Data Set (MDS) dated 4/10/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs. R22 used both the walker and wheelchair (w/c) for mobility in his room. On 5/7/14, at 7:59 a.m. R22's carpet was observed to have dark brown spots/stain on the carpet around the bed area and to the entrance of the room. On 5/9/14, at 9:34 a.m. DFO verified R22's carpet was not clean stated "Again this is one of the rooms that I would like to have a deep cleaning and was hoping the cleaning of the carpet would have been done after pest control was here yesterday." R56 was bedfast in the room. When R56's room was observed on 5/9/14, at 8:59 a.m. the carpet had several dark, black ground-in spots and stained red around the bed. R56's annual MDS dated 2/25/14, indicated R56 required extensive to total assistance with activities of daily living (ADLs) including transfers, was bed bound, used a w/c for mobility and had intact cognition. On 5/9/14, at 9:30 a.m. DFO verified the carpet in R56's room was not clean and stated, "It needs to be deep cleaned."	{21665}		

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{21665}	Continued From page 203 R33 On 5/6/14, at 9:00 a.m. surveyor noticed a strong malodorous urine smell coming out of R33's room and the carpet observed to have dark brown large stain/spots from the bed to the radiator and on the area between the foot of bed and dresser (walk area). During observation a housekeeping staff was observed standing outside R33's room but was cleaning the next room. On 5/9/14, at 9:38 a.m. DFO verified the smell stated, "It's very strong and this is another room that needs to have the carpet cleaned or replaced." DFO stated, "We were supposed to get the air freshener's from Ameri-Pride today but they were supposed to be delivered on Friday." DFO further stated the carpet cleaning company had been to the facility recently and cleaned the common areas. The DFO knew the contract was expired and directed questions to the administrator. R33's quarterly MDS 2/20/14, indicated intact cognition, required limited assistance with ADLs, had impairment to both lower extremities and used a walker and w/c for mobility. R33's also received a diuretic. Mechanical lift: E-Z stand handle did not have a cleanable surface. On 5/9/14, at 9:05 a.m. the E-Z stand was observed stored on the alcove on the West Hall and the left bar was observed to have vinyl peeling off exposing the foam underneath. The cracked vinyl was covered with gray duct tape and at the end the tape was exposing the sticky	{21665}		

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{21665}	Continued From page 204 side of the tape making it not a cleanable surface. When interviewed on 5/9/14, at 9:07 a.m. DFO verified stated, "I was told by the vice president to put the duct tape over for now and I have a bid for cushions and guard and am waiting." When interviewed on 5/9/14, at 8:38 a.m. the administrator stated there is a carpet cleaning plan with a contractor who would be coming in to clean a couple rooms at a time. Administrator further stated, "We are going to order replacement parts for the E-Z stand, we had been told that the duct tape was sufficient." Review of the w/c cleaning schedule for Maintenance dated May 2014 indicated R36's w/c had not been cleaned. The Wheelchairs To Pull For Night Washing sheets dated 5/1/14, through 5/9/14, also indicated R36's w/c had not been cleaned. The facility Maintenance Request Log Policy and Procedure revised April/2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs ..." The policy lacked information on how often residents carpets would be cleaned.	{21665}		
21730	MN Rule 4658.1415 Subp. 11 Plant Housekeeping, Operation, & Maintenance Subp. 11. Insect and rodent control. Any condition on the site or in the nursing home conducive to the harborage or breeding of insects, rodents, or other vermin must be eliminated immediately. A continuous pest control program must be maintained by qualified personnel.	21730		

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21730	Continued From page 205 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain a pest control program effective in the control of ants in 1 of 1 resident room (R56). Findings include: During observation on 5/7/14, at 7:42 a.m. 12 winged insects were noted on R56's bed and on the wall at the head of the bed. During observation on 5/7/14, at 7:59 a.m. R56's room was noted to have open food items, The carpeting next to the bed was heavily soiled with brown and red material, and a foul odor was noted in the room. On 5/7/14, at 8:41 a.m. an ant mound and three ants were noted in the corner of R56's room by the window. Multiple ants were noted crawling on and inside the heater under the window. When interviewed on 5/7/14, at 7:50 a.m. the director of facility operations stated the facility used Xtreme Pest Solutions for pest control. He stated staff identify any concerns with pests by documenting in the maintenance log kept behind the nursing station. When interviewed on 5/7/14, at 8:05 a.m. housekeeper-B verified there were bugs in R56's room and stated he had not seen them the prior Thursday when he'd cleaned the room. Housekeeper-B stated R56, "Has lots of sweets in her room and that may be why." On 5/7/14, at 8:09 a.m. the director of facility	21730		

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21730	Continued From page 206 operations was asked to come to R56's room and stated, "We have to get her out of the room right away!" and call the pest company. He stated he was not sure what the bugs were but thought they were ants or wasps. The pest control contractor was interviewed on 5/7/14, at 12:52 p.m. and stated the bugs were a form of pavement ants and he had treated the room and the surrounding areas. He reported the ants were drawn into the room for food and the facility would need to maintain treatment to the affected areas. Review of the Service Report dated 2/13/14, included treatment for mice and rats. Review of the Service Report dated 4/3/14, included treatment for multiple targeted pests including ants. The Service Report dated 5/7/14, at 12:30 p.m. included treatment for multiple targeted pests including ants and indicated four rooms on the south hall were treated as well as the exterior of the south wing. A policy regarding pest control was requested and the director of facility operations stated the facility did not have a policy.	21730		
{21850}	MN St. Statute 144.651 Subd. 14 Patients & Residents of HC Fac.Bill of Rights Subd. 14. Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and non-therapeutic infliction of	{21850}		

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{21850}	Continued From page 207 physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from non-therapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to others. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility neglected to provide adequate supervision to residents who had a known history of drug and alcohol use resulting in medical treatment, including hospitalization, for 2 of 11 residents (R37, R129) reviewed. In addition, the facility failed to implement adequate interventions to prevent elopements for 1 of 3 residents (R116) who left the facility with a WanderGuard (a system to alert staff when a resident leaves the facility). The facility's failure to provide adequate supervision and oversite had the potential to affect all 67 residents currently residing in the facility. In addition, the facility failed to ensure 1 of 1 resident (R34) was free from verbal and physical abuse from another resident (R36). Findings include: On 5/9/14, the facility had been informed of serious and immediate safety of the residents related to lack of adequate supervision for alleged drug and alcohol use and elopement. Although, the facility was aware of the serious implications on 5/9/14, the facility did not identify and implement interventions to protect the residents from potential harm. On 5/10/14 and 5/11/14, two	{21850}		

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{21850}	Continued From page 208 residents were hospitalized for drug and alcohol abuse. In addition, on 5/11/14, one resident had eloped from the facility three times with a WanderGuard on and no staff were present. R37's Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism. According to documented progress notes, R37 had been found with ETOH/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/14, 5/9/14 and 5/10/14. The record also indicated R37 had required hospitalizations related to the use of alcohol and or drugs on 2/22/14, 4/23/14, and 5/10/14. During observations of R37 the following was observed: -On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility. - On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was "crazy". - On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility. - On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see whether R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and speak to her and gave her his wallet back. At 8:24 a.m. R1 put	{21850}		

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{21850}	Continued From page 209	{21850}		

R37's wallet back in his left rear pant pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he did not feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. Nursing assistant (NA)-L approached R37 and stated she was with him today. NA-L verified she was assigned to provide the 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken out of the facility to an ambulance.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The Progress Notes were reviewed and the following was noted:
- On 5/2/14, R37 removed the WanderGuard (departure alert system) and refused a new one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21850}	Continued From page 210	{21850}		

to be placed.
- On 5/3/14, R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limousine and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. R37 had slurred speech, smelled of ETOH and had a staggering gait.
- On 5/5/14, at 10:25 p.m. R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, a notation had been made indicating it was a late entry for 5/5/14, at 6:00 p.m., the note indicated R37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of ETOH was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of ETOH on his breath. Four empty bottles and one unopened bottle of ETOH were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to ETOH withdrawal and demanded

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{21850}	Continued From page 211 medications. - On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of ETOH, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the ETOH bottle, it was ok for the resident to keep the ETOH and if he became drunk or disruptive to call the police and have him taken to detox. - On 5/8/14, at 3:42 p.m. indicated R37 was placed on one to one (1:1) [to be within arm's length at all times] observation related to incidences of getting intoxicated. - On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time. - On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from leave of absence (LOA) accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, and sluggish pupils. R37 was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s. - On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone. The Physician's Orders and Nurse Practitioners	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 212 (NP) Orders were reviewed and the following was noted: - On 1/8/14, included a diagnosis of ETOH abuse noted to have also occurred in the facility. - On 2/5/14, indicated R37 recently had a bottle of ETOH hidden in his pillow case and was noted to smell of ETOH. - On 2/28/14, directed to discharge R37 to another facility (that allowed drinking). - On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep." - On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis. - On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain. - On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's ETOH, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered. - On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams (mg) orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen. - On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a WanderGuard to check placement every shift for elopement even though R37 had cut off the	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 213 WanderGuard on 5/2/14, and refused to have a new one placed. A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37. A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 had been referred for assessment of behavioral health, chemical dependency and pain, and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed. R37's care plan was reviewed and noted the following: - The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision but was not safe to go on other unsupervised LOAs. - The depression care plan dated 3/11/14, included ETOH abuse and directed to arrange psych services as needed. - A behavioral symptoms care plan revised on 3/16/14, indicated ETOH consumption and concealing ETOH in room with a goal to have fewer episodes of ETOH abuse per week. The interventions included; encourage attending Alcoholics Anonymous (AA) or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA.	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 214 - A risk for elopement related to ETOH abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of ETOH consumption and/or with a supply of ETOH. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the WanderGuard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected ETOH. - A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of ETOH abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking ETOH with an intervention to check room daily for ETOH and check R37 for signs of intoxication. - An at risk for adverse reaction from medications related to ETOH care plan dated 4/25/14, indicated NP was aware of R37's ETOH use, nursing staff to encourage to restrain from using ETOH and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to ETOH abuse and intoxication. A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant ETOH use when out on unsupervised LOA. The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions. A Resident Refusal of Medical Treatment Form	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 215 dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of ETOH abuse, staggering gait and slurred speech. With the risks of refusal noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid. A letter dated 5/10/14, indicated the resident had received a first offense of the facility's smoking policy as R37 reported to staff he had gotten cigarettes from R9. On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 had obtained the ETOH from. The safety monitor, NA-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money for ETOH, and stated he has heard about exchanges but could not remember who he'd heard about it from. The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the ETOH was coming from but when she asked R37 he refused to tell her. The HUC said R37 had told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14, or 5/6/14, she had observed R37 in the parking lot, and had been told there was nothing they could do about it by the facility administrator. She said she'd requested assistance from the operations director	{21850}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 216 to get R37 back in the building. The HUC reported she had requested that the safety monitor put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever." On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for delirium tremens (DTs-a severe form of ETOH withdrawal that involves sudden and severe mental or nervous system changes). On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and licensed practical nurse (LPN)-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check. The DON was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 had refused to go to the bank with R37 and that friend-A had signed R37 out. The DON said the consultant administrator had been going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he had reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 217 When interviewed on 5/12/14, at 1:35 p.m. contracted licensed social worker (CLSW)-A stated during a room search a quart bottle of ETOH and three plastic containers with the labels removed, which nursing indicated were methadone containers, had been found in R37's room. When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and CLSW-A were involved in R37's LOA. The administrator stated CLSW-A was under the impression R37 was allowed to go on LOA and that R37 had returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed CLSW-A had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and stated the DON had not told him about the order for no LOA and friend-A's relationship with R1. Upon interview on 5/13/14, at 8:09 a.m. CLSW-A stated on 5/10/14, prior to R37 having left on LOA, she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and that she'd told friend-A that R37 could not go there. CLSW-A said friend-A had reassured her he had been sober for ten years and would never take R37 to a liquor store. The CLSW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and had informed her that friend-A was R1's drug dealer. CLSW-A stated it would have been	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 218	{21850}		

nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping ETOH under the edge of his mattress and she could not understand why nursing did not find the ETOH when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

R129 was identified by the facility to have a history of drug seeking and ETOH dependency. Although the facility had determined R129 required a 1:1 staff member since at least 3/18/14, according to a Vulnerable Adult (VA) assessment, the appropriate supervision was not implemented and/or effective.

According to review of the progress notes in R129's record, on 5/3/14, R129 had reported to the facility that she had obtained and consumed cocaine. The documentation indicated R129 had a staff assigned as a 1:1 at the time of the incident.
An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she had taken and indicated R129 then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 219 "confessed" to having taken cocaine. The report documentation indicated R129 had been sent to the emergency room (ER) and included, "She said, 'I knowingly took cocaine'.. Resident has been sent to ER. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1...remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." A North Memorial Medical Center (NMMC) Emergency Department (ER/ED) note dated 5/3/14, identified R129 had reported she'd taken cocaine at the nursing home. The ER note indicated R129 had taken the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED." The Clinician History of Present Illness section of the form identified R129 had reported to hospital staff she had snorted cocaine "5 hours ago." On 5/11/14, at 4:00 a.m. the progress notes indicated R129 had obtained and consumed a life threatening amount of ETOH, causing her to require hospitalization in an intensive care unit (ICU) with subsequent intubation (mechanical ventilator assisted breathing) as a result of a blood ETOH level of 0.323. (According to Minnesota Statute 169A.20, 0.08 is considered impaired for driving). A 1:1 staff was supposed to have been in place at the time of the incident. The resident's record included a note documented by the facility's HUC on 5/11/14, at 10:09 a.m. which indicated NMMC had called the facility "requesting" R129's medication administration records (MARs). The note indicated the registered nurse (RN) from the hospital had notified the HUC that R129 had been admitted to the ICU, and had been intubated "due	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21850}	Continued From page 220	{21850}		

to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of 0.323."

The record also included a note documented by the director of nursing (DON) on 5/11/14, at 10:55 a.m. The DON's note recapitulated R129 had been sent to the hospital, identified the time of transport as "around 4 a.m." on the night shift, and identified R129 had been sent in "for intoxication." The DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the nursing assistant (NA) staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but that she had not noticed any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident [R129] is visiting." In addition, the DON's documentation indicated R14 had denied giving or knowing how R129 had obtained the ETOH, and documented R14 had "mentioned that resident had alcohol overnight."

An additional progress note, dated 5/11/14, at 2:49 p.m. had been written by the DON indicating NMMC had been contacted to request updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."

Additional record review revealed an admission MDS dated 2/1/14, that indicated R129 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 221 BIMS score of 15, indicating R129 was cognitively intact. The MDS identified R129 was independent with all ADLs. The MDS identified R129 rejected cares and wandered one to three days during the assessment period. R129's comprehensive assessment analysis (CAA) for mood state dated 2/7/14, identified R129 as having intact cognition, with poor decision making and as having diagnoses of "substance induced psychotic disorder, opiate dependence, and ETOH dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug ETOH use" and depression. Although the CAAs identified R129 had a history of drug and ETOH dependence, the CAA lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment. A Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of ETOH abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA from the facility. The assessment identified R129 had behaviors including a history of rummaging through others' belongings and "drug use." The assessment indicated R129 had been placed on 1:1 due to rummaging in other resident rooms. R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep [R129] safe and prevent drug use" Additionally, the care plan	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 222	{21850}		

directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings." Review of the undated Group 7 NA assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and required a "1:1" which was spelled out in large bold print.

On 5/12/14, at 10:26 a.m. DON was interviewed about R129 having obtained ETOH and/or drugs while on a 1:1. The DON verified the 1:1 should have been within arm's length of R129 at all times. The DON denied having any knowledge of how R129 had obtained ETOH.

On 5/13/14, at 2:21 p.m. the administrator stated during interview that the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and ETOH use.

On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, "I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 223	{21850}		

computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home."

The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.

The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed:

"If staff have reasonable suspicion that a resident has used, has in their possession, or has

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 224 distributed to other residents in the facility ETOH, street drugs, or other pharmacological substances not prescribed by treating physician the facility staff, under the direction of administration, shall: · Search the residents room and remove such substances · Notify the physician and obtain an order for blood and urine drug testing · Notify the family and/or responsible party of the event If the tests return positive the resident with the positive results will be immediately discharged for placing the resident population at risk for abuse. If ETOH, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified." The facility's Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness." Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The policy also included "Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision." Appendix A of the policy included examples of neglect including: "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision)	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 225 which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety." According to the record, R116 eloped from the facility on 5/11/14, at 9:30 a.m., 11:30 a.m. and 11:52 a.m. while wearing a WanderGuard device which had been implemented to prevent the resident's elopement. Record review indicated R116 had been admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression. The record also indicated R116 had Hospice services initiated on 1/21/14. On 4/15/14, at 10:49 p.m. a nursing progress note indicated, "Pt [patient] is declining. He is very weak and needs a lot of assistance." A progress note dated 5/5/14, indicated R116 had been outside with his son and the resident had experienced a fall. R116's son was present at fall. Hospice was notified of fall and a new wheelchair (W/C) was ordered for resident. Staff had also placed a WanderGuard on the resident's chair to alert staff when the resident wanted to go outside to maintain resident's safety. "Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor." Additionally, a draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. "He requested going the bank to	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21850}	Continued From page 226	{21850}		

complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling."

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 227 exited the building, the DON, administration, and social worker (SW) updated." R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone." Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident." The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m.	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21850}	Continued From page 228 Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and ETOH and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door. On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby. On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had tested the doors and were not able to determine how the resident had gotten out of the facility by the back door. The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are	{21850}		

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	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21850}	Continued From page 229	{21850}		

documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed. The ombudsman stated she wanted to be sure the state agency surveyors were aware that resident's of the facility were purchasing ETOH and drugs. The ombudsman reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff were finding ETOH bottles. In addition the ombudsman reported R37 had been found intoxicated several times and she was involved in discussing abuse prevention planning and the effects of ETOH on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns. The ombudsman stated the police had been notified and had been to the facility "quite often". She also stated she was aware R129 was on a 1:1 and had somehow obtained and consumed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{21850}	Continued From page 230 an "illegal drug [cocaine]" in the facility. On 5/7/14, at 10:05 a.m. the administrator verified during interview that the ombudsman had been called 5/6/14, to speak with the facility regarding R37 having given his credit card to R117 to purchase ETOH because R37 had been "drunk for days." R34: On 5/6/14, at 9:49 a.m., 5/6/14, at 11:32 a.m., 5/6/14, at 2:48 p.m., 5/7/14, at 1:40 p.m., 5/8/14, at 9:29 a.m., 5/8/14, at 2:08 p.m., 5/10/14, at 12:45 a.m. R34 and R36 were both observed on the smoking patio. The annual Minimum Data Set (MDS) dated 4/1/14, for R34 included a Brief Interview of Mental Status (BIMS) score of nine which indicated moderate cognitive impairment and a Patient Health Questionnaire (PHQ-9) score of five which indicated mild depression. The MDS indicated R34 did not have delusions or hallucinations. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 4/3/14, lacked a summary regarding R34's cognitive status. A Vulnerable Adult Assessment date 3/18/14, indicated R36 was verbally abusive and condescending towards others. A Vulnerable Adult Assessment dated 4/4/13, indicated R34 had behaviors which made her susceptible to abuse by others. A Social Service Note dated 4/17/14, indicated R34 had reported on 4/15/14, R36 was verbally	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{21850}	Continued From page 231	{21850}		

abusive towards her. The note indicated when R36 was interviewed on 4/16/14, he stated he calls R34 "a parasite every time I see her because that is what she is." The note indicated R36 was told calling other residents names was verbal abuse and verbal abuse was not tolerated.

A Progress Notes dated 4/17/14, indicated the contracted licensed social worker (CLSW) met with R34 on 4/16/14, and R34 indicated R36 "calls her every name in the book, he is just mean."

A Progress Notes dated 4/17/14, indicated social services met with R36 and R36 stated he was going to "do what he wants" and would continue to call R34 a parasite. R36 was informed calling R34 names was verbal abuse and R36 responded "I don't care."

The Admission Record dated 4/28/14, indicated R34 was admitted to the facility on 3/28/13, with diagnoses which included dementia and depressive disorder.

A copy of an Incident/Accident Report dated 5/5/14, was provided on 5/8/14. The Incident/Accident Report indicated R34 had reported R36 had pushed her into a patio chair and R34 had become stuck when the patio chair fell over. It was noted the incident had occurred on 5/4/14, at night with no exact time. R36 was noted to have denied the incident; the police were called and spoke with R34. On 5/7/14, at 3:10 p.m. a copy of the facility investigation was requested. The Incident/Accident Report lacked any additional investigation into the incident.

A Progress Note dated 5/9/14, indicated R34 reported she did not like R36 because "he is an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 232	{21850}		

old drunk." The note indicated R34 had agreed to stay away from R36 and that R34 had stated she was used to handling old drunks, and had showed staff an old scar she reported was from when her late husband broke her leg.

When interviewed on 5/7/14, at 2:41 p.m. R34 stated R36 called her names "all the time." When asked how being called names made her feel, R34 stated she had filed a police report because R36 had "assaulted her" two nights ago. When asked what she meant by assaulted, R34 stated R36 waited until nobody was around and then pushed her. R34 reported the director of operations helped her file a police report. Review of the medical records for R34 and R36, lacked documentation regarding the incident which was allegedly reported on 5/5/14, and lacked indication of how R34 would be protected from R36.

When interviewed on 5/7/14, at 3:10 p.m. the director of operations reported he was aware of the incident which had occurred during the evening of 5/5/14, and confirmed he'd helped R34 call the police. During the interview, the administrator stated he was aware of the incident and that it had been reported to him on 5/6/14. The administrator reported R34 and R36 "spar all the time."

Upon interview on 5/8/14, at 11:36 a.m. the director of nursing (DON) reported he had received the Incident/Accident Report on 5/8/14. The DON stated he was not sure whether the incident was reportable because it had occurred on 5/5/14, and it was a "resident to resident altercation."

The director of operations was interviewed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

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{21850}	Continued From page 233 5/12/14, at 9:20 a.m. and stated R34 was very upset about the incident from 5/5/14, and had wanted the police called because it was not the first time, and that R34 had felt assaulted and wanted to press charges. Upon interview on 5/12/14, at 9:24 a.m. the administrator stated the incident on 5/5/14, had been reported to the state agency and that he would provide documentation regarding the report made. R34 was interviewed on 5/12/14, at 1:31 p.m., R34 stated R36 was abusive to her every day but that she'd heard he had gotten sent to another nursing home. R34 stated she felt what R36 was doing to her was both verbal and physical abuse. When interviewed on 5/12/14, at 1:52 p.m. the administrator and consultant administrator reported R34 and R36 have had an ongoing fight going on. The administrator stated R34 and R36 allege physical things and then change their stories. The consultant administrator stated that although the police had been called regarding the incident on 5/5/14, R36 had denied it happened and R34 had no visible injuries noted. The administrator stated when allegations of abuse are made, an incident report was to be filled out and a supervisor consulted to determine whether a report was needed. The administrator said the residents would be separated, an assessment would be made, the incident would be reported to the Common Entry Point (CEP) if appropriate, would be presented at their stand-up meeting the next day, and an investigation would be started. The administrator stated incidents were reported to the administrator, DON or CLSW but verified, "that system has not always been working." The administrator stated the incident form 5/5/14, had	{21850}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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{21850}	Continued From page 234 not been reported to the State Agency (SA) or to the CEP and acknowledged things needed to be reported right away and then investigated. Minneapolis Police Department officer (MPD)-E was interviewed on 5/12/14, at 3:38 p.m. and confirmed the police department had come to the facility regarding the incident between R34 and R36 on 5/5/14. MPD-E stated the facility was aware the residents called each other names and stated it was a facility problem. The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated May 2012, indicated staff must not permit "anyone" to engage in verbal or physical abuse. The policy indicated the facility would implement policies and procedures to ensure that residents are not subjected to abuse by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents. The definition of verbal abuse was described in the policy as, "the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." The policy indicated the facility would protect residents from harm during the investigation and would "report allegations to the state survey and certification agency and any other state agencies pursuant to state regulations."	{21850}		
{22000}	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and	{22000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{22000}	Continued From page 235	{22000}		

personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency.

(b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.

(c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{22000}	Continued From page 236 another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure their Prohibiliton of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Propery policies for immediate reporting and thorough investigation were implemented for 8 of 9 residents (R37, R129, R13, R116) reviewed with allegations of such; the facility also failed to screen new employees for reference checks, back ground studies and license/certification verification for 6 of 6 newly hired employees (registered nurse (RN)-C, RN-D, licensed practical nurse (LPN)-A, nursing assistant (NA)-U, NA-Q, NA-W). Findings include: The facility's policy, Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property dated as reviewed 1/2013, included: "Each resident has the right to be free from mistreatment, neglect, abuse, involuntary seclusion and misappropriation of property. Videll Healthcare, LLC facilities have zero--tolerance for abuse, neglect, mistreatment, and/or misappropriation of resident property. Staff must not permit anyone to engage in verbal, mental, sexual, or physical abuse, neglect, mistreatment, or misappropriation of resident property. The facility will implement policies and procedures to ensure that residents are not subjected to abuse	{22000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{22000}	Continued From page 237	{22000}		

by staff, other residents, volunteers, consultants, family members and others who may have unsupervised access to residents." The policy further included appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. According to the policy, "7. The facility conducts a timely thorough investigation of any allegations of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property in accordance with all state and federal regulations. a. The facility investigate all patterns, trends, or events that suggest the possible presence of abuse neglect or misappropriate of property in accordance with all state and federal regulations...9. The facility reports allegations to the state survey and certification agency (SA) and any other state agencies pursuant to state regulations...10. The facility reports any occurrences of injuries of unknown source immediately to the administrator or designee and to state agencies as required by individual state regulations. 11. The facility reports all alleged, suspected, and/or substantiated occurrences of abuse, neglect, and misappropriation of property or injuries of unknown source to the state survey and certification agency and other appropriate state agency (ies) including law enforcement officials based on state and federal regulations." The very last paragraph of the policy included, "State of Minnesota- The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations."

R37: An Incident/Accident Report dated 5/5/14, at 5:00 p.m. indicated R37 had reported "4 staff members were in his room today" and "a female

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{22000}	Continued From page 238 staff person came out of bathroom & grabbed his arms, causing reddish purplish areas on bilateral [upward pointing arrow] extremities." The report indicated R37 had refused vitals, had a reddish/purple mark on the left superior (upper arm) measuring 2.5 cm (centimeters) x 2.0 cm, a mark on the left inferior (lower arm) 5.75 cm x 2.25 cm., a mark on the right superior/forearm, 6 cm x 8 cm, and on the right hand measuring 4 cm x 3 cm. The report indicated the physician had been notified on 5/5/14, at 5:30 p.m. The form also indicated after R37 had reported after he had been grabbed by staff, he had "then told writer that he jumped off roof." The documentation on the form included, "Resident has slurred speech, staggering gait, & smelled of alcohol." The form indicated the "allegations unsubstantiated." "Resident encouraged to tell a nurse if situation happens again right away. Resident appears intoxicated, with an inconsistent story. Reddened areas appear that they have scratches & chaffing on them." Although R37 made an allegation of abuse, the clinical record lacked evidence the administrator or SA had been immediately notified. And although the report identified R37 had changed the story and identified evidence of potential intoxication, the clinical record lacked documented evidence the allegation had been thoroughly investigated. The report identified R37 was potentially intoxicated, however the clinical record lacked evidence of any screening to determine whether R37 had received alcohol (ETOH). R129: An Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 had "told the nurse that she took cocaine earlier during the shift." The report described R129 as "very sweaty, weak	{22000}		

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{22000}	Continued From page 239	{22000}		

and tired" and "looked very sleepy." R129's pupils were described as "large and nonreactive to light." The report also indicated the nurse had asked R129 what she'd taken and R129 had "confessed" to having taken cocaine. The form indicated the resident was sent to the emergency room, "She said, 'I knowingly took cocaine...Resident has been sent to ER [emergency room]. She will continue to be on 1:1 [one to one, in arms reach at all times] when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." The form was signed by the director of nursing (DON) and dated as 5/5/14. The clinical record lacked evidence the administrator and SA were immediately notified, and lacked evidence the incident had been thoroughly investigated.

R13: A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m. included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised; receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified.

On 5/8/14, at 12:44 p.m. the administrator was interviewed and stated he had not been notified of R13's alleged elopement 5/6/14 until Tuesday "the next morning." The administrator stated he was unclear why it had not been reported to him

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{22000}	Continued From page 240 until then. A SA report form dated 5/8/14 (no time documented on report) included, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 p.m. trying to get to her son, resident was found by the receptionist on the sidewalk." The clinical record lacked evidence R13's elopement was clearly documented, including date, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risks after having eloped. The clinical record also lacked evidence the administrator or SA had been immediately informed of the incident, or that the elopement was thoroughly investigated, including interview with staff present at the time of the elopement. On 5/9/14, at 1:43 p.m. LPN-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the form did not identify when the administrator or SA was notified. On 5/12/14, at 10:26 a.m. director of nursing (DON) stated he was not in the facility at the time of R13's elopement and had not been informed until 5/8/14. The DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with a WanderGuard were at risk for elopement and leaving the facility without supervision was a safety concern. The DON also verified the incident had not been thoroughly investigated.	{22000}		

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{22000}	Continued From page 241 R41: An Incident/Accident Report for R41 dated 5/1/14, at 3:05 p.m. indicated R41 had returned from a leave of absence and "apparently drove off curb [in a motorized wheelchair]." The report indicated R41 was found lying on the pavement on his right side. R41 was identified to have slurred speech, but identified he was alert and oriented. The report indicated R41 had sustained a laceration on his forehead and had complained of arm pain. The report also indicated 9-1-1 had been called and R41 had been transferred to North Memorial hospital. Documentation on the Incident/Accident report indicated R41 had stated he had been drinking alcohol and his "last drink [was] about 5 min (minutes) ago.'" "Requested order for no unsupervised LOA's [leave of absence] from physician." R41 was identified to not be wearing a seat belt in the wheelchair. The clinical record lacked evidence the administrator and SA were immediately notified of the incident which required medical attention. The clinical record also lacked evidence the incident had been thoroughly investigated. R70: An Incident/Accident Report for R70 dated 4/28/14, at 6:30 a.m. indicated R70's right arm had been pulled on when staff had helped R70 get up from a sitting position. R70 had subsequently complained of pain and an ice pack had been applied. The report indicated no swelling was observed and R70 was able to move the right arm, but had slight pain. The report also included, "Resident hurt self during cares" and indicated occupational therapy orders had been obtained for activities of daily living (ADLs) and pain. The incident lacked identification of potential problems with transfer assistance and did not indicate whether staff may have been transferring the resident incorrectly or whether the plan of	{22000}		

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{22000}	Continued From page 242	{22000}		

care had been followed in order to rule out neglect of care. The clinical record lacked evidence the administrator and SA were immediately notified of the incident, and lacked evidence the incident had been thoroughly investigated to rule out potential neglect.

R14: A Minnesota Department of Health OHFC (office of health facility complaints) report form dated 5/4/14, identified R129 had "handed popcorn [a slang name for a drug identified also as weed] that is wrapped in tissue paper to R14." R14 was asked to hand it back but refused. R14 was observed to put something in his mouth and swallowed. The report indicated, "Suspected that the item is not anything that is edible." The physician was notified, and R14 was ordered to go to the emergency room (ER), 9-1-1 was called and the police arrived. R14 was taken to North Memorial Hospital. Although the report indicated the SA had been notified, the clinical record lacked evidence the administrator was immediately notified, and the report form lacked documentation of the date, time and location of the incident.

R66: An OHFC report form indicated a report had been submitted regarding R66 on 4/30/14. The report indicated a NA was given a hand written letter from R66 that indicated the resident would not give the NA "$500" unless the NA could prove "that she [the NA] is being stalked [the NA had alleged she was being stalked and had asked R66 for money]." The DON had documented that the nursing assistant (NA) had denied taking or asking for money, but had admitted she was being stalked and had stated all staff knew it "including the residents." Although this alleged incident of potential financial exploitation had occurred on 4/28/14, it had not been reported to

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{22000}	Continued From page 243 the SA until 4/30/14. In addition, the clinical record lacked evidence the administrator had been immediately notified. On 5/9/14, at 1:43 p.m. the licensed practical nurse (LPN) manager-E stated the administrator should be immediately notified of all incidents in the facility and stated when the new incident report form was implemented, the new form did not include identification of when the administrator or SA was notified. R116 had eloped and the facility did not report to the administrator or SA in a timely manner. R116 was observed on 5/11/14, at 9:30 a.m. to be on the sidewalk west of the facility. The health unit coordinator (HUC) was bringing R116 back into the building. The HUC stated she "had found him as she was driving into work." The HUC stated R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC said she had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a wheelchair (w/c) to help bring him back to the facility. NA-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility. On 5/11/14, at 10:38 a.m. a progress note indicated, "At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend.' R116 currently has a WanderGuard and due to cognitive impairments	{22000}		

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{22000}	Continued From page 244	{22000}		

is unable to leave the facility unattended. He was verbally resistant to returning to the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, administration, and social worker (SW) updated."

R116's progress notes from 5/11/14, at 11:52 a.m. included: "Fire exit alarm again sounded at the end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c (wheelchair) due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."

Additional Progress Notes dated 5/11/14, at 4:27 p.m. included, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 [a.m.] resident left out another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident's WanderGuard (departure alert system) was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident."

The facility's HUC was interviewed on 5/12/14, at 10:00 a.m. and at that time the HUC verified

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{22000}	Continued From page 245 R116 had eloped from the facility three times on 5/11/14. The HUC stated R116 had left the building without staff present at 9:30 a.m., 11:30 a.m. and 11:52 a.m. Although the HUC verified the resident had eloped without staff presence, R116's Progress Notes had indicated staff were with the resident at 11:30 a.m. On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement) the DON was interviewed. The DON stated he had not reported R116's elopement because his understanding was that he had 24 hours to report. The DON stated he had wanted to investigate the issue and speak to the administrator, and was still working on the report. The DON verified he was not aware of the Federal regulations which included immediate reporting. The DON verified he was not aware that a resident who exited the building unsupervised while wearing a WanderGuard, without staff knowledge, could constitute elopement and potential neglect of care. On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made to the SA for the additional elopements at 11:30 a.m. and 11:52 a.m. On 5/13/14, at 2:21 p.m. the administrator verified he had not been immediately notified of the above incidents and stated the DON was developing a "log" to keep track of when he was notified. The administrator stated he'd thought the SA had been immediately notified. EMPLOYEE SCREENING:	{22000}		

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{22000}	Continued From page 246 On 5/12/14, at 10:00 a.m. the employee files were reviewed and the following was observed: Licensure verification: Licensed practical nurse (LPN)-A's employee file folder lacked verification of the LPN's license. The administrator verified at 12:45 p.m. there had been no proof of nursing licensure obtained for LPN-A from the Minnesota Board of Nursing. Registered nurse (RN)-C's employee personnel file indicated RN-c had been hired on 4/8/14, and that a back ground study request had been submitted on 4/8/14, however there were no results yet. In addition, no licensure verification completed, only a copy of a license with expiration of 10/4/13. Background study: RN-D's file indicated RN-D had been hired 4/16/14, and that a background Study Request had been submitted on 4/14/14. However, the background study incorrectly indicated NA-U's background study information. Nursing assistant (NA)-U's file was reviewed and was found to include a statement that NA-U had a Minnesota Department of Human Services Background Study (MN DHS BS) form dated 5/25/14, which indicated NA-U "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The administrator verified that NA-U could not provide care but had been providing care unsupervised, from 4/23/14, through 5/12/14. NA-U had RN-D's BS in NA-U's employee file. Also, RN-D's BS was in NA-U's employee folder. RN-D's BS indicated that RN-D could not perform	{22000}		

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{22000}	Continued From page 247 cares unsupervised. However, during the survey the administrator obtained the blue BS form which indicated RN-D could perform cares unsupervised. NA-Q was hired on 3/6/14. The facility received a yellow MN DHS BS on 3/10/14, which indicated NA-Q "cannot provide Qualified Professional or Personal Care Assistance services in the personal care program under Minnesota Health Care Programs." The white BS computer genreated copy request indicated the form was submitted on 3/6/14, and passed as of 3/10/14, however the employee file lacked the information as the facility provided the information during survey. The facility did not have system in place to ensure BS were being monitored for the employees ability to work unsupervised. Reference checks: RN-C was hired on 4/8/14, and no reference checks had been completed. RN-D was hired 4/16/14, and no reference checks, could be located in the employee file. LPN-A's file lacked a hire date and no reference checks were completed as the facility policy had directed staff to complete. NA-W hired 4/23/14, had no reference check completed. On 5/12/14, at 12:35 p.m. the administrator stated the human resources (HR) person was in charge of doing license verifications and background checks for new employees. The administrator further stated the HR person had been terminated two weeks ago and no one else	{22000}		

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{22000}	Continued From page 248 had been designated to follow-up on background checks that had been flagged. The administrator acknowledged the facility had not ensured tracking for new employees' license verification and background checks. On 5/13/14, at 8:10 a.m. NA-U verified during interview that she was a NA and had started orientation on 4/23/14. When asked if she worked under supervision, NA-U stated she had received "a couple of days training" and had started working on her own on 4/28/14. On 5/13/14, at 9:00 a.m. LPN-A verified her start date was 4/2/14. LPN-A stated her days were "sporadic" for a few weeks, but stated she had been working full time on her own since 4/16/14.	{22000}		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF REPEAT VIOLATIONS AND IMMINENT RISK TO RESIDENT CARE OR SAFETY

FedEx Tracking Number 8047 7140 3710

June 2, 2014

Mr. Leah Killian-Smith, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5544023

Dear Ms. Smith:

On May 13, 2014, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 18, 2014.

This is to inform you that during this reinspection, we found repeat violations within the preceding two year period which created an imminent risk to resident care or safety, and repeat violations in the four highest daily fine categories prescribed in rule.

The above facility was surveyed on March 10, 2014 through March 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. Section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the licensing orders cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

In accordance with MN Stat. Section 144A.11 Subd. 2. (a) the commissioner of health shall initiate proceedings within 60 days of notification to suspend or revoke a nursing home license or shall refuse to renew a license if within the preceeding two years the nursing home has incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule.

The following violations cited at the time of the survey completed on March 18, 2014 are repeat violations and were previously cited within the preceding two year period:

0165 - Licensee, Provision of Adequate Financing - MN Rule 4658.0050 Subp. 3.F.
0530 - Use of Restraints - MN Rule 4658.0300 Subp. 4.
0560 - Comprehensive Plan of Care, Contents - MN Rule 4658.0405 Subp. 2.
0830 - Adequate and Proper Nursing Care, General - MN Rule 4658.0520 Subp. 1.
1375 - Infection Control, Program - MN Rule 4658.0800 Subp. 1.
1695 - Plant Housekeeping, Operation and Maintenance - MN Rule 4658.1415 Subp. 4.
2000 - Reporting - Maltreatment of Vulnerable Adults - MN Statutes 626.557 Subd. 14 (a)-(c)

The following violations cited at the time of the survey completed on March 18, 2014 are repeat violations and carry fines in the four highest fine categories:

0530 - Use of Restraints - MN Rule 4658.0300 Subp. 4.
0560 - Comprehensive Plan of Care, Contents - MN Rule 4658.0405 Subp. 2.
0830 - Adequate and Proper Nursing Care, General - MN Rule 4658.0520 Subp. 1.
1375 - Infection Control, Program - MN Rule 4658.0800 Subp. 1.

In addition, repeat violations noted at the time of the survey completed on March 18, 2014 created an imminent risk to direct resident care or safety.

State licensing orders issued pursuant to the last survey completed on March 18, 2014, found not corrected at the time of the May 13, 2014 reinspection and subject to penalty assessment are as follows:

20130 - MN Rule 4658.0050 Subp. 1 -- Licensee;general Duties
20135 - MN Rule 4658.0050 Subp. 2 -- Licensee;specific Duties
20165 - MN Rule 4658.0050 Subp. 3.F -- Licensee;provision Of Adequate Financing
20255 - MN Rule 4658.0070 -- Quality Assessment And Assurance Committee
20265 - MN Rule 4658.0085 -- Notification Of Chg In Resident Health Status
20530 - MN Rule 4658.0300 Subp. 4 -- Use Of Restraints
20540 - MN Rule 4658.0400 Subp. 1 & 2 -- Comprehensive Resident Assessment
20545 - MN Rule 4658.0400 Subp. 3 A-C -- Comprehensive Resident Assessment; Frequency
20565 - MN Rule 4658.0405 Subp. 3 -- Comprehensive Plan Of Care; Use
20570 - MN Rule 4658.0405 Subp. 4 -- Comprehensive Plan Of Care; Revision
20625 - MN Rule 4658.0450 Subp. 1 A-P -- Clinical Record Contents; In General
20800 - MN Rule 4658.0510 Subp. 1 -- Nursing Personnel; Staffing Requirements
20830 - MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General
20900 - MN Rule 4658.0525 Subp. 3 -- Rehab - Pressure Ulcers
21325 - MN Rule 4658.0725 Subp. 1 -- Providing Routine & Emergency Oral Health Ser
21426 - MN St. Statute 144A.04 Subd. 4 -- Tuberculosis Prevention And Control
21475 - MN Rule 4658.1005 Subp. 1 -- Social Services: General Requirements
21530 - MN Rule 4658.1310 A.B.C -- Drug Regimen Review

21535 - MN Rule4658.1315 Subp.1 ABCD -- Unnecessary Drug Usage; General
21610 - MN Rule 4658.1340 Subp. 1 -- Medicine Cabinet And Preparation Area;storage
21665 - MN Rule 4658.1400 -- Physical Environment
21850 - MN St. Statute 144.651 Subd. 14 -- Patients & Residents Of Hc Fac.Bill Of Rights
22000 - MN St. Statute 626.557 Subd. 14 (a)-(c) -- Reporting - Maltreatment Of Vulnerable Adults

The following violations cited at the time of the reinspection completed on May 13, 2014 are repeat violations and carry fines in the four highest fine categories:

0530 - Use of Restraints - MN Rule 4658.0300 Subp. 4.
0830 - Adequate and Proper Nursing Care, General - MN Rule 4658.0520 Subp. 1.

Also, at the time of this reinspection completed on May 13, 2014 additional violations were cited as follows:

20285 - MN Rule 4658.0100 Subp. 2 -- Employee Orientation And In-Service Education
20820 - MN Rule 4658.0510 Subp. 5 -- Nursing Personnel; Assignment Of Duties
21730 - MN Rule 4658.1415 Subp. 11 -- Plant Housekeeping, Operation, & Maintenance
21995 - MN St. Statute 626.557 Subd. 4a -- Reporting - Maltreatment Of Vulnerable Adults

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

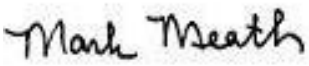
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, PO Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Mark Meath, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4118
Fax: (651) 215-9697
Email: mark.meath@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	R 05/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite resurvey was conducted on May 5, 6, 7, 8, 9, 10, 11, 12, and 13, 2014, to determine compliance with State licensure requirements issued during a licensing survey exited on March 18, 2014. During the onsite visit it was determined that the	{2 000}	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 15, 2014

Hand Delivered on May 15, 2015

Mr. Mark Lindeman, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Immediate Jeopardy Not Removed - Project Number: S5544023

Dear Mr. Lindeman:

On March 18, 2014 an extended 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.

At the time of our March 18, 2014 extended survey your facility was not in substantial compliance with the participation requirements and conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

We notified you on April 8, 2014 that state monitoring was being imposed effective April 13, 2014 (42 CFR 488.422).

We also notified you that remedies were being recommended for imposition to the Centers for Medicare and Medicaid Services (CMS).

CMS informed you in their letter of April 11, 2014, that the following remedies were being imposed:

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective April 29, 2014 (42 CFR 488.417(b))

- Federal Civil Money Penalty (CMP) of $6,300.00 per day for nine days beginning March 9, 2014 and continuing through March 17, 2014 for a total of $56,700.00 (42 CFR 488.430 through 488.444)

- Federal CMP of $250.00 per day beginning March 18, 2014 (42 CFR 488.430 through 488.444)

- Discretionary termination of your Medicare and Medicaid provider agreement effective August 18, 2014 (42 CFR 488.412 and 488.456)

Also, the CMS Region V Office notified you in their letter of April 11, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from March 18, 2014.

IMMEDIATE JEOPARDY NOT REMOVED AT POST CERTIFICATION REVISIT

On May 13, 2014 a post certification revisit (PCR) was completed at your facility by the Minnesota Department of Health 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.

At the time of the revisit completed on May 13, 2014, your facility was found not in substantial compliance and conditions in the facility constituted **both substandard quality of care and immediate jeopardy to resident health or safety**. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required.

Failure to remove the immediate jeopardy situation will result in imposition of the following remedy by CMS:

• Termination of your facility's Medicare and Medicaid provider agreement effective June 5, 2014.

Enclosed is a narrative describing the conditions of Immediate Jeopardy in your facility. We will forward you, in a subsequent letter, information regarding other findings that may result in substandard quality of care, loss of nursing aide training programs, and/or additional deficiencies.

REMOVAL OF IMMEDIATE JEOPARDY

You must submit a written allegation of removal of immediate jeopardy including evidence of steps taken to remove the immediate jeopardy. Once we have received this information and it is accepted, we will conduct an on-site visit to verify correction. Failure to submit a written allegation of removal of immediate jeopardy will result in termination of your facility's provider agreement no later than 23 calendar days from the May 13, 2014 exit.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care

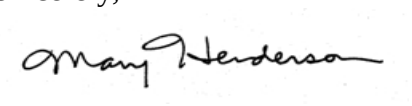
deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

Feel free to contact me if you have questions about this letter.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-4115 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

Minnesota Department Of Health
Division of Compliance Monitoring
Licensing and Certification Program

INFORMATIONAL MEMORANDUM

PROVIDER: Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

DATE OF SURVEY: May 5, 2014 through May 13, 2014

BEDS LICENSED:

HOSP: NH: BCH: SLFA: SLFB:

CENSUS:
HOSP: NH: 68 BCH: SLF:

BEDS CERTIFIED:
SNF/18: SNF 18/19: NFI: NFII: ICF/MR:
OTHER:

NAME(S) AND TITLE(S) OF PERSONS INTERVIEWED:

SUBJECT: Post Certification/Licensing Revisit

ITEMS NOTED AND DISCUSSED:

A mandatory onsite re-visit was made to follow up federal and state licensing deficiencies issued as a result of a survey completed on March 18, 2014. The results of this visit were delineated during an exit conference. A summary of findings for the immediate jeopardies identified, but not removed prior to exit follows:

F224 J

Based on observation, interview and document review, the faciliy failed to provide supervision and care to prevent harm from occurring to residents. Although an Immediate Jeopardy had been identified at F323 on 5/9/14, at 2:03 p.m. for lack of supervision and resident drug and alcohol use for R37 and R129, the administration failed to initiate immediate action to remove the immediacy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were informed of an Immediate Jeopardy being identified at F224 for neglect of

care for R37 and R129, due to their failure to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care and subsequent hospitalizations for R129 and R37 that occurred on 5/11/14.

R129 was identified by the facility to have a history of drug seeking and alcohol dependency. Although the facility required a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times), the facility neglected R129. On 5/3/14, R129 reported to the facility she obtained and consumed cocaine. R129 had a staff assigned as 1:1 at the time of the incident; on 5/11/14, at 4:00 a.m. R129 obtained and consumed alcohol, causing her to require hospitalization in the intensive care unit (ICU) and intubation (mechanical ventilator assisted breathing) for a blood alcohol level of .323. R129 was assigned a facility staff to accompany the resident 1:1 at the time of the incident. Neither incidents were immediately reported to the administrator or the State agency. The clinical record lacked complete documentation of the incidents, assessment of R129 at the time of the incidents and lacked evidence both incidents were thoroughly investigated.

The admission Minimum Data Set (MDS) dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R12Nired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with activities of daily living (ADLs). Although the CAAs identified R129 had a history of drug and alcohol dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment.

The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of alcohol abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA (leave of absence) from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, identified to "monitor for ETOH [alcohol] use or oversedation." The North Memorial Medical Center lab report indicated a Drug Screen was completed, identified the use of Morphine, Oxycodone, effexor, Soma, Tylenol, desmethylvenlafaxine. The clinical record lacked documented verbiage regarding the circumstances of the drug screen.

The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking

behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1," "remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14.

An Emergency Department Chart [a form from the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department or ER]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1.

A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD [medical doctor] and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD."

On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, alcohol and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were

conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep Gail safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings."

Review of the undated Group 7 nursing assistant (NA) assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print.

Nursing Progress Notes:
- On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."
- On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money."
- On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment.
- On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
- On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport

informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP.

- On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
- On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
- On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms."
- On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal drugs was identified, reported to the administrator immediately, reported to the State agency or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another resident in

this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.
- On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer].

On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arms length from R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M.
- At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern.
- At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129.
- At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway.
- At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129.
- At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top

of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking beside (to the left) of R129.
- At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14.
- At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor.
- At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk.

On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and alcohol treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room

of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of alcohol or drugs being exchanged on "my shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse.

On 5/8/14, at 11:40 a.m. NA-S stated the had seen alcohol bottles in residents rooms and smelled alcohol on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January or February. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."
On 5/8/14, at 11:55 a.m.. a housekeeper (H)-A was asked if they were aware of any residents drinking alcohol in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any alcohol bottles found in the facility "and has." H-A was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the alcohol bottles came from, H-A stated she was unclear, but thought they may have been provided by family.
On 5/8/14, at 12:03 p.m. LPN-H stated she had confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, but was unclear how the alcohol was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility.
On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated

R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming alcohol in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the alcohol was coming from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and alcohol use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocets tablets delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
- On 5/11/14, at 10:09 a.m. a note written by the health unit coordinator (HUC) indicated North Memorial Medical Center (NMMC) called the facility "requesting" R129's medication administration records (MARs). The note indicated the registered nurse (RN) from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough alcohol to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time.
- On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her alcohol.
- On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMH was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."

- On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of alcohol was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."
- Was asked regarding R129 obtaining alcohol or drugs while on a 1:1, DON verified the information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and alcohol while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained alcohol, but verified R129 was harmed by the incident.

On 5/13/14, at 2:21 p.m. administrator verified he was not notified immediately and the State agency was not notified immediately of R129's cocaine incident and alcohol ingestion. The administrator verified R129 obtaining an illegal drug and alcohol while on a 1:1 was neglect. The administrator verified the facility lacked a system to ensure residents on 1:1 were supervised to ensure they were not neglected. The administrator verified a thorough investigation regarding resident access to illegal drugs while R129 was on 1:1 should have been completed and documented thoroughly. The administrator verified 1:1 staffing was a short term solution and was not a viable long-term intervention to address R129's drug seeking and alcohol use.

On 5/12/14, at 2:43 p.m. contracted licensed social worker (CLSW)-A stated, " I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home. "

The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.

Progress notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism.

Observations of R37 revealed the following:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was crazy.
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37's wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.
- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he didn't feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 is intoxicated, when he was friendly and chatting.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The progress Notes were reviewed and the following was noted:
- On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed.
- On 5/3/14, indicated R37 was walking in the hallway "wobbling" and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared "intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait.
- On 5/5/14, at 10:25 p.m. indicated R37 was "intoxicated" and was found with an almost empty bottle of vodka.
- On 5/6/14, which indicated it was a late entry for 5/5/14 at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were found in R37's room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to alcohol withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 "was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37's room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood pressure of

178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for methadone.

The Physician's orders and Nurse Practitioners orders were reviewed and the following was noted:
- On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed "do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included "place wander guard [sic] for res. [resident] safety" and "pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37's alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered.
- On 5/6/14, directed to recheck R37's blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a Wanderguard to check placement every shift for elopement even though R37 had cut off the Wanderguard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated "refer to chemical dependency counselor and pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of "strongly recommend a full psychiatric assessment" within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The Depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week.

The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA.
- A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37's safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37's alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37's cognitive skills for daily decision making was independent with consistent/reasonable decisions.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was "wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn't be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37's medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been "drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor's order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 got alcohol from.

The safety monitor, nursing assistant (NA)-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated "it's a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated "we're not doing [R37] any justice" and "it's a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:19 p.m. the consultant administrator was approached after several staff reported they had not been informed of the immediate jeopardy (IJ) that was called on 5/9/14, at 2:02 p.m. The consultant administrator stated she wanted the adminstrator to indicate why staff was not informed of the IJ and asked "are we in trouble?" The administrator approached and stated, yesterday when the IJ was called, by the time we were done with a meeting with our boss, the nurse managers had gone for the day. The administrator stated he thought they would come up with a plan and would have an all staff meeting 5/10/14, to inform staff of the IJ. The administrator further stated a meeting was scheduled at 1:45 p.m. and verified staff had not been informed of the IJ.

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for DTs.

On 5/12/14, at 8:59 a.m. registered nurse (RN)-B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The director of nursing (DON) was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend-A]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that friend-A was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and friend-A signed R37 out. The consultant administrator was going to go with R37 and friend-A to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. SW-A stated during a room search a quart bottle of alcohol had been found in R37's room and three plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and social worker (SW)-A were involved in R37's LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he had not followed his agreement to only go to the bank. The administrator stated friend-A would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed SW-A and had not checked the chart. The administrator stated he was also not aware of friend-A's relationship with R1 and the DON had not told him about the order for no LOA and friend-A 's relationship with R1.

Upon interview on 5/13/14, at 8:09 a.m. SW-A stated on 5/10/14, prior to R37 leaving on LOA she was told by nursing (she could not remember who) that R37 could leave the facility with supervision. She reported she made it clear to friend-A that R37 could only go to the bank and nowhere else. She stated she told friend-A that R37 would try and talk him into going to the liquor store and R37 could not go there. Friend-A reassured her he had been sober for ten years and would never take R37 to a liquor store. The SW-A stated after R37 left, nursing (did not remember who) told her R37 had orders for no LOA and friend-A was R1's drug dealer. She stated it would have been nice to know the information before she had allowed R37 to go on a LOA. She stated she had not looked at R37's chart because she trusted nursing knew the correct information. She also stated R37 had been keeping alcohol under the edge of his mattress and she could not understand why nursing did not find the alcohol when they made the bed.

When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14, and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs and friend-A's relationship with R1 prior to R37 being allowed to leave on LOA.

The facility Special Staffing-One to One Assignment reviewed May 2013, directed "One to one assignment keeps a resident at arm's length at all times."

The facility Drug and Alcohol Free Facility Care Environment-Camden Specific effective 5/11/14, directed "If staff have reasonable suspicion that a resident has used, has in their possession, or has distributed to other residents in the facility alcohol, street drugs, or other pharmacologic substances not prescribed by treating physician the facility staff, under the direction of administration, shall:

- Search the residents room and remove such substances
- Notify the physician and obtain an order for blood and urine drug testing
- Notify the family and/or responsible party of the event

If the tests return positive the resident with the positive results will be immediately discharged for placing the resident population at risk for abuse. If alcohol, street drugs, or pharmacologic substances are found not prescribed by a physician during a room search the resident will be immediately discharged for placing the population at risk for abuse. If the substances found during a room search are suspected of being illegal the police will be notified."

The facility Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy reviewed January 2013, defined neglect as "The failure to provide goods or services necessary to avoid physical harm, mental anguish, or mental illness. "Under item 6, the policy directed; "Supervisors will immediately intervene, correct, and report identified situations where abuse, neglect or misappropriation of resident property is at risk for occurring." The policy included a definition of criminal crime neglect as "A caregiver or operator who intentionally neglects a vulnerable adult or knowingly permits conditions to exist that result in the abuse or neglect of a vulnerable adult is guilty of a gross misdemeanor. Neglect means a failure to provide a vulnerable adult with necessary food, clothing, shelter, health care, or supervision. "Appendix A included examples of neglect as "Failure of a caregiver to provide a resident with (or the absence or likelihood of absence of) care or services (e.g. food, clothing, shelter, health care or supervision) which are reasonable and necessary to obtain or maintain the vulnerable adult's physical or mental health or safety."

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Based on observation, interview and document review, the facility failed to ensure adequate supervision was provided to prevent potential injury from alcohol and drug use for 4 residents (R37, R41, R117, R129). In addition, the facility failed to ensure residents were supervised adequately to prevent elopement for 2 residents (R13 and R116). This resulted in an Immediate Jeopardy (IJ) situation being identified for these residents on 5/9/14, at 2:03 p.m.

Findings include:

Review of the progress notes indicated R37 had been found with alcohol/vodka on 2/21/14, 2/22/14, 2/27/14, 3/2/14, 4/13/14, 4/23/14, 4/24/14, 4/25/14, 5/3/14, 5/5/14, 5/6/14, 5/7/1, 5/9/14 and 5/10/14. R37 was hospitalized 2/22/14, 4/23/14 and 5/10/14, related to alcohol/drug use. The Admission Record dated 1/14/14, indicated R37 was admitted to the facility on 9/19/13, with diagnoses which included altered mental status, and personal history of alcoholism.

Observations of R37 revealed the following:
-On 5/5/14, at 2:53 p.m. R37 was observed approaching a white minivan parked in front of the facility.
- On 5/6/14, at 1:30 p.m. R37 was observed staggering down the hallway with the health unit coordinator (HUC) and in a loud voice stated he was crazy.
- On 5/6/14, 2:02 p.m. R37 went outside without shoes on. Two staff stopped him at the nursing station and sent him back to his room for shoes. R37 left his room and went directly outside without shoes on again, walked to the smoking patio and returned to the facility.
- On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117 on the smoking patio with his wallet out. Another resident (R1) arrived and R37 handed his wallet to her. Surveyor was unable to see if R1 took anything from the wallet before she handed it back to R37. R37 was observed to lean close to R1 and talk to her and gave her his wallet back. At 8:24 a.m. R1 put R37 ' s wallet back in his left pants pocket.
- On 5/8/14, at 11:48 a.m. R37 was observed in bed with his back to the door. R37 rolled over and looked at surveyor and rolled back towards the wall. R37 stated he did not want to talk now and would talk in an hour or two.

- On 5/8/14, at 3:46 p.m. an attempt was made to interview R37 and he refused.
- On 5/9/14, at 7:23 a.m. R37 was observed coming out of his room, stated he didn ' t feel good and was going to see if there was any coffee. At 7:28 a.m. R37 was observed coming from the West hallway. R37 was then observed to push another resident back down the West hallway and was observed outside room 186 R9. There was no staff with R37 when he was observed. When R37 returned to the nursing station, he told the HUC he had gotten cigarettes from R9. The HUC asked R37 if he was alone and R37 responded that he was and she asked him where his partner was. NA-L approached R37 and stated she was with him today. NA-L verified she was providing 1:1 for R37.
- On 5/10/14, at 1:07 p.m. R37 was observed being taken to an ambulance. R37 was animated and chatting with the medics. Staff reported that was how you know R37 is intoxicated, when he was friendly and chatting.

The Nutritional Status Care Area Assessments (CAAs) dated 9/26/13, indicated R37 was at risk for impaired nutritional status due to chronic ETOH abuse and cirrhosis. Review of the Cognitive Loss/Dementia, Mood State, Behavioral Symptoms and Psychotropic Drug Use CAAs dated 10/7/13, revealed a lack of a summary regarding the triggered areas.

The progress Notes were reviewed and the following was noted:
- On 11/26/13, noted CD treatment/AA was discussed and R37 had participated in AA services in the past which he was successful with three years of sobriety before recent relapse. The note indicated nursing had reported two episodes of alcohol intoxication while in the nursing home since the last visit and R37 acknowledged the report to be accurate. The assessment/plan included social worker to assist with available CD services, R37 stated he was open to CD services and no alcohol use with nursing to monitor. The NP indicated there were " clear dependency concerns."
- On 1/8/14, indicated alcohol abuse which had also occurred in the facility.
- On 2/21/14, indicated R37 had been drinking vodka and a finished bottle was found. R37 was observed to be distributing money to staff and residents. When R37 noticed he had no money to buy vodka, he went to the automatic teller machine (ATM) machine to get money. The note indicated staff was concerned about his safety and judgment. On 2/21/14, at 7:07 a.m. indicated R37 was handing out his money to " anyone who would listen " and staff took $116.00 dollars from him and locked it up.
- On 2/22/14, at 10:14 p.m. indicated R37 called 911 and sent himself to the hospital. It was noted R37 had been drinking during the a.m. shift and was drunk. The a.m. shift took a bottle of vodka from him. R37 asked the p.m. shift to return the vodka or pay him $25.00.
- On 2/27/14, at 1:13 p.m. indicated R37 wanted to leave on an LOA, was advised he could not go on unsupervised LOA and left the facility.
- On 2/27/14, at 10:07 p.m. indicated R37 was " drunk " and had a blood pressure of 147/105.
- On 3/2/14, indicated R37 was " drunk " and was noted to have a blood pressure of 176/98 and a pulse of 99.
- On 4/1/14, indicated R37 had complained of shortness of breath and chest pain with a blood pressure of 146/102 and a pulse of 109 and was sent to the hospital.
- On 4/13/14, indicated R37 " seemed intoxicated " and one full bottle of vodka and one quarter full bottle were removed from the room.
- On 4/23/14, at 3:44 a.m. indicated R37 was shouting and yelling and appeared intoxicated. One empty bottle of vodka and one 75% emptied were found in R37 ' s room. At 12:04 p.m.

staff checked R37 ' s room and found two empty bottles in his room. Staff discussed discharge plans and R37 reported he wanted to stay and the facility and was told it was not ok to drink alcohol at the facility. R37 was offered a transfer to a facility that allowed drinking and he declined. At 3:13 p.m. R37 approached staff and appeared to be intoxicated with slurred speech and smelled of alcohol. R37 stated he would like to get help to have alcohol removed from his body. Staff called 911 and police escorted R37 to detox.
- On 4/24/14, at 9:30 a.m. indicated R37 reported chest pain and shortness of breath. R37 was noted to have a blood pressure of 162/103 and a pulse of 88 and was noted to smell of alcohol.
At 12:01 p.m. indicated R37 approached staff and " again was clearly intoxicated." Social worker (SW)-A and a police officer entered R37 ' s room and found an empty vodka bottle under the mattress. The officer told staff he could not remove the resident from the building because R37 was not disturbing anyone and was not aggressive or assertive in any way.
A facility Progress Notes dated 4/25/14, at 3:40 a.m. indicated R37 was observed walking into and out of another resident (R117) room and " seemed to be like an exchanged of some transactions." The note indicated staff believed this was a trade and staff would need to monitor R37 for alcohol consumption. " A few hours later " R37 was shouting and appeared " intoxicated " and a 75% emptied bottle of vodka was found in R37 ' s room.
- On 4/25/14, at 9:58 a.m. noted R37 " was clearly inebriated ", had slurred speech and could barely wake up. R37 refused to provide his resource where he continued to get alcohol.
- On 4/25/14, at 3:24 p.m. indicated staff reported R37 appeared intoxicated, was outside swaying back and forth, was very talkative with staff and smelled like he had alcohol on his breath.
- On 5/2/14, indicated R37 removed the wander guard and refused a new one to be placed.
- On 5/3/14, indicated R37 was walking in the hallway " wobbling " and requested staff give him a shower at 3:00 a.m. R37 was unable to maintain his balance and appeared " intoxicated." Two almost empty bottles of vodka were found in his room.
- On 5/5/14, at 3:53 p.m. indicated R37 had exhibited signs of intoxication with an unsteady/staggering gait, slurred speech, odor of alcohol and unkempt appearance. R37 was noted to have continually gone outside, stated he had called a limo and was going to Las Vegas.
- On 5/5/14, at 4:56 p.m. indicated R37 had slurred speech, smelled of alcohol and had a staggering gait.
- On 5/5/14, at 10:25 p.m. indicated R37 was " intoxicated " and was found with an almost empty bottle of vodka.
- On 5/6/14, which indicated it was a late entry for 5/5/14 at 6:00 p.m. indicated R 37 was noted walking outside towards the back of the building. R37 was noted to be walking alone with a staggering gait. When approached by staff, R37 stated he was going to Las Vegas. No odor of alcohol was noted and when asked what he had been doing to become so impaired, R37 reported he had gotten cocaine and heroin from another resident and confirmed he had been injecting the drugs. Several scattered purple bruises were noted on his forearms. At 1:55 a.m. indicated R37 reported his heart was thumping out of his chest and was found to have a blood pressure of 168 /118 with a pulse of 118. At 4:37 a.m. indicated R37 exited his room without clothing and had a strong odor of alcohol on his breath. Four empty bottles and one unopened bottle of alcohol were found in R37 ' s room and were removed by staff. Also noted R37 started having tremors and palpitations with increased pulse and blood pressure due to alcohol withdrawal and demanded medications.
- On 5/7/14, at 12:04 p.m. indicated R37 was exhibiting signs and symptoms of intoxication

as evidenced by odor of alcohol, unsteady/slow/staggering gait, slurred speech, confusion and unkempt appearance. A pattern of missed pain clinic appointments due to intoxication was noted and indicated further appointments would not be made due to ongoing intoxication and inability to follow through with appointments. In addition, R37 had a full bottle of vodka and refused to give the bottle to staff. The note indicated the administrator directed if R37 was unwilling to willingly give staff the alcohol bottle, it was ok for the resident to keep the alcohol and if he became drunk or disruptive to call the police and have him taken to detox.
- On 5/8/14, at 3:42 p.m. indicated R37 was placed on 1:1 observation related to incidences of getting intoxicated.
- On 5/9/14, indicated R37 " was clearly intoxicated." An empty pint bottle of vodka was found in his room and was noted as the third empty pint bottle taken from R37 ' s room in a 48 hour span of time.
- On 5/10/14, indicated R37 was observed giving his credit card to R117 on 5/9/14. A second note indicated R37 returned from LOA accompanied by a friend of another resident (R1). R37 was observed to be shaky and verbalized he was unsteady on his feet. R37 was noted to have shakiness, profuse sweating, sluggish pupils and was noted to have a blood pressure of 178/130 and a pulse of 120s to 140s.
- On 5/11/14, indicated R37 had a drug screen positive for methadone at the hospital. R37 did not have a prescription for Methadone.

The Physician ' s orders and Nurse Practitioners orders were reviewed and the following was noted:
- On dated 1/8/14, included a diagnosis of alcohol abuse noted to have also occurred in the facility.
- On 2/5/14, indicated R37 recently had a bottle of alcohol hidden in his pillow case and was noted to smell of alcohol.
- On 2/28/14, directed to discharge R37 to another facility (that allowed drinking).
- On 3/5/14, directed " do not call on-call MD [physician] or NP after hours if resident is intoxicated unless he is medically compromised. Allow resident to go to bed [and] sleep."
- On 4/9/14, indicated R37 was hospitalized from 4/1/14 from 4/8/14, with respiratory distress and pneumonia with pleural effusions requiring chest tube placement, treated for sepsis and required thoracentesis. A NP note dated 4/9/14, indicated R37 required ongoing Kristalose and Mag-ox for chronic cirrhosis.
- On 4/10/14, included diagnoses of chemical dependency, hepatic cirrhosis, and chronic pain.
- On 4/24/14, included " place wander guard [sic] for res. [resident] safety " and " pursue guardianship." A second order dated 4/24/14, indicated NP was aware of R37 ' s alcohol, to encourage R37 not to use and if R37 appeared intoxicated it was ok to administer all medications as ordered.
- On 5/6/14, directed to recheck R37 ' s blood pressure in one hour, call NP if diastolic blood pressure was greater than 100, give Ativan 0.5 milligrams orally every six hours as needed times three days for withdrawal symptoms (tremors, shaking, and increased heart rate) and a urine toxicology screen.
- On 5/7/14, directed no LOA-supervised or other. Also, the NP included an order for a Wanderguard to check placement every shift for elopement even though R37 had cut off the Wanderguard on 5/2/14, and refused to have a new one placed.

A Clinical Summary dated 2/3/14, indicated " refer to chemical dependency counselor and

pain psychologist." A prescription dated 2/3/14, ordered a behavioral health evaluation for diagnostic evaluation and treatment recommendations for R37.

A Physician Visit/Progress Note written by a licensed drug and alcohol counselor (LADC) dated 2/13/14, indicated R37 was referred to assess behavioral health, chemical dependency and pain and included an order/comment of " strongly recommend a full psychiatric assessment " within 60 days to evaluate medications and therapy. The medical record lacked evidence of the psychiatric assessment having been completed.

R37's care plan was reviewed and noted the following:
- The vulnerable adult care plan revised on 3/5/14, indicated R37 may leave to go to medical appointments without supervision and was not safe to go on other unsupervised LOAs.
- The Depression care plan dated 3/11/14, included alcohol abuse and directed to arrange psych services as needed.
- A behavioral symptoms care plan revised on 3/16/14, indicated alcohol consumption and concealing alcohol in room with a goal to have fewer episodes of alcohol abuse per week. The interventions included; encourage attending AA or other substance abuse support programs, assisting with arrangements as needed, may go to medical/dental appointments unsupervised and no other unsupervised LOA.
- A risk for elopement related to alcohol abuse and psychoses care plan revised 3/16/14, noted a history of returning to facility after unsupervised LOA displaying signs of alcohol consumption and/or with a supply of alcohol. The goal included R37 would not to leave facility unattended unless a medical appointment and R37 ' s safety will be maintained. The interventions indicated R37 cut off the wander guard and refused to have another one placed and was placed on 15 minute checks. Check room if suspected alcohol.
- A Mood/Behavior care plan initiated on 4/23/14, indicated R37 had a history of alcohol abuse and actively drank at the facility. The care plan noted R37 was sent to detox on 4/23/14, due to being very intoxicated. The goal indicated R37 would like to stop drinking alcohol with an intervention to check room daily for alcohol and check R37 for signs of intoxication.
- An at risk for adverse reaction from medications related to alcohol care plan dated 4/25/14, indicated NP was aware of R37 ' s alcohol, nursing staff to encourage to restrain from using alcohol and if R37 appeared intoxicated it was ok to administer medications. Another intervention dated 5/8/14, included 1:1 supervision due to alcohol abuse and intoxication.

A Vulnerable Adult Assessment dated 3/16/14, indicated R37 had both past and recent substance abuse, was not safe for unsupervised LOA except to appointments and had significant alcohol use when out on unsupervised LOA.

The quarterly Minimum Data Set (MDS) dated 3/18/14, indicated R37 ' s cognitive skills for daily decision making was independent with consistent/reasonable decisions.

Review of the Interagency Transfer Orders dated 4/1/14, included Non-Hospital Problems of alcohol intoxication and alcohol withdrawal noted 9/23/13, and substance abuse noted 2/23/14.

A Care Conference Summary dated 4/1/14, indicated a discharge plan of " discharge to a facility that allows drinking, he declined, has been sober since." The summary indicated R37

had a history of drinking and bringing alcohol in the building or going on unsupervised LOA and R37 had stayed in the building with no alcohol use since 3/3/14.

A Resident Refusal of Medical Treatment Form dated 5/5/14, indicated R37 was " wander guarded [sic]" to the facility for resident safety related to history of alcohol abuse, staggering gait and slurred speech. With the risks of refusing noted as facility wouldn ' t be aware if R37 left with potential for fall risk and injury off facility grounds with no one to provide aid.

A letter dated 5/10/14, indicated a first offense of the facility smoking policy as R37 reported to staff he had gotten cigarettes from R9.

On 5/7/14, at 10:02 a.m. the ombudsman was interviewed and wanted to know if surveyors were aware of residents purchasing alcohol and drugs. Reported she believed residents were giving other residents money and credit cards to go out and purchase things for them. She reported a resident with chemical dependency problems had been drinking, room checks were being completed and staff was finding alcohol bottles. Reported R37 was being found intoxicated and she was involved in discussing abuse prevention planning if intoxicated and the effects of alcohol on R37 ' s medications. She reported the physician was encouraging discharge planning to a facility that allowed drinking. She also indicated a number of residents were accessing illegal drugs at the facility. The ombudsman reported she had been at the facility on 5/6/14, to discuss the concerns.

On 5/7/14, at 10:05 a.m. the administrator stated the ombudsman was called 5/6/14, to speak with the facility regarding R37 giving his credit card to R117 to purchase alcohol and R37 had been " drunk for days."

On 5/8/14, at 11:51 a.m. licensed practical nurse (LPN)-B stated she was aware R37 had a doctor ' s order and can drink as long as there are no behaviors and if behaviors occur she can call detox. LPN- B stated she did not know where R37 got alcohol from.

The safety monitor, nursing assistant (NA)-M was interviewed on 5/8/14, at 11:55 a.m. and stated he has not seen R37 exchange money or alcohol and stated he has heard about exchanges but could not remember who he heard it about.

The HUC was interviewed on 5/8/14, at 12:15 p.m. and stated " it ' s a nightmare; [R37] is drunk every day." She stated she had her suspicions about where the alcohol was coming from but when she asked R37 he refused to tell her. R37 told her he had given his credit card to R117 to buy things for him. The HUC stated R37 was drunk every day when she left and was drunk when she came in on 5/8/14. She reported that on 5/5/14 or 5/6/14, she had observed R37 in the parking lot, was told there was nothing they could do by the facility administrator and requested assistance from the operations director to get R37 back in the building. The HUC reported she had requested the safety monitor to put R37 on every 15 minute checks but knew that was not enough. She stated other residents were on 1:1 for drug use and wanted to know what the facility was going to do to keep R37 safe. The HUC stated " we ' re not doing [R37] any justice " and " it ' s a shitty plan to keep people on 1:1 forever."

On 5/10/14, at 1:30 p.m. the administrator stated R37 had been taken to the hospital for DTs.

Upon interview on 5/12/14, at 8:59 a.m. registered nurse (RN)- B and LPN-A stated R37 had gone to the bank with a friend on 5/10/14, and were not sure if the 1:1 had gone to the bank or not and would have to check.

The director of nursing (DON) was interviewed on 5/12/14, at 9:05 a.m. and stated a "guy named [friend of R1]" who is a friend of R1 went with R37 to the bank. The DON stated both the administrator and the consultant administrator were aware that other-J was a friend of R1. The DON stated the 1:1 refused to go to the bank with R37 and other-J signed R37 out. The consultant administrator was going to go with R37 and other-J to the bank until it was decided the facility was not comfortable with her going with to the bank either. The DON stated he reminded R37 he could not go because he had orders for no LOA and the administrator, consultant administrator and the social worker decided R37 could go anyway. The DON stated he had no idea where R37 had gotten methadone from.

When interviewed on 5/12/14, at 1:35 p.m. SW-A stated during a room search a quart bottle of alcohol had been found in R37 ' s room and 3 plastic containers with the labels removed which nursing indicated were methadone containers.

When interviewed on 5/12/14, at 1:52 p.m. the administrator stated he and social worker (SW)-A were involved in R37 ' s LOA. The administrator stated SW-A was under the impression R37 was allowed to go on LOA and R37 returned with a card from Walgreens so they knew he hadn ' t followed his agreement to only go to the bank. The administrator stated other-J would not be able to take R37 on LOA again. The administrator stated he was not aware R37 had orders for no LOAs and he believed SW-A and had not checked the chart. The administrator stated he was also not aware of other-J's relationship with R1 and the Don had not told him about the order for no LOA and other-J's relationship with R1.

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When interviewed on 5/13/14, at 2:20 p.m. the administrator was asked about the discrepancy between what the DON reported had happened on 5/10/14 and what the administrator stated had happened and he verified he was not aware R37 had an order for no LOAs.

Although R129 was identified by the facility to require a staff member to be assigned to follow/accompany R129 one to one (1:1, to be within arms length at all times); R129 reported to the facility she obtained and consumed cocaine on 5/3/14. R129 obtained and consumed

alcohol on 5/11/13, at 4:00 a.m. causing her to require hospitalization in the intensive care unit (ICU) and intubation (mechanical ventilator assisted breathing) for a blood alcohol level of .323.

The admission Minimum Data Set (MDS) dated 2/1/14, indicated R129 had a Brief Interview of Mental Status (BIMS, a tool to determine potential cognitive losses) score of 15, indicating R129 was cognitively intact. The MDS identified R129 was Independent with all activities of daily living (ADLs). The MDS identified R129 rejected cares and wandered 1-3 days during the assessment period. R129's Care Area Assessment (CAA) for mood state dated 2/7/14, identified R129 had poor judgement, impaired cognition and poor decision making and had diagnosis of "substance induced psychotic disorder, opiate dependence, and alcohol dependence." The CAA identified further diagnoses of hepatitis C, "Hx [history] of drug alcohol use" and depression. R129 was identified to be independent with activities of daily living (ADLs). Although the CAAs identified R129 had a history of drug and alcohol dependence, the CAAs lacked documentation of interventions to promote sobriety while in the facility, such as but not limited to offering chemical dependency (CD) treatment.

The Vulnerable Adult Assessment dated 3/18/14, identified R129 had a history of alcohol abuse and identified R129 had, "Ongoing drug-seeking & over medication with additional Rx [prescriptions]." R129 was identified as being susceptible to abuse "r/t [related to] substance use, varies" and required supervision with LOA (leave of absence) from the facility. The assessment identified R129 had a behavior and history of rummaging through others belongings and "drug use." The assessment indicated R129 was placed on 1:1 due to rummaging in other resident rooms.

R129's Smoking Evaluation dated 3/18/14, identified to "monitor for ETOH [alcohol] use or oversedation." The North Memorial Medical Center lab report indicated a Drug Screen was completed, identified the use of Morphine, Oxycodone, effexor, Soma, Tylenol, desmethylvenlafaxine. The clinical record lacked documented verbiage regarding the circumstances of the drug screen.

The Pain Evaluation and Management Plan dated 5/1/14, identified R129 had chronic pain daily, identified a history of pain and drug seeking. "Resident is on a restricted recipient program due to drug seeking [a program where only one pharmacy may fill the prescriptions for narcotics, a program to potentially deter drug seeking behaviors]." The evaluation identified R129 had a history of "drug seeking" and indicated, "MD is aware of drug seeking behaviors and aware pain is not controlled. MD will not order any more pain medications for resident due to her drug seeking behaviors. Resident is on the restricted recipient program due to drug seeking."

A Incident/Accident Report dated 5/3/14, at 11:00 p.m. indicated R129 "told the nurse that she took cocaine earlier during the shift." The note identified R129 to be "very sweaty, weak and tired" and "she looked very sleepy." The resident's pupils were "large and nonreactive to light." The note indicated the nurse asked R129 what she took and indicated R129 then "confessed" to taking cocaine. The report documentation indicated R129 was sent to the emergency room (ER), identified, "She said, 'I knowingly took cocaine'" and, "Resident has been sent to ER [emergency room]. She will continue to be on 1:1 when she returns to the nursing home." The report identified R129 had a history of drug use, "resident is on a 1:1,"

"remains on a 1:1," and "Hx [history] drug seeking, receiving drugs from others." Although the incident occurred on 5/3/14, the form was signed by the director of nursing (DON) on 5/5/14.

An Emergency Department Chart [a form from the ER] dated 5/3/14, identified R129 reported to have taken cocaine at the facility. The note indicated R129 took the cocaine to "help with the pain" in her abdomen. "Patient [R129] is triaged directly back to ED [emergency department or ER]." The Clinician History of Present Illness section of the form identified R129 reported to hospital staff she snorted cocaine "5 hours ago." Although R129 was identified to go to the ER for a potential drug overdose, the Emergency Department Chart did not address the cocaine use and only addressed R129's pain. The labs indicated various pertinent laboratory values were checked by the ER, but lacked a toxicity screening for cocaine, drug or alcohol use. R129 was given two doses of dilaudid (a narcotic pain medication) and returned to the facility at 6:00 a.m. with no new orders. The clinical record lacked evidence the administrator, or the State agency were notified of the incident. The clinical record lacked evidence of new interventions to address R129's report of drug use, such as CD treatment. In addition, the clinical record lacked evidence the use of cocaine by R129 was investigated to determine how the drug may have been obtained while the resident had a staff assigned to her 1:1.

A unlabeled typed page insert immediately in the front of R129's paper chart dated 4/15/14, indicated, "If Res [resident] goes to the Hospital for any reason she is to go to St. Joes [sic] Hospital Only per primary care MD [medical doctor] and the MN [Minnesota] restricted recipient program" and further directed "all scripts [prescriptions] no matter where they come from must be approved by [MD's name] or their oncall MD."

On 5/7/14, at 10:24 a.m. the ombudsman was contacted via telephone per an emailed request to be contacted by the surveyor. The ombudsman stated she had been informed by a nurse of the facility of "drug use" and "drugs shared with residents" at the facility "a couple days ago." The ombudsman stated rather than call the nurse back, she came to the facility "yesterday [5/6/14]," had spoken with various residents of the facility and communicated with the facility's management regarding drug, alcohol and discharge planning concerns. The ombudsman stated residents, facility staff and the ombudsman were "suspicious residents may be giving money or credit cards to another [resident] to go out and purchase things [alcohol and drugs] for them." The ombudsman stated the police had been notified and been to the facility "quite often." The ombudsman stated there were problems with residents who were chemically dependent, who were drinking in their rooms and facility staff were conducting room checks per shift and "finding empty alcohol [vodka] bottles" in resident rooms. The ombudsman stated residents had been found by facility staff to be "intoxicated" in the facility. The ombudsman specifically stated R129 was on a 1:1 and had "somehow" obtained and consumed and "illegal drug [cocaine]" in the facility. The ombudsman stated although the facility had employed "three temporary social workers," the ombudsman stated she felt "social services is overwhelmed" due to "no policies and procedures in place."

R129's care plan for safety/vulnerability dated 3/25/14, identified R129 was able to make her needs known, but was vulnerable due to her history of opioid abuse and drug seeking behavior. A care plan intervention dated as initiated 4/11/14, directed R129 required "1:1 supervision at all times to keep Gail safe and prevent drug use" Additionally, the care plan directed, "1:1 to discuss CD concerns, encourage [R129] to consider going to a treatment

facility." The care plan for mood/behavior dated 3/25/14, identified, "I have a history of opioid abuse and I exhibit drug seeking behavior as evidenced by attempting to see several different MD's to obtain prescription medication. I have a history of walking into other residents rooms and looking thru their personal belongings."

Review of the undated Group 7 nursing assistant (NA) assignment sheets (forms carried by the NA staff for quick reference direction on the resident care plan) indicated R129 was continent, independent with ADLs and "1:1" in larger bold print.

Nursing Progress Notes:
- On 3/14/14, at 6:18 p.m. a note indicated R129 "had an appointment yesterday and was immediately transferred to the hospital." The note indicated "while on the way home [unclear on prior destination]" R129 "stopped at Cub foods" and picked up a prescription for eight tablets of Norco 5/325 milligrams [a narcotic and Tylenol pain medication]. The note indicated R129 "failed to alert staff and stated that there were no new orders." The hospital, oncall MD and triage nurse were called and updated on R129's "history of narcotic use."
- On 3/16/14, at 6:34 a.m. a note indicated R129 was "caught going through another resident's belonging." The note indicated a resident observed R129 "opening her purse. The note indicated R129 admitted going in the room but denied taking "any money."
- On 3/17/14, at 3:34 p.m. a note indicated, "Resident still remains on 1:1 observation." Although the note identified R129 was assigned a 1:1 staff, the clinical record lacked documentation regarding starting 1:1 with the resident. At 10:17 p.m. a note indicated R129 "called on call [physician]," reported two incontinent episodes, her "lower extremities [sic] hurts" and edema. Staff encourage R129 to "sit and rest the leg" but R129 refused and stated the pain became "unbearable." R129 stated she wanted to go to the ER for evaluation and "called 911 herself." Although a previous note indicated R129 required a 1:1, the note indicated R129 would "take care of her own transportation to ER" and "left the facility" at 10:20 p.m. The note did not indicate if a staff person accompanied R129 to the appointment.
- On 3/18/14, at 3:56 a.m. a note indicated R129 returned from the ER at 3:30 a.m. with "new order. No new concern at this time." At 2:31 a.m. a note indicated R129 reported to the business office manager she felt "depressed due to being on a 1:1." The concern was reported to social services and the nurse on duty.
- On 3/20/14, at 10:08 a.m. the physician identified by R129 as her new primary care physician (PCP) was contacted regarding R129 living in a health care facility, that orders must be coordinated with the nursing home, gave update regarding R129 changing her PCP, trips to the ER and "drug seeking beh's [behaviors]." The note further indicated, "Transport informed to bring pt [patient] to/from the clinic and no other stops to include the pharmacy." At 2:45 p.m. R129 "went for her appointment to her care provider today. At the appointment, resident was given script for Ambien (a hypnotic medication used to promote sleep). Resident said she filled the prescriptions at the pharmacy but she misplaced the pills. patient [sic] will be monitored for increased sedation." Although the previous note indicated the transportation company was notified of restrictions in R129's transport, the note identified R129 was still brought to the pharmacy. At 3:11 p.m. a note indicated R129 reported she "lost" the Ambien. The note indicated the "escort" assigned to go with R129 to the appointment, reported R129 "went to the pharmacy and filled her script." The escort reported R129 would not allow the staff to "see the script" or the filled prescription. "Per the escort [R129] went to the bathroom. On the ride home [R129] reported that she lost the bottle of pills. Upon return she reported that same story to this writer and requested that staff get a new script." The physician was

contacted and verified a prescription for Ambien and R129 loosing the medication was reported. The physician denied taking R129 on as a PCP and referred the facility to R129's current PCP.
- On 3/28/14, at 11:52 a.m. a note indicated R129 met with social services and "Also spoke with resident regarding her drug seeking. She [R129] admits that she is addicted to pain medication." The note indicated R129 was scheduled to see psychologist and encouraged R129 to discuss her concerns and her "addiction."
- On 4/4/14, at 7:11 p.m. a note indicated R129 met with psychologist. The note indicated R129 met with DON and social worker after the appointment. The note indicated R129 "does not like being on 1:1's" and the DON "informed her [R129] she was on 1:1's because of her frequent drug seeking." The note indicated R129 "admits that she has urges to seek medications to manager her pain" but "denies addiction." The note indicated "inpatient treatment" was discussed, such as drug and emotional counseling, R129 rejected the treatment. The note indicated the psychologist agreed with the need for treatment and "However, should resident continue to display behaviors of drug seeking and declines treatment a CD commitment maybe considered to be in her best interest."
- On 4/7/14, at 10:47 a.m. the note identified R129 remained on 1:1 and R129 had requested to be taken off 1:1's. The note indicated R129 was on 1:1 "for going into other resident rooms."
- On 5/4/2014 12:03 a.m. a note indicated R129 "told the nurse that she took cocaine earlier during this shift." The note recapitulated the data from the incident report dated 5/3/14. The note further indicated, "The nurse asked the resident what she had taken and where she got it from or [who] gave it to her. She took the nurse to [room number for R1]. She also report that the package that resident in room [R14's room] swallowed earlier was marijuana." R129 accepted to to to the ER for evaluation. "The nurse requested for toxicology screen and that a copy should be send [sic] to the nursing home per the administrator order." Although the note indicated R129 obtained cocaine from another resident and identified R129 involvement with a second resident and a different illegal drug, the clinical record lacked evidence law enforcement was notified, the clinical record lacked evidence a toxicology screen was obtained. Although R129 was identified to have a 1:1 assigned to follow her, the clinical record lacked evidence the incident of R129 obtaining and ingesting illegal drugs was identified, reported to the administrator immediately, reported to the State agency or investigated. In addition, the clinical record lacked evidence R129 was further evaluated for chemical dependency, had immediate changes or increases in monitoring to ensure her supervision and safety. At 7:23 a.m. a corporate nurse documented R129 approached the nurse and R129 "admitted to writer that she took drugs given to her by another resident in this building. She was able to verbalize insight related to why she regretted this choice." The note indicated R129 "remains on 1:1. 1:1 was present during this conversation." The clinical record lacked evidence 1:1 monitoring of R129 was reviewed after being identified to have accessed illegal drugs twice while on 1:1 monitoring.
- On 5/4/13, at 12:12 p.m. a note indicated an attempt was made to notify R129's doctor regarding the incident from 5/3/14. The operator at the doctor's office informed writer that they are only accepting on-call emergencies. Staff will notify doctor in the morning of 5/5/14. Resident was returned from the hospital at 6:00 a.m. with no new orders. Although R129 had two doses of dilaudid administered at the ER, R129 immediately requested pain medication upon return to the facility [the note was not closed or signed by the writer].

On 5/5/14, during the initial tour of the facility NA-K was observed to be sitting in a chair

directly outside R129's room, the door was open and R129 was observed to be lying in bed, fully dressed with her eyes closed. NA-K stated she was assigned to be a 1:1 for R129. NA-K stated she needed to remain with R129 and the 1:1 was due to R129 going into "other resident rooms."

On 5/6/14, at 8:30 a.m. R129 was observed to have NA-M (1:1 staff) follow her down the hallway and out to the smoking patio. R129 retrieved a cigarette from her front pocket, lit the cigarette and replaced the lighter in the side pocket (right). NA-M stood on the side walk outside the designated smoking area with a large cinder landscape block planter between R129 and NA-M. NA-M remained out of arms length from R129 and was observed to talk with the female staff monitoring the smoking area, looking away from R129. R129 stood with other residents and smoked her cigarette out of direct sight of NA-M.
- At 8:33 a.m. R129 sat on a bench with another female resident on the other side of the smoking patio and out of sight of NA-M. NA-M stood on the edge of the cinder landscape block planter edge and chatted across the smoking area to the same female staff in the smoking area. NA-M was not near enough to R129 to interfere if concern.
- At 8:37 a.m. staff spoke to each other and then NA-M turned his back on smokers (including R129) and spoke to a male in a car in the parking lot. NA-M then jumped down and entered the smoking area to speak to the female staff directly. NA-M was not within arms length or direct eye sight of R129.
- At 8:38 a.m. R129 stood up and walked to the front entrance of the facility. NA-M jumped to catch up with R129 and followed directly behind into the facility. R129 then pushed the wheelchair of a male resident entering the building and walked rapidly down the hallway.
- At 9:34 a.m. R129 was observed to push R62 in her wheelchair out of the facility and to the smoking patio. While pushing R62, R62 held out a cigarette and R129 took it out of R129's hand and tucked it into her own hand, concealing the cigarette. NA-M followed behind R129 and did not appear to notice or intervene when R129 took the cigarette. NA-M immediately turned his back to R129 once on the smoking patio, applied a surgical mask and talked to the female staff assigned to monitor the smoking patio. Both staff had their backs to R129.
- At 9:35 a.m. the female staff pushed R22 back into the facility and pulled the smoking cart behind her. NA-M remained outside with R129 near the smoking patio watching a van in the parking area. NA-M had his back to R129 and was approximately 14 feet away from R129. Multiple other residents were observed to come and go from the smoking patio. R129 interacted freely with the other residents unsupervised.
- At 9:37 a.m. R117 was observed to come out of the facility, light his cigarette at the front entrance, jump up onto the cinder landscape block planter with ease, and walk across the top of the planters with a skipping gait. Neither the smoking monitor and another female staff in the area did not intervene. R117 was observed to speak briefly with the female smoking monitor, approach R36, pull out a large wad of cash and exchanged money with R36. R117 then went to R129 and R62. R117 remained with both residents smoking and talking. R129 sat on the edge of the cinder landscape block planter, NA-M was not within arms reach of R129, was not within eye site of R129 and was not supervising R129. NA-M remained with the other female staff, back to R129.
- At 9:40 a.m. R129 stood and pushed R62's wheelchair towards the front entrance of the facility. Although NA-M followed, NA-M did not come into arms reach of R129 until the front door of the facility. R129 was observed to push the wheelchair down the hallway with NA-M walking beside (to the left) of R129.
- At 10:19 a.m. R120 was observed to walk out of the facility and onto the designated

smoking area. NA-M followed approximately ten feet behind outside, then stood on the sidewalk. NA-M then left the area and returned into the facility. R129 retried a cigarette from a pack. Multiple residents were observed to be coming out to smoke. The smoking monitor was on the patio but did not watch R129. R129 sat on planter side and spoke with R14.
- At 10:23 a.m. NA-M returned to the smoking area from inside and immediately stood on sidewalk on other side of planter approximately 20 feet away from R129. NA-M made no attempt to make contact with R129, was not in arms reach of R129 and did not make eye contact with R129. NA-M spoke with the smoking monitor.
- At 10:25 a.m. NA-M and R129 returned to the facility. NA-M walked to the left of R129 and within arms reach of R129 upon entering the building. Once in the building, NA-M remained in arms length while walking down the hallway towards the nursing desk.

On 5/8/14, at 11:22 a.m. R129 was observed to be laying in bed, NA-E was observed to be making the roommate's bed. NA-E verified she was assigned to be the 1:1 with R129. NA-E offered to stand outside the door while R129 was interviewed and the door to the room was closed. R129 stated she was waiting for an apartment and verified she "snorted cocaine" on 5/3/14, and verified she reported it to facility staff. When asked when this occurred, R129 stated it was "on Saturday [5/3/14]." When asked where she snorted the cocaine, R129 stated "not in the facility," and explained she received and snorted the cocaine "down the block." When asked if she received the cocaine from a resident (as indicated in the clinical record), R129 stated "someone from the street" gave it to her, but denied being able to remember their name, description, or gender. When asked how much cocaine she snorted, R129 stated "about $20 worth." When asked what happened after she reported the cocaine use to the facility, R129 stated, "They sent me to the hospital." and then stated, "They [facility staff] accused me of giving it to someone else." R129 explained she was accused of giving R14 cocaine on the same day. R129 stated the staff who accused her was the 1:1 staff assigned to her at the time. R129 stated the 1:1's name (NA-G) and explained the one to one was assigned to be with her at all times. When asked why she had a 1:1 assigned to her, R129 stated it was because she was accused of "rummaging" in other residents rooms and stated the 1:1 was assigned to be with her "since March." When asked where the 1:1 was when she received the cocaine from the person on the street, R129 shrugged looked up and away and stated, "I don't know. She wasn't with me." R129 verified she was "a recovering addict." When asked after snorting the cocaine, if the facility assisted her with rehabilitation or psychiatric services, R129 denied social services were offered including assistance with drug and alcohol treatment. R129 stated she would like to go to outpatient rehabilitation for drug addiction. R129 further added she was "not checked" for cocaine use at the emergency room of the hospital and stated the emergency room gave her two shots of dilaudid. R129 explained she "thought" that was going to happen, but she was "surprised" to have received doses of dilaudid. R129 appeared relaxed, but uncomfortable during the interview and was hesitant to answer questions and would not make eye contact.

On 5/8/14, at 11:30 p.m. NA-G verified their 1:1 responsibility was to remain at arms length with R129 at all times.

On 5/8/14, at 11:41 a.m. NA-J verified she worked on R129's unit and stated she was not aware of alcohol or drugs being exchanged on "my shift," but stated she was aware of situation "weeks ago" when she came to work, she noticed R14 was not in his room. NA stated she asked where he was and a nurses aide "who was R129's 1:1" saw R129 go into

R14's room and "exchange something." She stated she learned R14 was sent to the hospital for "eating something." Stated she had not witnessed any exchanges and stated if she saw any she'd report to the nurse.

On 5/8/14, at 11:40 a.m. NA-S stated the had seen alcohol bottles in residents' rooms and smelled alcohol on another resident and reported it to a nurse. NA-S was unclear when. NA-S stated they "Heard rumor" of a resident dealing drugs in the facility. NA-S further recalled seeing a resident with marijuana in January or February. NA-S stated she "could smell it." NA-S further stated when she was assigned to be the smoking monitor, she heard residents talk about it. NA-S stated they believed R117 was a dealer. When asked why, NA-S stated R117 left the facility "a lot" and went to the gas station. NA-S further stated she believed R117 was talking money from residents to also "buy cigarettes." NA-S stated she was unclear what happened to the resident after she reported the marijuana, but stated the nurse was "agency" and told her the resident "could have it."
On 5/8/14, at 11:55 a.m.. a housekeeper (H)-A was asked if they were aware of any residents drinking alcohol in the facility. H-A stated they had seen "empty pint bottles [vodka]" in the trash "by front doors." When asked the last time she found vodka bottles in the front trash, H-A stated, "A few months ago." H-A stated they would report any alcohol bottles found in the facility "and has." H-A was unclear which resident was drinking, but believed the pint bottles were placed in the front trash so they "wouldn't get caught." When asked if H-A knew where the alcohol bottles came from, H-A stated she was unclear, but thought they may have been provided by family.
On 5/8/14, at 12:03 p.m. LPN-H stated she confiscated alcohol from R37. LPN-H verified alcohol was provided to R37 and suspected to other residents of the facility, but was unclear how the alcohol was provided to the resident. LPN-H verified R129 was on 1:1 and 1:1 should remain in arms reach of the resident. LPN-H was unaware R129 had obtained cocaine in the facility.
On 5/8/14, at 12:10 p.m. the health unit coordinator (HUC) stated she was aware of resident drug and alcohol use in the facility. HUC stated there was "always hearsay between residents they're selling [drugs and alcohol] to each other" included hearsay stories regarding heroin and cocaine "it's always stories." HUC stated she has put "a lot of time in" reporting to hospitals, clinics and ER if a resident was a "drug seeker" and on restrictive recipient program. HUC stated R129 was going to ER, calling herself and getting Ambien, oxycodone and "is happy after." HUC stated R129 "refuses to tell them the script." HUC stated she "goes to the social worker to report" these concerns and when R129 denied she had pills, "but I know she did get them." HUC stated "every week" R129 had picking a new doctor, stated R129 was not giving paperwork to physicians or altering the paperwork. HUC verified she was aware of residents consuming alcohol in the facility, verified she was aware of residents becoming intoxicated, but was unclear where the alcohol was coming from. "I feel like we're supposed to do something, 'cuz no one will take charge." HUC verified she was aware of R129 obtaining cocaine and going to the ER. Stated she was not clear if there was a toxicology screen, but stated she had asked for them in the past. HUC stated she and other facility staff believed R129's "son" (HUC made quoting gesture with both hands) was also R129's dealer and described him as a native man who R129 called her son, was at the facility at the time R129 snorted cocaine.

On 5/8/14, at 3:59 p.m. NA-F stated they were scheduled as the safety monitor in the facility. NA-F stated they were aware of a resident "caught with several bottles of vodka" in their room

but denied knowing about drug use amongst residents in the facility. NA-F stated they would report any suspected drug and alcohol use to a supervisor or the charge nurse. NA-F verified R129 was assigned a 1:1 and the staff should remain in arms reach of R129.

Further review of the nursing progress notes indicated the following:
- On 5/9/14, at 7:31 p.m. the pharmacy was contacted regarding R129's Percocet (a narcotic pain medication) refills and determined R129's prescription had 110 Percocet tablets delivered and outlined the delivery dates and the amounts provided. The note indicated R129 was informed of the information.
- On 5/11/14, at 10:09 a.m. a note written by the health unit coordinator (HUC) indicated North Memorial Medical Center (NMMC) called the facility "requesting" R129's medication administration records (MARs). The note indicated the registered nurse (RN) from the hospital notified HUC R129 had been admitted to the ICU, had been intubated "due to acute alcohol intoxication." The note indicated R129's toxicology screen was "negative for drugs but positive for alcohol with a level of .323." Although R129 had a staff person assigned as 1:1, R129 obtained and ingested enough alcohol to be life threatening. Although the note identified the administrator was updated, the clinical record lacked evidence the State agency was immediately notified of the incident. The clinical record lacked documentation at the time of the incident, lacked pertinent assessment information such as vital signs at the time, descriptions of R129's symptoms, immediate determination of how, when or where R129 obtained the alcohol and/or if the assigned 1:1 was interviewed at the time.
- On 5/11/14, at 10:55 a.m. a note written by the DON, recapitulated R129 was sent to the hospital, identified the time of transport as "around 4 am" on the night shift, and identified R129 was sent in "for intoxication." DON's note indicated R129 had "become weak" and needed to be lowered to the floor." The note indicated two licensed practical nurses (LPNs) were contacted and the NA staff assigned to the 1:1 was called. The note indicated the NA assigned to R129 "reported that resident has been in and out of [R14's room number] but did not notice any exchange of alcohol. She also reported that resident [R14] was upset because the 1:1 has to be in his room too while resident is visiting..." The note indicated R14 denied giving R129 alcohol, but "mentioned that resident had alcohol overnight." R14 denied knowledge of where R129 could have obtained her alcohol.
- On 5/11/14, at 2:49 p.m. a note written by DON indicated NMMH was contacted to receive updates on R129's status. The note indicated, "I also requested to have the resident undergo a chemical dependency assessment to ensure that the resident can be transferred to a residential chemical dependency facility as appropriate, considering the resident's recent hospital trip to the hospital for snorting cocaine."
- On 5/12/14, at 12:07 a.m. a late entry note (no indication for the date or time the late entry was for) indicated an NA staff "report to this writer that resident was in the bathroom longer than usual, came out and appeared drowsy, unsteady gait" and identified R129 was at risk for falling, was verbally aggressive to staff and R129 stated, "I'm drunk." The note indicated the room was checked and no evidence of alcohol was found. The note indicated R129 "threw herself to the floor" and was sent to the ER at 4:00 a.m.

On 5/12/14, at 10:26 a.m. DON verified had not read the plan of correction from the previous survey and and did not know what the plan was. Verified was not aware of policy, system or facility changes made as a result of the survey. DON reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. DON stated he read the online public survey results for the facility from 2013 and stated he was not

given an accurate picture of the facility problems. DON stated there was "no system for monitoring staff to ensure facility policies were followed."
- Was asked regarding R129 obtaining alcohol or drugs while on a 1:1, DON verified the information was not documented in the clinical record. DON stated it was "because the LPN did not have access to document" and explained it was because she was "gone for a longer time." DON was unclear when the documentation was going to be completed, or why the LPN did not have access to computer documentation. DON verified the 1:1 should have been in arms length of R129 at all times. After surveyor explained observations of the 1:1 14-20 feet away from R129 outside the facility, DON stated the staff assigned to the 1:1 on 5/6/14, was "not compliant" with facility policy. DON was unclear on when to report to the administrator and stated he "believed it was within 24 hours," DON was unclear when to report to the State agency and verified he had not documented the investigation. When asked if DON had determined if R129 may have been neglected, having obtained both cocaine and alcohol while being assigned to be supervised by a facility staff person 1:1, DON stated he was concerned regarding the "safety component" and was not aware R129 was neglected. DON further stated he was "unaware how" R129 could have been neglected. DON was unclear how the resident obtained alcohol, but verified R129 was harmed by the incident.

On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B both verified upon hire to the facility, they had been working on "re-writing care plans and discharge planning." SW-A stated there was a third social worker who no longer came to the facility and a part time social worker on evening who was "reducing her hours to once a week." Both verified they had not specifically worked with R129 for chemical dependency (CD) treatment and verified was last noted to be offered to R129 on 4/4/14. Both verified they should have revisited CD treatment options after R129 reported cocaine use on 5/3/14. Both verified they did not know R129 was hospitalized for alcohol toxicity and expressed they "should have been notified." Both stated they were not in the facility over the past few days due to the facility not paying their company's bill. SW-B stated she was concerned for the residents of the facility and verified R129 should have been reassessed after obtaining cocaine. Both verified R129 was harmed. At 2:43 p.m. CLSW-A stated, " I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and guess what, there was no nursing notes. I went outside to the desk and told the administrator and DON to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1. For me 1:1 means the person needs to be somewhere else not at the nursing home. "

The Special Staffing - One to One Assignment policy dated as reviewed 5/2013, indicate 1:1 staffing may be assigned "under special circumstances," must be prior authorized by the Director of Clinical Services (DCS) and "One to One staffing assignments are not permanent but rather in place based on assessed need until appropriate permanent alternative arrangements can be made." The reasons identified for the 1:1 staffing included threat of suicide, altered mentation that may "dislodge treatment lines and devices," escalating exit seeking behavior, altered cognition in an agitated state that "is not easily redirected" and "does not respect boundaries of other residents." The procedure directed to assess the resident, DON and administrator to agree 1:1 was necessary and consult DCS; instruct staff assigned to 1:1 the purpose of assignment, and directed to keep resident at "arm's length at all times." The procedure indicated if resident was not suicidal, privacy with toileting could be

provided. The procedure directed to document the 1:1 assignment in the clinical record and revise the care plan.

On 5/5/14, and 5/6/14, R13 was observed to be allowed to leave the facility unescorted to smoke in the designated smoking area. Although R13 had a wanderguard applied, the wanderguard alarm was disabled when R13 left the building. On 5/6/14, at 4:45 p.m. R13 was observed to have eloped from the facility and was observed on the city sidewalk by the surveyor.

Upon arrival to the facility on 5/5/14, at 1:35 p.m. R13 was observed to be out on the designated smoking area with four other residents and two facility staff. R13 was observed to be in a wheelchair with a half laptray on the left side of the wheelchair. R13 was observed to be smoking a cigarette independently.

On 5/6/14, at 8:30 a.m. R13 was observed to wheel independently to the front door. A chirping sound was heard and R13 was observed to exit the facility and wheel herself backwards to the smoking patio. No staff escorted her. Seven residents were observed to be in the designated smoking area. R13 wheeled to the table under the arbor, was assisted to light a cigarette by the smoking monitor and smoked independently.
- At 8:33 a.m. R13 remained on the smoking patio with four other residents smoking.
- At 8:46 a.m. R13 extinguished her cigarette appropriately and wheeled herself back into the facility. A loud beeping noise was heard as R13 entered the facility. The sound was immediately silenced to a slight chirping sound. R13 wheeled into the facility and down the hallway. No staff escorted her.
- At approximately 11:00 a.m. R13 was randomly observed to smoking in the designated smoking area, a male staff was observed to be monitoring the smokers. R13 was observed to complete smoking her cigarette at approximately 11:20 a.m. and wheel herself into the facility unescorted. The smoking monitor did not assist. A quiet chirping noise was heard as R13 entered the building.
-At 4:45 p.m. R13 was observed by the surveyor to be at the end of the driveway in her wheelchair wheeling with her feet towards the 49th Avenue North. R13 turned left upon reaching the sidewalk and began wheeling herself with difficulty towards 6th street. After a few feet, R13 mad a U-turn and began pushing herself backwards down the sidewalk. The street was observed to be busy with multiple cars driving rapidly 30+ miles per hour (MPH). The smoking monitor was observed to be behind a pillar with his back to the street and R13.
- At 4:46 p.m. the front desk monitor (O)-C was notified by the surveyor of R13 observed on the city sidewalk. O-C verified R13 "could not" be on the sidewalk near the street unsupervised and immediately ran outside to R13. When O-C reached the resident, R13 was approximately 20 feet past the end of the driveway and half way to 6th street, wheeling backwards facing oncoming traffic. O-C was observed to speak with R13 and after several minutes, wheeled her back into the facility. O-C could be heard to tell the smoking monitor to watch for residents eloping. O-C returned R13 to the facility.

R13's Diagnosis Report dated 2/4/09, indicated diagnoses to include hemiplegia affecting the dominant side, depressive disorder and cognitive deficits due to cerebrovascular disease.

The Vulnerable Adult Assessment dated 6/24/13, identified R13 had history of wandering into other residents rooms, history of unsafe smoking and taking other peoples belongings. The

assessment identified R13 had cognitive deficits, short-term memory loss, impaired decision making and poor judgement. In addition, R13 was identified to require supervised LOAs (Leave of Absences) only and identified R13 had a past history of drug abuse.

LOA Safety Assessment dated 6/24/13, identified R13 had cognitive impairments related to dementia, and resident was unable to leave the facility unsupervised.

A Camden Care Center Care Conference form dated 10/1/13, indicated, "[R13] propels herself independently in a wheelchair to all destinations within the building - at times she will propel herself backwards and needs frequent reminders to not do this. She has a history of wandering from the facility and thus wears a wanderguard to alert staff if she attempts to leave the building. She also has a history of wandering into other resident rooms and taking their belongings, which can cause other residents to become frustrated with her so she needs frequent redirection."

The Nursing Assessment Packet Review for the reference period 3/19 - 3/25/14, included a safety Risk (Fall) Assessment dated 3/19/14. The assessments did not address or review the need for a wanderguard.

R13's quarterly Minimum Data Set (MDS) dated 3/25/14, indicated R13 was cognitively intact, was identified to have no behavior problems, and required extensive assistance with activities of daily living (ADLs).

A Care Conference summary dated 4/10/14, and another Care Conference form (undated) did not address R13's use of a wanderguard or elopement risk.

R13's Physician's Order Sheet dated 4/16/14, directed to check R13's wanderguard every shift beginning 9/19/13.

The Behavior Monitoring Documentation form (undated) identified R13's target behavior was, "Wandering into other resident rooms" and indicated appropriate interventions such as assist resident to attend activities, assist resident to the bathroom if needed, anticipate needs, visit with resident if she needs help. Dated as reviewed last on 4/23 (no year).

R13's Vulnerable Adult care plan dated 4/28/14, identified she had a history of elopement. The goal identified R13 would remain safe at Camden Care Center. An intervention dated 10/7/11, indicated, "Wanderguard in place." An intervention dated as initiated 3/16/12, directed, "Resident has been assessed and may not leave this facility without supervision.

An undated Group 5 assignment sheet (a form carried by nursing assistant staff for quick reference to care plan needs) identified R13 had a wanderguard.

The clinical record lacked evidence R13's elopement was documented, including dated, time, location, and those involved. The clinical record lacked evidence R13 was evaluated for elopement risk after being found to elope, or R13's physician was notified at the time of the incident. The clinical record lacked evidence the administrator or State agency were notified of the incident. In addition, the clinical record lacked evidence the elopement was thoroughly investigated, including interview with staff present at the time of the elopement.

A nursing progress note for R13 written by administration on 5/8/14, at 9:04 a.m., "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk, redirected back into the facility. Resident has her WanderGuard on. Receptionist [O-C] reported that the she reminded the resident that resident cannot leave the facility unsupervised, receptionist was educated that when residents with WanderGuard would like to get out of the building to smoke, the smoke monitor should be alerted. Son and daughter notified. Message left to NPs [nurse practitioner] voicemail to update on resident. Although the note indicated a message was left for NP, the NP was not called until four days after the incident.

On 5/8/14, at 12:44 p.m. the administrator stated he was notified of the elopement on Tuesday "the next morning" but was unclear why it was not reported to him until then.

The State agency form dated 5/8/14 (no time documented of report), indicated, "Report received that the resident attempted to leave the facility on Tuesday May 6 around 4 pm trying to get to her son, resident was found by the receptionist on the sidewalk."

On 5/9/14, at 11:00 a.m. R13 was observed to wheel herself backwards out of the facility through the front entrance. The wanderguard did not sound. O-C was observed to be at the front desk and was observed to reach to the right. O-C verified she reached to silence the alarm for the wanderguard. R13 was observed to exit the facility without staff and wheel without staff to the designated smoking area.
- At approximately 11:25 a.m. R13 was observed to wheel herself out of the designated smoking area, push the handicapped switch to open both doors and wheel herself backwards into the facility. O-C was observed to silence the wanderguard alarm (reach down to activate switch). R13 wheeled herself backwards down the hallway into the facility. At the time of the observation, O-C stated she disabled the wanderguard alarm for residents who wanted to smoke in the designated smoking area. At not time during the observation, do O-C alert the smoking monitor or staff of R13 leaving the building.

On 5/9/14, at 1:11 p.m. RN-C stated she was in the room when O-C reported R13 had eloped. RN-C stated the announcement was made and RN-C, LPN-E, LPN-A and dietary manager (DM) were present for the announcement. RN-C stated she did not report the concern as it was LPN-A's responsibility and verified R13 was assigned to her unit. RN-C stated LPN-E was not available for interview. RN-C stated if a resident was found to elope, the staff should try to locate the resident; notify the family and physician of the elopement and if the resident was not located to notify law enforcement. RN-C stated an incident report should have been completed. RN-C did not indicate when the administrator or State agency (SA) would be notified. When asked if and when the administrator and SA should be notified for elopement, RN-C stated LPN-A was responsible and she "believed" she may have notified the administrator or SA. RN-C was unclear if this occurred and was unclear when to notify the administrator and SA. Information, including the incident report and notifications, were requested at the time of the interview.

On 5/9/14, at 1:26 p.m. RN-C verified no incident report was completed regarding R13's elopement and provided a copy of the report to the State agency dated 5/8/14. RN-C stated the report was made "48 hours later." RN-C provided a copy of a corresponding nursing

progress note dated 5/8/14. RN-C verified the clinical record did not indicate when the administrator or State agency was notified.

On 5/12/14, at 10:26 a.m. DON stated he was not in the facility at the time of the elopement and he was not informed until 5/8/14. DON explained the incident was not reported to the administrator or SA because he was not at the facility. DON was unclear who was assigned to report in his absence. DON confirmed R13 should not have left the facility unescorted and stated residents with wanderguards were at risk for elopement and leaving the facility without supervision was a safety concern. When asked if staff knowingly allowing a resident with a wanderguard to leave the facility unsupervised was potentially neglect, DON stated he was aware of a "safety component" but was unclear on if this was neglect. DON verified the incident was no thoroughly investigated. In addition, DON verified the details of the incident were not documented in the clinical record and should have been. DON verified R13 should have been evaluated for elopement risk after the incident.

On 5/12/14, at approximately 2:00 p.m. contracted licensed social workers (CLSW)-A and CLSW-B stated they were not informed of R13's elopement on 5/6/14. Both verified they should have been informed so they could assess the resident.

The Videll Healthcare LLC Elopement policy dated as effective 5/2012, identified, "Videll Healthcare LLC facilities shall provide a save environment for resident who are assessed at risk for elopement." The policy defined elopement as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure directed if exit seeking behavior was identified to immediately implement interventions to "manage exit seeking behaviors" such as applying "personal security devices such as WanderGuard..." The procedure to directed to complete a "thorough" investigation of the event, document a factual account of the occurrence in the medical record and to update/complete an elopement risk evaluation. Although the policy included pertinent direction for searching if a resident eloped, the policy did not address risks such as smoking and access to the designated smoking area.

On 5/12/14, at 10:26 a.m. the director of nursing (DON) was interviewed, verified had not read the plan of correction and did not know what the plan was. DON verified he was not aware of changes made and reiterated he was "waiting for this [the survey]" to "blow over" and then he had plans to work on "problems" in the facility. Stated he read the survey results from 2013 and stated he was not given an accurate picture of the facility problems. Verified there was no system for monitoring staff to ensure facility policies were followed.

The facility failed to provide supervision to prevent ingestion of alcoholic substances, which resulted in actual harm to R41 on 5/1/14. While intoxicated the resident drove his motorized wheelchair (w/c) off the curb, fell over, sustained injury to his right forehead and right arm. R41 was hospitalized with low blood pressure, low magnesium and low potassium.

R41 was observed to sun himself in the facility driveway, outside of the front door and toward the public sidewalk on 5/5 at 2:09 p.m. and 5/6 at 10:46 a.m., 5/7 at 10:45 a.m., 5/8 at 2:15 p.m , 5/9 at 3:00 p.m., 5/10 at 2:30 p.m. , 5/12 at 2:00 p.m., and 5/13/14 at 3:35 p.m.. On 5/11/14 at 11:15 a.m., R41 was observed to sun himself on the smoking patio. All observations were unsupervised.

R41 was admitted to the facility per the Admission Record dated 2/4/14, from another long term care facility. R41 had a history of bipolar disorder (a mood disorder with manic and depressed phases), schizophrenia and polyneuropathy in diabetes (nerve damage usually in the feet and legs that can create sensory, motor and bodily function problems).

The admission Minimum Data Set (MDS) dated 2/17/14, indicated R41 had a Brief Interview for Mental Status (BIMS) score of 15/15, which indicated no cognitive impairment. A Patient Health Questionnaire (PHQ9 - detects depression) was completed and R41 had a score of 7/27, which indicated mild depression. R41 had verbal behaviors directed at others one to three days during the seven day look back period. R41 was dependent on staff and required total assistance of two persons and a mechanical lift for transfers and toileting; extensive assistance of two persons for bed mobility; extensive assistance of one person for personal hygiene, dressing. R41 was totally dependent on the electric, tilt in space, w/c for locomotion on and off the unit. The Care Area Assessments (CAAs) dated 2/17/14, indicated R41 would be referred to the house psychologist.

An LOA (leave of absence) Safety Assessment dated 2/10/14, indicated R41 was safe to leave the facility on unsupervised LOA, and left the facility daily on unsupervised LOA according to staff.

A Vulnerable Adult Assessment dated 2/10/14, indicated the resident utilizes an electric w/c for ambulation. " Resident is OK to go on unsupervised LOA. " A Smoking Evaluation dated 2/10/14, indicated independent with smoking and smoking materials.

The care plan revised on 3/18/14, indicated R41 had impaired cognitive function or thought process related to personality disorders of bipolar and schizophrenia. R41 had a history of being verbally abusive to staff and other residents, and required assistance with activities of daily living (ADLs), and was safe for unsupervised LOA.

A Physician ' s Progress Note dated 4/15/14, indicated the visit was to establish primary care and recommend R41 for a psychiatry consult per R41 ' s request. In addition, a recommendation was made by the physician for R41 to have a referral made to a pain clinic consult for chronic use of opiates (oxycodone) and morphine (both narcotics). The medical record lacked evidence that the physician ' s recommendations were scheduled and that R41 went to the consults.

A progress note dated 5/1/14, at 3:05 p.m. revealed R41 was off the property in the neighborhood. He became intoxicated (on a leave of absence (LOA) in the neighborhood), when he returned to the facility he drove his electric w/c off the curb on the driveway to the facility. R41 was found lying on pavement on his right side and his speech was slurred, but R41 remained alert and oriented. " He stated his last drink was 5 minutes ago. He was incontinent of urine and had a laceration on his forehead, he complained of right arm pain " The physician was notified and 911 was called. R41 was transferred to North Memorial Medical Center (NMMC) for further evaluation. He was admitted to intensive care unit (ICU) with low blood pressure, low potassium and low magnesium. The medical record lacked evidence that the assessments were reviewed and/or revised for R41 ' s LOA status. On 5/1/14, the fall risk care plan was updated to include the fall on the driveway, but lacked

mention of the causative factor of intoxication.

On 5/5/14, at 1:43 p.m. R41 returned to facility. New diagnoses from the Intra-agency Transfer Form dated 5/5/14, included: fall, intoxication, and alcoholism. A Physician ' s Order on 5/5/14, included, "No longer okay to leave unsupervised LOA's. " A WanderGuard (a personal alarm attached to resident to alert staff the resident attempted to leave the building) was ordered for the resident. The care plan revised on 3/18/14, lacked mention of supervised LOA.

On 5/6/14, at 9:16 a.m. the facility met with resident to discuss the incident that occurred on 5/1/14, the facility obtained an order for supervised LOA. Resident stated he was drinking because he was depressed. The facility placed a WanderGuard on his w/c.

Even though R41 had a WanderGuard placed on the w/c, R41 continued to remain at risk due to the facility, as the facility staff continued to silence the alarm at the front desk and let him out of facility. R41 continued to leave the facility and move about the property unsupervised. R41 ' s medical record lacked evidence of any social service intervention at the facility for his depression and drinking related to depression which would include providing information such as alcoholics anonymous (AA) or referral to any place for help or support. Even though the CAAs dated 2/17/14, indicated R41 was referred to a house psychologist, R41 ' s medical record lacked any evidence R41 had seen the house psychologist.

On 5/8/14 at 8:02 a.m. a list of residents who were alleged to bring drugs and alcohol into the facility, and a list of residents known to take drugs or alcohol in the facility was requested and provided by administration at 11:00 a.m. on 5/8/14. The facility identified R117 as questionably buying cigarettes and drugs, and selling within the facility.

R117 the facility failed to act upon allegations that R117 was bringing drugs, alcohol and cigarettes into the facility that caused actual harm and hospitalization to other residents. In addition the facility failed to prevent R117 from obtaining credit cards of vulnerable adults within the facility.

R117 was admitted to the facility 1/21/14, with admission diagnoses of cardiomyopathy (weakened heart muscle with decreased pumping ability), Atrial fibrillation (irregularly irregular heart beat that causes the heart chamber to be under filled when pumped and can lead to inadequate heart pump and life threatening blood clots in the heart), chronic Coumadin use (to thin the blood and prevent blood clots from forming) congestive heart failure (fluid buildup in the lungs or extremities due to poorly pumping heart), shortness of breath, hypertension (high blood pressure), anxiety, and depression.

The admission MDS dated 2/3/14, indicated: a BIMS score of 15/15, no cognitive impairment. R117 was independent in all cares and with mobility. CAAs dated 2/3/14 were triggered for falls, nutritional status, dental care, and psychotropic medications.

The care plan dated 1/27/14, and last revised 4/27/14, indicated: R117 does exhibit verbal abuse / aggression towards staff. He seemingly has a very loud voice and difficulty speaking in a calm, non-threatening manner. Staff has reasonable cause to believe that Resident has

brought alcohol & drugs into the facility for other Residents. R117 has actual physical behaviors/ physical fight with roommate r/t Poor impulse control, anger, depression. Often R117 will play music very loud and will not turn music down which disrupts other residents. R117 often leaves the facility and does not return at said time Interventions: Resident will cease bringing any type of alcoholic beverages or illegal drugs into the facility. Resident will not exhibit threatening behavior toward staff or other Residents, will follow the facility policies & procedures: Re: (not all inclusive)Playing his music so loud that it is disruptive to others; returning to facility at designated time or will call facility to report he will be late, will not physically threaten or harm anyone. If Resident becomes disruptive, aggressive/not redirect able, threatening to others, 911 will be called. If Resident becomes verbally aggressive, staff will walk away and return when Resident has calmed down.
Resident has a history of verbal & physical aggression toward other Residents & staff. He chooses to not list anyone as an emergency contact or Health Care Agent. He was evicted from his Group Home, therefore has no place to go if discharged, working with relocation to plan for a safe discharge. Vulnerable adult: resident is a VA due to history of homelessness. Anxiety CHF, HTN, and mood disorder. He chooses not to list anyone in case of an emergency or to designate anyone to be his health care agent. Was evicted from his last place of residence-the reason is unclear from history. He has a history of drug use. Intervention: If there is any indication of resident bringing alcohol or drugs into the facility, at any time. A room search will be completed by 2 staff persons. Resident has been assessed and is appropriate to leave the facility on an unsupervised LOA. R117 was unable to self-medicate due to drug seeker behaviors, street drug use, and poor choices.

R117 a LOA Safety Assessment dated 3/18/14, indicated the resident was assessed as appropriate to leave the facility unsupervised, a Smoking Assessment dated 3/18/14, indicated R117 was safe to smoke. A Vulnerable Adult assessment dated 3/18/14, indicated a recent history of resident to resident aggression, can be aggressive when confronted, had a history of substance abuse, but denied recent use, and was safe for unsupervised LOA.
On 2/12/14, at 9:11 p.m. a progress note indicated: Health status note: resident signed out at 10:00 a.m. and wrote to be back at 6:00 p.m. tonight. Resident is not back yet. Resident did not leave number to call and does not have emergency contact person to call. Writer called 911 and reported him missing. Writer also notified administrator.
2/13/14 at 6:39 a.m. a progress note indicated: Police took report during this shift about resident reported missing during the PM shift. Resident did (not) return to facility at this time. Will continue to search. Progress notes lacked documentation of R117 return to the facility.
2/16/14, 9:06 a.m. a progress note indicated: resident was aggressive and verbally abusive to fellow resident that is his roommate, he was swearing at him, calling him the F word, told him to get the F out of here, even went beyond and told him, there nothing wrong with you. Roommate said he gave a lot of trouble. A call was placed to administrator and DON we are continuing to monitor supervisor is aware.
3/27/14 at 16:01, a progress note indicated: resident had a visit from his relocation worker today; he became upset and was yelling and swearing during their visit. Writer and environmental services director approached to follow up with him. He was not in his room; drug paraphernalia was on his dresser and removed room the room. Resident was found in the staff lounge and he was educated that he could eat his meal in the dining room with other residents, continued to refuse to leave and swore at relocation worker who called 911. Police arrived and took drug paraphernalia and spoke with resident. ...states he wants to be independent. Writer called Hennepin county adult protection services to express the concern

about resident ' s behaviors and potential risk to others. They stated that they could not take a report unless actual harm occurs. Staff educated to call 911 and CEP should aggressive behaviors towards others occur. Resident is calm at this time.
On 3/31/14 at 04:43 a progress note indicated: AM nurse reported resident went out on LOA on 3/30/14, as usual. However, resident did not return to facility as required. About 02:00 a.m. writer called police and made the report. Two police officers came to the facility and said the report should only be made after 24 hours. On 3/31/14, at 13:40 resident had still not returned from LOA on 3/30/14. No phone numbers on file to try to reach resident.
On 3/31/14 at 2:58 R117 just returned from LOA at 2:30 p.m. Meeting held with resident about LOA orders as resident does not have overnight LOA orders. Those present, Writer, Administrator, DON and NA-N, nurse. Discussed with resident that if he signs out he must return at said return time as facility is responsible for resident and cannot care for him if he is not here. Resident yelled out that he needs a safe discharge place and MD orders in order to d/c. Writer stated that is different from AMA as AMA means he is discharging himself without MD orders. Resident stated understanding. Discusses that if resident goes on LOA he must be back at midnight or he would be AMA d/c. Resident stated understanding
On 4/11/14 at 15:18, Residents relocation worker met with him today. He is frustrated about the time that the relocation process is taking. He toured GRH housing this past week, however, did not like the setting it was in. Relocation worker will be bringing resident to apply for his MN ID and social security card on Monday 4/14. Resident is working on applying for his birth certificate and has stated that he will do this independently. Relocation services continue to follow, social services continue to follow discharge planning.
On 4/25/14 at 10:11 a progress note indicated: Per staff, there is suspicion that Resident is bringing alcohol into facility for other Residents. LSW & Director of facility operations (DFO) met with Resident to report that due to the continuous suspicion of alcohol being brought into the building, we would be going through his things to check for any alcohol, drugs or other materials deemed unsafe in a Residents room due to the State & Federal safety guidelines. There were tools, power tools, exacto knives, multiple scissors & many other sharp objects that were gathered and placed in a duffle, which was filled, taken to the Maintenance room to be inventoried and kept safe by the DFO. Resident made several sarcastic comments while we were in his room. Overall, he posed no problem and was not threatening in any way. Will continue to do random checks.
On 4/26/14, a progress note indicated: officer from MPD came regarding the 7 credit cards found in resident ' s room that were not his name. Officer took the cards and will check to see if any of them had had any activity or been reported stolen.
On 4/30/14, at 3:00 p.m. a Quarterly Social Service Assessment (progress note) indicated: Staff continues to provide cues and reminders as Resident does present with forgetfulness at times. Resident's relocation worker will continue to assist Resident in securing alternate placement in the community. Resident at times becomes frustrated over this d/t length of time it is taking. He has been assessed and may leave the facility unsupervised. Facility has reviewed requirements for unsupervised LOA with Resident and he is aware that if they are not followed that he may be required to only leave the facility with supervision. Resident has been assessed and is an independent smoker. Resident has a history of bringing in alcohol and drugs in to facility. Recently Resident was found to have numerous credit cards in his possession that were not his, police were notified and credit cards were confiscated.
ON 5/2/14, at 2:00 p.m. a progress note indicated: Resident declined to come to the smokers meeting to be updated on the facility policy and procedure regarding smoking. Writer and administrator attempted to meet with resident to give resident a copy of the facility

policy and discuss the rules regarding smoking. Resident refused to meet, writer asked if a copy of the policy could be left with the resident, he stated "no" Writer asked when a good time would be to come back, he stated "tomorrow" (which he also stated yesterday when he refused to come to the meeting). Writer expressed the importance of receiving the information today, he continued to decline. Writer informed him that not following the facility policy may result in losing his smoking privileges and could result in being given a discharge notice, writer again asked to meet or at least to leave the policy with him, he responded "no." Writer and administrator left, resident came out shortly after and began yelling about the noise in the hallway and receiving his mail. Writer attempted to approach resident but he walked away. Writer and administrator met with business office manager regarding his mail complaint, she stated that resident is waiting for his check and has been looking for it daily. She stated that his check usually comes on the 3rd of the month. She stated that she has informed him that he will receive his mail the day it comes.
5/5/14, at 15:55 a progress note indicated: Writer was updated by NAR that this resident received money from another resident (#02445) to go by cigarette from the store. Writer approached this resident reminding him of the smoking rules. Resident told this writer that soon as he buys the cigarettes for resident #02445, he will bring them and give it to the smoking NAR. Writer reminded resident that this was discussed in the meeting and was one of the items discouraged. Writer left resident and updated the Administrator about this incident. Administrator will follow-up.
On 5/6/14, at 9:37 a.m. R117 was observed to come out of the facility, walked across the top of the planters (jumped up with ease, skipping gait) and had lit his cigarette at the front entrance. Smoking monitor and a dietary manager (DM) did not intervene. R117 spoke with female staff, then went over to R36, exchanged money, and then went to talk with R129 (who had 1:1 staff that was standing 20 feet away from R129) and R91. [Note R117 pulled out a wad of cash, and R36 was observed to give him cash the smoke monitor and 1:1 staff did not observe the exchange]. R129 sat on planter and smoked with R91 and R117. R117 then returned to the building.
On 5/6/14, at 10:41 a.m. Michael observed to walk back to the smoking area from the street sidewalk. (it was unknown how R117 exited the building).
On 5/7/14, at 8:18 a.m. R37 was observed standing next to R117, who was sitting on the planter on the rear of the smoking patio. R37 had his wallet out and both R37 and R117 were watching the smoke monitor while R27 held his wallet open. R1 arrived back with the transport van and zoomed into the smoking patio at a high rate of speed on her motorized scooter, leaving her one to one staff behind. R37 handed R1 his wallet, (we were not able to see if she took anything from it). R1 then handed the wallet back to R37. He whispered over to her. At 8:24 a.m. R37 again gave his wallet back to R1, (we were not able to see if she took anything from it), she then reached down and put the wallet into his lower left leg pants pocket.

ON 5/7/14, at 843 R1 stated "there were no smoking problems here until this thing started (referring to 1:1 for unsafe smoking and not following facility rules), I used to buy 50-60 packs of cigarettes a day for these guys and I never charged them a thing." "Now because I have a 1:1, R117 buys things and he charges them a pack of cigarettes just to walk down to that little store." R1 stated that R117 was also known to charge for getting drugs and alcohol. R1 turned to R9 (roommate) and stated isn't that right! R9 versified the statement was true. The facility identified R1 as known smoking issues and questionably drugs and the facility identified R9 as a known pot smoker.

On 5/7/14, at 9:27 p.m. R117 lit his cigarette as he walked out the front door (non-smoking area), then sauntered to the smoking patio.

On 5/7/14, at 1:15 p.m. a call was made to the Minneapolis Police Department (MPD)-A to see if the facility had reported suspected drug dealing. MPD-A stated the facility called today to report suspected drug dealing, but had not reported it between 3/18/14 (date of survey exit) and today (5/7/14).

5/8/14, at 02:28 a.m. an administrative progress note indicated: Call received from NA-N that resident was not in his room. He was reported to have left during the AM shift, and has indicated that he will be coming back by 9:00 pm last night. NA-A was told to have the nurse documents this, and call 911 to report. Will follow up in the AM.
5/8/14, at 02:38 a.m. a progress note indicated: Resident left facility since morning of 5/7/14, and has not returned to facility. Time now is 02:40 the DON had been notified, 911 had been called, and they are on their way to come and do a missing persons report. There is no phone number on file to contact the resident. Will continue to update as time goes on.
5/8/14, 02:38 a.m. a progress note indicated: It is 5/8/14, 06:30, resident is still not back to the facility. The police are aware, have made a police report, and have assigned a case number for missing person. Please call MPD-C at phone number 612-673-5303 as soon as resident return to facility.
On 5/8/13, at 3:35 p.m. the interdisciplinary team (IDT) met to discuss the elopement and issued a 30 day discharge notice, and supervised leave only.
5/9/14, at 10:34 a.m. R117 was observed back in the facility. At 11:22 a.m. no progress notes have been entered to acknowledge R117 was back in the facility.
A note dated 5/9/13, at 10:38 (was added to the progress notes) Resident returned to facility unharmed. Resident verbalizes that resident is OK and has been safe at Treasure Island Casino. Writer called primary care physician (PCP) to update on residents return and request an order that states: Resident must be supervised on all LOA's except medical appointments. Awaiting return call from clinic.
On 5/9/14, at 11:50 Writer received a new order from PCP that resident cannot leave the facility unless supervised. Also resident can leave the facility unsupervised if going to a medical appointment. While writer was speaking to resident writer observed residents eyes were bulging and he had very rapid jaw movement. Resident appears to be under the influence of something. Writer placed another call to PCP office to inform MD that writer believes resident is under the influence. Writer also reported to nurse at PCP's office that resident has not taken any medications. Writer also asked resident if he would complete a toxicology screen and resident denied. Resident also denied any drug or alcohol use to writer. Writer is concerned of his safety. Awaiting response from MD office.
On 5/9/14, at 12:00 p.m. writer received spoke with nurse at PCP office and orders received to send resident to the emergency room at St. Joseph ' s office due to suspected drug use along with his heart conditions. Resident will be sent to St. Joseph ' s hospital.
On 5/9/14 at 12:23 p.m. two police cruisers (3 officers) and an ambulance were observed to pull up to the facility and enter the building. The consultant administrator informed the surveyors that R117 was being really unruly, had been out of the facility for several days and not been taking his medication (including Coumadin), stated his eyes are bulging and I am so concerned he is going to have a heart attack, he is refusing to do a tox screen here (urine

drug screen). We have called the doctor and he said to transfer to the hospital for evaluation. The police have been called to back up EMS, since he is not cooperating.
On 5/9/14, at 12:32 p.m. R117 was escorted out of the facility by two police officer holding his arms, the EMS (emergency medical services) gurney followed behind. The gurney was put back into ambulance. The police searched R117 and removed a package from his pocket, he then got into the rig at 12:35. Rig pulled away at12:37 p.m.
On 5/9/14 at 12:35 p.m. a progress note indicated: Paramedics and police arrived to facility to transport per MD orders. Resident was unwilling with the officers and refused to get on the gurney. Three police office had to physically walk resident out of the building. While resident was walking out resident continued to scream "I am leaving AMA, I am leaving AMA. Writer gave paramedics full report on resident ' s condition and the fact that resident has not taken Coumadin for three days with his Atrial fibrillation and CHF condition. All medication sheets, Face Sheet, code status, and physician orders sent with paramedics. Writer called St. Joseph ' s ER and gave report and updated on status, along with requesting toxicology screen.
5/9/14, at 1:04 p.m. a social work progress note indicated: Resident discharged from the facility against medical advice today; May 9th, 2014 at 12:45 p.m. Administrator informed writer that resident was threatening to leave AMA. Writer went to meet with resident to discuss his plan, where he was planning on going, and why. When writer approached resident yelled "Are you LSW-C?" Writer responded affirmatively, resident then yelled "Why did you tell R81, I was threatening him? He's my friend and I have the right to see him." Writer informed resident that writer was not aware of what he was talking about, writer asked who R 81 was. R117 walked away. Another social worker approached resident regarding his statement that he was leaving AMA. Social worker asked to talk with resident he yelled "no" and slammed the door. Social worker knocked on the door and asked resident what his plans were, he again slammed the door. Writer and social worker were informed that resident appeared to be under the influence of a substance and had been asked to have a tox- screen done, when he refused his MD gave an order for resident to be sent to St. Joseph's hospital (where his cardiologist is) so that he could be monitored given his heart condition and not knowing what substances he had ingested. The police and paramedics arrived to take the resident to the hospital, resident stated that he was leaving the facility AMA. The police asked him "you are leaving the facility against medical advice?" resident stated "yes." Police and EMT then stated that his doctor gave an order for him to be admitted to the hospital so they had to take him. Resident again refused. The police informed him that they had to take him. Resident was asked to sit on the gurney he refused multiple times, the police escorted him out of the building. They asked resident if he had any drugs on his person, he stated "yes" in his back pocket. Residents person was searched, a wallet and a pack of cigarettes were removed from his back pockets. A rolled up bag was removed from his fleece jacket pocket and resident identified this as cocaine. As resident walked down the hall he continued to yell "I am leaving AMA" Resident refused to sign the Release of Responsibility for Discharge Against Medical Advice form. While resident was threatening to leave AMA the administrator called adult protection to update them on the concern that resident was threatening to leave and we were not able to get the information about where he would be going. The adult protection worker stated that they could not take the report until resident actually left the building. Writer called adult protection at 12:50 PM stating that resident had discharged against medical advice at 12:45 PM. Writer informed them that resident had left via ambulance and was being sent to St. Joseph's hospital in St. Paul. Provide diagnosis listing, doctors name and contact information, date of residents admission, that he had come to the facility after being evicted from a group home, that he had not provided the facility with an

emergency contact (although he has a girlfriend in the community, her name and identifying information is unknown). Adult protection was also informed that resident had stated that he would not allow them to admit him to the hospital. Adult protection asked that a follow up be done with St. Joseph's hospital to determine if resident had been admitted and then to follow up with adult protection. Social services will continue to follow if resident was admitted to the hospital. All other social service interventions are discontinued at this time.
5/9/14, at 2:34 a progress note indicated: writer received a call from nurse at St. Joseph's hospital. Resident refused to do a toxicity sample at the hospital. Per nurse resident stated" It is not nobodies damn business". Resident is going to be discharged from St. Joseph's. IDT team notified.
5/9/14, at 15:47 p.m. a progress note indicated: writer called St. Joseph's hospital, they do not have any documentation of resident being there. Writer spoke with E.R. nurse; she confirmed that resident had come into the E.R. but left AMA at 2:35 p.m. The E.R. nurse did not know where resident went. Writer called Hennepin County Adult Protection and updated them with the above information.
5/9/14, at 6:27 p.m. a progress note indicated: R117 returned to facility at 6:20 p.m. R117 was visably [sic] under a mind altering substance [sic]. He was presenting with facial tics and iradic [sic] behavior. Police were notified and no trespassing notice form was completed by MPD-D. Officer was also provided with plastic baggies containing drugs that were found on R117. R117 had been advised that his belongings will be packed up and ready for pickup by 10 a.m. tomorrow. As R117 chose to leave facility AMA early today. R117 also left AMA from ER. Officer advised R117 that when he is ready to pick up his belongings he must call the police prior and an officer will accompany him to the facility to get his belongings. He is not allowed on Camden property and notice is valid for 1 (one) year. DON and administrator present.
5/9/14, at 6:43 p.m. an administrator progress note indicated: Resident was on LOA and did not return at stated return time. Staff called police and reported him missing on 5/8/14. Resident returned today and appeared to be under the influence with eyes bulging and rapid mouth contortions. Concern for resident's health due to extended LOA without medication and that there were other drugs in his system. Nursing asked Resident for toxicology screen and resident refused. See nursing notes regarding subsequent DC summary and AMA. Resident left emergency room AMA and returned to this facility and was advised he had been discharged. Police were again called as R117 would not leave premises and was issued a trespass notice.
On 5/10/14 at 12:25 R117 was observed sitting on the air conditioner at the building next door to the facility, facing the freeway frontage road.
On 5/10/14 at 1258 the administrator stated that R117 was issued a trespass order, and escorted by police to the NMMC ambulance yesterday and then had left AMA from the hospital. He was supposed to call the police this morning and be escorted to the facility to pick up his belongings. But he had not yet called.
When interviewed on 5/12/14, at 2:43 p.m. contracted social worker (LSW)-A stated there was alleged rumor that there had been an exchange with R1 and other resident who had been discharged from the facility (R117) and had exchanged something with resident R129 who had been admitted to the hospital on 5/11/14, with alcohol intoxication with a level of 0.323. LSW-A stated I have personally had to question the 1:1 staff here at the facility when I have seen them sitting outside the door when resident is in the room with the door shut. When I have asked 1:1 staff how they are monitoring the resident when sitting outside the door some have gotten argumentative and said the resident did not want them in the room

and I have told them you are supposed to be at arm-length not behind but in-front to make sure nothing is exchanged. I cannot imagine how a resident who was on 1:1 would get that much alcohol in her system and when I got here on Sunday I came to the office to open the computer to see what happened and there were no nursing notes. I went outside to the desk and told the administrator and director of nursing to get the nurse in to document and have the 1:1 fired. There are so many people here than I have seen on 1:1 for me 1:1 means the person needs to be somewhere else not at the nursing home.
R116, with a WanderGuard (a personal alarm that would alert staff when the resident left through the doors) was able to elope from the facility on 5/11/14, at 9:30 a.m. and according to staff two more times at 11:30 and 11:52. The facility consistently allowed residents with WanderGuard's to exit the building by silencing the alarm, and so lacked a system to immediately search for missing residents when the WanderGuard alarm sounded. R116 had a significant decline in cognitive abilities, and it was unknown if he could have found his way back to the facility if the HUC had not seen him eloping while driving into work.

R116 was admitted to the facility on 1/20/14, with diagnoses of lung cancer with metastasis (cancer moving from one body organ to another) to the liver and the brain, metabolic encephalopathy (temporary or permanent damage to the brain that occurs when the liver cannot clear the toxins from the body), confusion and depression.

R116 signed on to Hospice 1/21/14, was independent in self cares, transfers, and mobility. A Brief Inventory for Mental Status (BIMS) was completed and R116 ' s score was 15/15 which depicted R116 to be cognitively intact. However, since R116 had a hospice recommendation R116 had an expected decline in cognitive and functional status.

The admission MDS dated 2/17/14, indicated a BIMS score of 15/15, which showed no cognitive deficit, and a PHQ9 score of 4, which indicated minimal depression. R116 was independent in bed mobility, transfers, toileting, dressing, locomotion on an off the unit and required supervision for personal hygiene. The CAA worksheet dated 2/2/14, were triggered for vision, falls, activities of daily living, nutritional status, pressure ulcer potential, and psychotropic drug use. No referrals were made.

On 4/15/14, at 10:49 p.m. a nursing progress note indicated, " Pt is declining. He is very weak and needs a lot of assistance. "
The care plan 5/2/14, indicated cognition intact, and independent with activities of daily living, with the potential to decline in cognition and function related to terminal diagnosis. R116 was diagnosed with depression and alcohol abuse and alcohol dependence, paranoid state, and an episode of smoking in his room.

A draft progress note (a electronic progress note that was not in date sequence due to lack of completion) and stays dated 5/2/14, at 9:14 p.m. " Resident was found by nursing assistant (NA) drinking Listerine mouthwash in his room. Amount consumed is unknown. Empty Listerine bottle removed from room and dumped. " Writer explained the risks of drinking Listerine to resident's health. " Res states "I know, it kinda helps with my throat. Resident seems to be more confused while narrating this to the writer. "

A progress note dated 5/5/14, R116 was outside with his son and the resident had a fall. R116 ' s Son was present at fall. Hospice was notified of fall and a new wheelchair (W/C)

was ordered for resident. Writer also placed a WanderGuard on resident to alert staff when resident wants to go outside to maintain resident ' s safety. " Resident is allowed to go outside although staff needs to be alerted. Son is aware and in agreement with interventions. Nursing is to continue to monitor. "

A draft progress note dated 5/5/14, at 10:47 p.m. indicated R116 had increased confusion. " He requested going the bank to complete his transaction that he began earlier. He was leaning down to the floor to pick up of stuff which was apparently not there (visual hallucination). He was ambulating around getting out of w/c. Towards the end of shift he was on one to one rotation to prevent him from falling. "

A progress note dated 5/6/14, at 2:55 p.m. indicated R116 continued to sit at nursing station with staff due to attempts to self-transfer and unsteady gait.

A progress note dated 5/8/14, at 3:12 p.m. indicated, " Two packets of cigarettes and a lighter are found in resident's room. His room smelled smoke as if he has been smoking there. The cigarettes have been taken from him, and put in the lock box. He has been reminded that he cannot smoke in his room, only at the designated smoking areas of the facility. "

A progress note dated 5/8/14, at 12:53 P.M. " Resident came to his care conference today, Resident has impaired cognitive abilities; he did not recall the meeting with this writer and the administrator last week regarding the smoking policy. This policy was reviewed with him during the care conference again. He was also informed that he may lose his smoking privileges if he continues to be noncompliant with the smoking policy. Writer asked if he would agree to routine room checks to ensure he did not have cigarettes or lighters. Given his altered cognitive state he does not have the ability to remember the smoking policy and rules. He will be reminded and checked regularly to maintain his and others safety and to allow him to continue to smoke. Resident ' s son has also been updated on the smoking policy and will receive a copy of the smoking policy so he is aware of the facilities policy and procedure. "

On 5/11/14, at 9:30 a.m. the health unit coordinator (HUC) was observed walking R116 back toward the rear of the facility on the sidewalk. The HUC stated she had found R116, as she was driving into work. R116 had a WanderGuard on and she was surprised to find him walking outside since he was not able to walk every day. The HUC had called the facility and alerted them to the fact that R116 had left the facility and requested someone bring a w/c to help bring him back to the facility. Nursing assistant (NA)-R and safety monitor/NA-O had also come outside to look for R116. Two other NA's NA-P and NA-Q came outside with a w/c to meet R116 and return him to the facility.

On 5/11/14, at 10:38 a.m. a progress note indicated, " At 9:30 a.m. upon arrival to work this writer found R116 outside the facility walking down the sidewalk. When approached he stated 'I am going to visit a friend." R116 currently has a WanderGuard [sic] and due to cognitive impairments is unable to leave the facility unattended. He was verbally resistant to returning the building but was eventually returned with staff assist of three. Note resident left out a fire exit at the end of the hall. Staff was in route to locate whom ever had exited the building, the DON, Administration, and social work (SW) updated. "
On 5/11/14, at 11:52 a.m. a progress note indicated: "Fire exit alarm again sounded at the

end of the hallway. Staff immediately responded and found R116 outside. He again stated that he was going to visit a friend. This time he was verbally and physically resistant to returning to the building. Three staff were able to convince him to return in a w/c due to unsteady/weak gait. DON, SW, and charge nurse notified. Call placed to son who was updated and encouraged to visit and offer support to R116 if able. Son voiced that he understands that this confusion and resistance is likely a direct result of the Cancer. Support provided via phone."
- At 3:18 p.m. a progress note indicated: "R116's family was in to provide support today after episodes of elopement. Hospice was called; RN was updated regarding elopements, increased confusion, anxiety and restlessness. RN will update the Primary nurse in the am. R116 has been placed on 30 minute checks, staff alerted to residents increased confusion and elopements. R116 was given PRN Ativan (an anti-anxiety medication) that has been effective for anxiety/restless with no further elopement attempts."
- At 3:40 p.m. per interdisciplinary team (IDT) "resident will be on 15 minute checks VS 30 minute checks"
On 5/11/14, at 4:27 p.m. a progress note revealed, "At 0930 AM resident went out the fire exit and was walking down sidewalk. Staff intervened and resident was brought into facility. Resident stated he was going to visit a friend. At 11:30 resident left another exit. Staff was with resident and brought resident into facility. Hospice, family and administration were notified. Resident ' s WanderGuard was in place and functioning. Resident also placed on 15 minute checks. Hospice updated on increased confusion along with family. Family was here to visit resident. "
On 5/11/14, at 10:07 a.m. the administrator was interviewed and stated the day staff, afternoon staff, and night staff had been educated on the immediate jeopardy for drugs and alcohol and elopement and he could not believe the fact that R116 had gone out the back door, and was able to leave the facility. The administrator stated the investigation so far, was that staff heard the back door open, went and looked but had not seen anyone, so they assumed it was staff. The administrator verified that there was no WanderGuard alarm on the back door.

On 5/12/14, at 10:14 a.m. (more than 24 hours after the first elopement event) the director of nursing (DON) was interviewed and stated he had not made a report of the elopement of R116; his understanding was that he had 24 hours to report. He wanted to investigate and talk to the administrator and was still working on the report. The DON verified that he was not aware that federal regulations state immediate reporting. The DON verified that he was not aware that a resident with a WanderGuard exiting the building unsupervised was considered elopement.

On 5/12/14, at 11:00 a.m. surveyors tested the key pad coded door which was locked, but noted that staff unlock the door and enter without regard to which residents are nearby.

On 5/12/14, at approximately 11:30 a.m. a report was made to the Office of Health Facility Complaints (OHFC) regarding the 9:30 a.m. elopement on 5/11/14. No reports were made for the additional elopements.

On 5/13/14, at 1:00 p.m. the consultant administrator stated the facility had checked the key pad coded door to the access hallway to the back exit, which was functional and also there was a WanderGuard system in place on the back door, which was functional, the facility had

tested the doors and were not able to determine how the resident had gotten out of the facility by the back door.

The facility Elopement policy dated 5/12, indicated... If exit seeking behavior is identified the licensed nurse immediately implements interventions to manage exit seeking behaviors. These interventions may include a personal security device such as a WanderGuard, or diversion activities. The interventions are documented on the care plan and the nursing assistance care plan. ...If the resident is not located within 30 minutes, the Administrator or designee notifies the law enforcement officials, the corporate compliance officer and corporate director of clinical services. When the resident returned to the facility a physical assessment would be done, a thorough investigation of the event would be completed by the DON or designee. A factual account of the occurrence would be documented in the medical record, and the care plan would be reviewed and revised. The administrator of designee reports the event to the appropriate state agency (SA).

F490 K

Based on observation, interview and document review, the faciliy failed to ensure systems were in place to support patient care, supervise staff, and monitor the plan of correction from the survey exit date 3/18/14. An Immediate Jeopardy was identified at F323 on 5/9/14, at 2:03 p.m. for lack of supervision and resident drug and alcohol use for R37, R129, R41, R117, and lack of supervision with resulting elopement for R13. At 2:14 p.m. the administrator, consultant administrator and DON were notified of the Immediate Jeopardy. On 5/12/14, at 2:51 p.m. the administrator and consultant administrator were notified that R116 was added to the Immediate Jeopardy at elopement (F323). In addition they were informed an Immediate Jeopardy was being identified at F224 for neglect of care for R37 and R129, and that an Immediate Jeopardy was being identified at F490 for administration failure to act upon the immediate jeopardy notification from 5/9/14, to educate staff, develop a plan, and ensure systems were in place, that may have prevented the neglect of care for R129 and R37 that occurred on 5/11/14.
An onsite revist survey was conducted 5/5/14-5/13/13, the plan of correction POC with the latest completion date of 4/28/14, had not been fully implemented and 33 federal deficiencies were re-issued, with 25 state licensing tags and 3 Immediate Jeopardies identified at F323, F224, F490.
On 5/7/14, at 12:59 p.m. The director of facility operations (DFO), stated last Wednesday, three employees were told by administator and consultant administrator that it was a crisis to get the medical records room reorganized and they stayed until 3:00 a.m. to complete it.
On 5/7/14 at 2:10 p.m. an Officer MPLS PD, badge 7312, squad 432 4th precinct. Spoke with facility who identified residents who were suspected of criminal activity. The officer reviewed observations by surveyors. And stated the CRT team (undercover) would be doing the investigation. In the future information about the investigation could be obtained by calling 612-673-5704 and asking for the safe unit (who could provide information of what the outcome of this report was. For copies of police reports call 612-673-2961.
On 5/8/14 at 8:02 a.m. a list of residents who were alleged to bring drugs and alcohol into the facility, and a list of residents known to take drugs or alcohol in the facility was requested and provided by administration at 11:00 a.m. on 5/8/14. The facility identified R117, R1, R81, and R113 as questionably buying cigarettes, alcohol and drugs, and selling the substances within the facility. In addition the facility identifed residents known to ingest illegal or contraband

substances within the faciilty as R9, R129, R1, R117, R62, R86, R115, R14, R41, R81, R113, R37.

On 5/12/14, the administrator and consultant administrator acknowledged they were not aware of the two additional elopements for R116 that had occurred on Saturday 5/11/14. The administrator verifed he had not been called and stated he did understand the seriousness of the situation, and they would act accordingly.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245544	CAMDEN CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

B					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 18623	05-08-2014	05-13-2014	0.00	0.00	21.00	1.00	1.50	0.00
2. 19693	05-05-2014	05/13/2014 ~~05-21-2014~~	0.00	4.00	48.00 ~~50.25~~	0.00	0.75 ~~1.25~~	43.00
3. 25480	05-05-2014	05-13-2014	0.00	1.00	57.50	0.00	0.00	19.00
4. Team Leader 30951	05-05-2014	05/13/2014 ~~05-21-2014~~	1.00 0.00	1.00	64.00 ~~71.75~~	0.00	0.50	46.75
5. 31223	05-06-2014	05-13-2014	0.00	1.00	35.00	0.00	0.00	12.50
6. 32982	05-06-2014	05-13-2014	0.00	4.00	51.75	0.00	0.00	15.00
7. 34086	05-12-2014	05-13-2014	0.00	1.00	18.00	0.00	0.00	29.25
8. 34087	05-12-2014	05-13-2014	0.00	1.00	18.00	0.00	0.00	28.50
9.								
10.								

Total Supervisory Review Hours ..... 34.75 ~~50.75~~

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... N

FORM HCFA-670 (12-91)

All off site documentation has been applyed to the 1st PCR ML & MJ

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245544	CAMDEN CARE CENTER

Type of Survey (select all that apply):

D					

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. Team Leader 28120	5/1/2014	5/1/2014	0.25	0.00	0.00	0.00	0.00	0.25
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.25

Total Clerical/Data Entry Hours..... 0.00

Was Statement of Deficiencies given to the provider on-site at completion of the survey? 0.25

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IRYI

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**
2.STATE VENDOR OR MEDICAID NO.
(L2) **456190000**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMDEN CARE CENTER**
(L4) **512 49TH AVENUE NORTH**
(L5) **MINNEAPOLIS, MN** (L6) **55430**

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) **12/01/2012**

6. DATE OF SURVEY **03/18/2014** (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 **87** (L18)

13.Total Certified Beds **87** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Becky Wong, HFE NE II 04/25/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/06/2014 (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
01/01/1991
(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.
00320
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24-5544

At the time of the extended standard survey completed 03/18/14, the facility was not in substantial compliance with the participation requirements and the conditions in the facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. See CMS-2567 for survey results. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 4, 2014

Ms. Noreen Cochran, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544023

Dear Ms. Cochran:

On March 18, 2014, an extended survey was completed at Camden Care Center 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constituted immediate jeopardy (Level K) whereby corrections were required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

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

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

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;
Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We verified, on March 16, 2014, that the conditions resulting in our notification of immediate jeopardy for deficiency cited at F323 have been removed. We also verified, on March 18, 2014, that the conditions resulting in our notification of immediate jeopardy for deficiency cited at F223 have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3792
Fax: (651) 201-3790

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective April 9, 2014. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at: F223 at a S/S of J (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F226, at a S/S level of F (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F314, at a S/S level of G (42 CFR 488.430 through 488.444)

- Civil money penalty for the deficiency cited at: F323, at a S/S level of K (42 CFR 488.430 through 488.444)

- Optional Denial of Payment for New Admissions (DPNA) effective April 24, 2014 (42 CFR 488.417 (b))

- Discretionary termination of your provider agreement effective August 18, 2014 (42 CFR 488.412 and 488.456)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. <u>If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.</u>

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Camden Care Center is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective March 18, 2014. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by June 18, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 18, 2014 (five months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

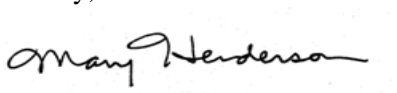
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,



Mary Henderson, Program Assurance Supervisor
Minnesota Department of Health
Compliance Monitoring Division
Telephone: (651) 201-4115 Fax: (651) 215-9697
mary.henderson@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's electronic plan of correction (ePOC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. An extended survey was conducted by the Minnesota Department of Health on 3/10/14 through 3/18/14. The survey resulted in an Immediate Jeopardy (IJ) at F223 related to the facility's failure to protect a resident from willful abuse by another resident which resulted in the high potential for harm or death. For F323 related to the facility's failure to supervise residents with unsafe smoking, which resulted in the high potential for harm or death. Facility staff had been notified of the IJ's on 3/12/14, at 5:00 p.m. The IJ was removed on 3/16/14, at 12:17 p.m. however non-compliance remained at the scope and severity E, a pattern with no actual harm, with the potential for more than minimal harm. For F323 on 3/13/14, at 1:50 p.m. failure to safely use a mechanical lift device was added to the IJ at F323. The IJ was removed on 3/16/14, at 12:17 p.m. however non-compliance remained at the scope and severity E, a pattern with no actual	F 000	This Plan of Correction is submitted as required under Federal and State regulations and statutes applicable to long-term care providers. This plan of correction does not constitute an admission of liability on the part of the facility, and such liability is hereby denied. The submission of this plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute deficiency, or that the scope and severity regarding the deficiency are correctly applied. Please accept this plan of correction as our credible allegation of compliance. Our compliance will be achieved by the dated identified on the plan of correction.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlotte M. Cochran	Administrator	4-18-2014

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

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F 000	Continued From page 1 harm, with the potential for more than minimal harm. For the F223 IJ for willful abuse by another resident began on 3/9/14, and the facility was notified of the IJ on 3/12/14, at 5:00 p.m. The IJ was removed on 3/18/14, at 1:00 p.m. however non-compliance remained at the lower s/s of a D, no actual harm, with the potential for more than minimal harm.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. 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 individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 155	F 155 Sampled resident R11 is no longer in the building. For all residents at the facility, they will be allowed to exercise their right to refuse treatment of all kind. The facility has a policy titled "*Resident Refusal of Medical Treatment*". This policy was effective 06/2012.This policy will be made operational for all residents at the facility that refuse medical treatment. Additionally, the facility has a form "Resident Refusal of Medical Treatment Form" that documents the risks of refusing medical treatment. The use of this form or a comparable form in PCC (PointClick Care) will be used to document risk vs benefit discussions with the resident and IDT.	

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F 155	Continued From page 2 review, the facility failed to consistently inform 1 of 1 resident (R11) of the risks and benefits associated with refusal of all activities of daily living (ADLs), range of motion (ROM), physician visits, therapies, assessments and interventions. Findings include: On 3/11/14, at 9:48 a.m. during the initial stage one interview R11 stated, "I don't like people." R11 further verified he did not allow facility staff to assist him with ADLs, bathing or ROM. R11 verified he had a contracture of his left hand. R11 stated he did not take showers. - At 10:12 a.m. surveyor asked to see R11's left hand. R11 was observed to have a contracture of the left arm, wrist and hand. R11 stated the contracture was due to an aneurysm and stroke. Stated he "didn't let them [facility staff] touch it" and only allowed staff he "trusted" to cut the nails (of the contracted hand, to prevent the nails from growing into the skin of the hand). R11 stated he cleaned his left hand (inside the contracture, to prevent potential breakdown) under the faucet with running water, but was unclear on how frequently he cleaned the left hand. R11 verified he did not allow staff to monitor the skin of his hand for potential breakdown. - At 12:32 p.m. R11's hair was observed to be long, uncombed and appeared to be unwashed. R11 wore a dark colored baseball cap. R11's nails were long on the right hand with dark colored debris observed under the nails. R11 was observed to be wearing a dark colored coat, t-shirt and dark sweat pants. On 3/13/14, from 8:00 a.m. to 9:00 a.m. R11 was observed to be wearing the same baseball cap, t-shirt, dark colored sweat pants and coat as the	F 155	Clinical record audits to ensure the appropriate management of residents refusing medical treatment will be conducted for a random sampling of residents on a monthly basis for 6 months. The results of these audits will be reviewed by the DON and facility Administrator. Both will sign off on the audits. The audits will be reported to the QA committee monthly X6 for review and further intervention as found necessary. Responsible: Administrator, DON, licensed staff, social services Compliance date: 4/28/2014	

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F 155	Continued From page 3	F 155		

initial interview. R11 appeared to have unwashed, uncombed hair. At no time during the observation were staff observed to approach R11 and offer assistance with grooming or range of motion. During the observations, R11 was observed to be in bed and fully dressed in the same clothing.

On 3/13/14, at 9:42 a.m. a nursing assistant (NA)-M stated R11 "refuses everything." NA-M explained "today was [R11's] shower day" and stated R11 refused the shower. NA-M stated when staff re-approach R11, he was verbally abusive and verified he would make derogatory statements to staff. NA-M stated staff was expected to "re-approach" R11. "We usually come back and ask, but he always refuses." NA-M was unclear how R11 was bathed/cleaned and explained staff usually took care of R11 on the evening shift.

On 3/13/14, at 10:00 a.m. NA-E stated R11 "refused all cares" and stated she went back to R11 to re-approach if there was a refusal. NA-E stated she offered all means of bathing (shower, bed bath, tub bath) and R11 refused "all." NA-E explained she then reported refusals to the nurse and documented "refused" on the shower sheet. NA-E was unclear if risks of his frequent refusals were explained to R11.

R11's Medicine Admission History and Physical dated 12/31/13, included information regarding R11 prior to admission to the facility. The form identified R11 had a chronic problem with homelessness and R11 had "lost his medical respite bed at Harbor Lights [a shelter facility for the homeless] due to refusal to shower in their facilities." The form indicated R11's left sided spasticity was "Worse since he has not taken any

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F 155	Continued From page 4 of his medications since 12/24" and directed to resume baclofen (a muscle relaxer used to treat muscle symptoms). The Admission Record indicated R11 was admitted to the facility on 12/31/13. A Therapy Screening Form dated 1/2/14, indicated R11 was screened upon admission to the facility. The form indicated R11's ADL's, and mobility were impaired. The form indicated R11 "declines" splint/orthotic. The "Comments" section of the form indicated, "Pt [patient/R11] repeatedly declined offer of therapy services, stating he doesn't like people. Declines needing or wanting help for any ADL's, waiting for electronic scooter to arrive, is independent with manual w/c [wheelchair]. Requests not to have therapy services, no orders requested." The form indicated therapy services for physical therapy, occupational therapy, or speech therapy was "Refused." Although the form was dated 1/2/14, at the top of the form, the bottom of the form was signed by a therapist and dated for 3/11/14. The screening form indicated R11 was identified to refuse care and services shortly after admission. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 was cognitively intact, had a mood problem of feeling tired, and had no behavior problems. The MDS indicated R11 was independent with bed mobility, transferring, locomotion on the unit and eating; required supervision with locomotion off the unit, dressing and toilet use; R11 was identified as requiring extensive physical assistance from staff for personal hygiene. The Care Area Assessment	F 155		

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F 155	Continued From page 5 (CAA) for nutrition dated 1/7/14, identified diagnoses of spastic hemiplegia on left side, history of alcohol abuse and congestive heart failure. The CAA identified R11 had "no upper teeth and few lower teeth" and, "He does not wish to receive a mechanically altered diet." The CAA for ADL Functional/Rehabilitation Potential dated 1/13/14, identified the CAA was triggered due to R11's need for supervision with ADLs. The CAA identified R11 had left sided hemiplegia due to a history of cerebrovascular accident (CVA, stroke). The CAA identified R11's other pertinent diagnoses to include altered mental status, and homelessness. The CAA identified R11 "was eval [evaluated] for therapy" and refused. The CAA identified R11 was continent of bowel and bladder, had no skin issues or falls. The CAA for falls and pressure ulcers (both dated 1/13/14), recapitulated the same data as ADL CAA. Although R11 initially refused therapies upon admission, and was identified to refuse therapy in the CAAs, the MDS did not identify refusal of care behaviors. Although the behavior of refusing therapies was identified in the CAA, the clinical record lacked evidence R11 was provided documented risk benefit information associated with refusals. The Social Services Comprehensive Assessment Packet dated 1/13/14, included: a LOA (leave of absence) Safety Assessment, Smoking Assessment and Vulnerable Adult Assessment dated 1/2/14. No behaviors of refusing cares were identified in the assessments. The Vulnerable Adult Assessment appeared incomplete. Although R11 was identified to have refused to take showers at the homeless shelter (resulting in R11 losing a respite bed there) and R11 had behaviors of not taking medications such	F 155		

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F 155	Continued From page 6 as baclofen, the assessment didn't identify R11 had any behaviors, such as refusal/rejection of cares. The Safety Risk (Fall) Assessment dated 1/4/14, indicated, "Resident does display behaviors calling staff 'Niggers', refuses cares and treatments. Nsg [nursing] to continue to monitor & update." Although the assessment identified and refusals of care behavior, the clinical record lacked evidence R11 was monitored for the behaviors. The clinical record lacked evidence the risks and benefits associated with refusal of cares and safety were provided to R11. The undated Range of Motion Assessment identified "complete impairment" of R11's arm, hand, leg and foot on the left side. Review of R11's Weekly Audit (an evaluation of a residents' skin to identify potential changes, such as pressure ulcers or skin breakdown of the left contracted hand) form dated for both "12/31" and "1/01" indicated "Refuses body audit." The audit dated 1/9/14, and 1/16/14, both indicated R11 refused his bath/shower. Although R11 was admitted to the facility on 12/31/13, and R11 was scheduled for showers/baths weekly, the clinical record lacked evidence facility staff attempted to re-approach R11 for bathing after 1/16/14. The clinical record lacked evidence the risks associated with refusal of body audits were explained and provided to R11. The clinical record lacked evidence R11 was evaluated/assessed by a nurse practitioner or physician within the required time frames. R11's care plan only had a focus for activities	F 155		

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F 155	Continued From page 7 dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's refusals of care or behaviors. The clinical record lacked evidence R11 had care plans developed (including goals and interventions) to address: R11's identified behaviors of refusals/rejection of cares. In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming and skin assessments/evaluations and refusals of doctor visits. Review of the IDT Progress Notes from 12/31/13, through 3/17/13, indicated the following: - On 12/31/13, an admission note at 10:47 p.m. identified R11 was admitted to the facility, identified R11 was cognitively intact, continent of bowel and bladder, and transferred independently. A note at 11:53 p.m. identified R11 was able to make changes in body position when in bed to "release pressure." Although R11 had left sided weakness and a contracture of left arm and lower leg, the note incorrectly identified R11 was "able to independently walk to and from toilet." - On 1/1/14, a Late Entry note at 3:43 a.m. indicated R11 refused three attempts at a "body audit" and indicated R11 stated, "'I do not have anything on my skin, no wound.'" At 1:43 p.m. a note identified R11 required one staff physical assist with ADLs. At 10:20 p.m. a note identified R11 "refused make change of clothes and went to bed with his street clothes." - On 1/2/14, at 6:29 a.m. a note identified, "Resident vehemently refused vital sign to be	F 155		

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F 155	Continued From page 8 obtained, even when reapproached. Noted some blood show on his nares but he adamantly rejected nursing intervention, instead he placed a tissue papper [sic] in the nose, he refused to use 4x4 [gauze]. We will continue to encourage with care and support at this moment." At 10:13 p.m. a not indicated, "Resident refused cares and re-approached throughout the shift but he refused stating to be left alone." - On 1/4/14, a note at 10:40 p.m. indicated R11 refused "all attempts for the vital signs to be taken and cares to be provided." The note identified R11 "Requires help with ADLs but refuses." Although a behavior of refusing/rejecting cares was voiced by R11, the note indicated, "No behavioral problems noted." - On 1/20/14, at 3:16 p.m. a social services note indicated SSD met with R11 and discussed R11's discharge plan to remain in the facility "short term [sic]." The note identified R11 had determined his stay was short-term and identified R11 "is homeless" but would "like to find placement." The note indicated SSD would assist with discharge planning. - On 2/4/14, at 12:54 p.m. a social services note indicated the county public health nurse and SSD met with R11 regarding relocation options. At that time the note indicated R11 would "like to return to the streets when it gets warmer outside." R11 refused assistance from both. The note identified SSD "explained the risks of returning to the streets." - On 2/5/14, at 11:01 p.m. R11 was identified to be abusive to staff "using N-word to the nursing staff." The note indicated staff attempted to speak with R11, but R11 cursed at staff, refused to allow staff to assist with cutting his nails "stating he [would] look for qualified person to cut his finger nails."	F 155		

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F 155	Continued From page 9 - From 2/5/14, through 2/24/14, all notes indicated when R11 had nose bleeds or if no nose bleeds were noted. The notes identified period, but consistent refusals of assistance with nose bleeds. The notes did not indicate the physician was notified of potential nose bleeds. - On 2/25/14, at 3:17 p.m. a note from medical records indicated, "[R11] has refused all medical appt [appointments] since admit to include cardiology on 1-19-14. He has refused all offers of appts at the Indian Health Board for Primary care follow up. D.O.N. (director of nursing), clinical care manager and Admin [administrator] updated. Plan is for pt [patient] to be seen by the Medical Director." - From 2/25/14, through 3/17/14, notes address monitoring for nose bleeds. Although R11 was noted to refuse all cares, treatments, interventions and assistance, the clinical record lacked evidence R11's refusals were assessed and clinically related social services were provided. The Follow Up Question Report for 3/1/14 through 3/13/14, identified the daily NA documentation from Care Tracker. The report indicated the following: - "Bathing: Self Performance - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower" was documented "Not applicable" daily. - NA's documented a behavior of both "Rejection of Care" and "Abusive Language" as "Yes" daily. - "Dressing: Self performance - How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis or TED (anti-embolism stockings) hose. Dressing includes putting on and changing pajamas and housedresses" was documented "Resident	F 155		

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F 155	Continued From page 10 Refused" for 16 out of 18 opportunities. - "Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (Excludes baths and showers)" indicated "Resident Refused" eight times, "Not applicable" two times, "Independent - No help or staff oversight at any time" eight times out of 18 opportunities. The clinical record lacked evidence R11's consistent refusals documented in care tracker and the IDT Progress Notes were identified and evaluated. In addition, the clinical record lacked evidence R11 was informed of the specific risks associated with consistent refusals of cares, rejection of therapies and rejection of physician's visits. On 3/14/14, at 11:20 a.m. a physical therapist (PT)-J verified R11 refused therapy. PT-J stated risks and a benefit were provided to R11, but was unclear on documentation of the risk/benefits. On 3/14/14, at 10:41 a.m. social service designee, (SSD) stated she was not aware of R11 refusing any or all cares. SSD stated R11 was "easy to communicate with" and her first impression of R11 was he "wouldn't refuse." SSD further stated she "believes if [R11] was re-approached [when refusing]," R11 would "go for it." SSD stated facility staff should have been reporting the refusals to her and stated she would then have "approached and explained the risks and benefits" to R11. SSD stated she reviewed the (interdisciplinary team, IDT) progress notes, but stated the behaviors were not appropriately being documented in the clinical record. SSD	F 155		

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F 155	Continued From page 11 stated "documentation was missing" and there "wasn't appropriate documentation [on behaviors]." SSD stated it was "very important for staff to document" and further stated she "relied heavily" on the documentation. SSD stated she was "not closely interactive with residents and staff." SSD verified she had access to "PCC [Point Click Care, the electronic medical record or EMR], and stated she did not know the NA staff documented R11's refusals daily "at the kiosks [in Care Tracker]." SSD stated she did not have access to the "kiosk" or Care Tracker. When asked about R11's discharge plan, SSD stated, "When [R11] came, I did my psychosocial assessment, offered him services." Although SSD stated she was unaware of R11's refusal, R11 was "easy to communicate with" and R11 would "go for it" if re-approached during a refusal of a care or treatment, SSD stated, "He [R11] refused services and said he was going to back to the streets." SSD confirmed she was aware of R11's unsafe discharge plan and stated she "referred him to the county for relocation services." SSD further verified her awareness of R11's refusals and stated the "Public health nurse attempted to visit with him, he refused for the moment." The clinical record lacked evidence of SSD's psychosocial assessment. On 3/13/14, at 2:24 p.m. the licensed practical nurse (LPN)-D verified there was no monitoring for behaviors towards staff, such as refusal/rejection of cares. On 3/13/14, at 2:37 p.m. a facility staff member (O)-E verified there were no physician's visits for R11 in the clinical record. O-E stated R11 refused referrals to "Indian services," cardiology and the medical director. O-E stated R11 had expressed	F 155		

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F 155	Continued From page 12 he was in the facility until the weather warmed, then he "planned to return to the streets." On 3/13/14, at 2:40 p.m. LPN-D stated monitoring for refusal of care was in the NA "kiosks" and documented in "Care Tracker [a computer based data collection tool for the electronic medical record]" and should report the refusals of care to the nurse. LPN-D verified refusals should be documented in the clinical record. LPN-D was unclear on evaluation of the refusals or explanation of risks and benefits associated with specific refusals. On 3/18/14, at approximately 2:05 p.m. the director of nursing (DON) verified the clinical record lacked evidence R11 was provided with specific risks information regarding refusals of all cares, treatments, therapies and physician's visits. DON verified documented risk benefit information should have been provided. The Resident Refusal of Medical Treatment policy dated as effective 6/2012, indicated when a resident refused medical treatment, the resident (and family/representative and/or guardian) will be fully informed of the risk vs. benefit of such a refusal. The procedure indicated when a resident refused medical treatment, a meeting with the resident (family or legal representative) including the attending physician and representative(s) from the facility shall be held. The intent of the meeting was to discuss all of the risks and benefits, ensure resident/representative were "totally educated," that the rationale was comprehended by all parties, and all relevant parties were totally informed of the risks associated with the refusal. The policy indicated the meeting and discussion should include	F 155		

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F 155	Continued From page 13 potential for resident decline, pain/suffering, infection, hospitalization and/or death as potential outcomes. The policy directed the facility "will enter a thoroughly documented account of the same in the clinical record." The policy directed to follow up with the physician to ensure the physician documented the discussion in the progress notes in "comprehensive detail." The policy referred to completion of Resident Refusal of Medical Treatment form, directed what information was required on the form, and that the form was "kept in the resident's permanent record." The refusals of medical treatment "will be reviewed at least quarterly."	F 155		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a	F 157		

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F 157	Continued From page 14 change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to notify the physician and family member in a timely manner of the development of pressure ulcers for 1 of 1 resident (R64) reviewed for notification of changes. Findings include: R64's current diagnoses according to their Admission Face Sheet, dated 1/14/14, revealed senile dementia uncomplicated, diabetes, essential hypertension, senility without mention of psychosis and lack of coordination. On 3/11/14, at 4:03 p.m. family member (F)-D was interviewed and indicated they were the primary contact for R64. F-D stated they were not being called by the facility with changes in condition. They were notified of changes only by the hospice agency who was working with R64. On 3/14/14, at 7:22 a.m. licensed practical nurse (LPN)-A was observed to measure open areas on R64's scrotum. LPN-A identified them as a single 4 centimeter (cm) x 2 cm superficial area, LPN-A said they were two areas that looked like they had	F 157	F 157 Sampled resident R64 is no longer a resident at the facility. For all residents at the facility, the facility shall ensure that physicians and families are notified in a timely manner of changes in condition. The family and physician of all residents will be notified of the development of a pressure sore. Additionally, if hospice is involved with resident care, all notifications of physician and/or families will be coordinated with hospice. All notifications to the physician and/or family will be clearly documented in the clinical record. The facility has a reference list titled *"When To Call a Physician"* in the policy and procedure manual. Licensed nurses will be inserviced about this reference list.	

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F 157	Continued From page 15 merged into one large area. LPN-A felt they were related to incontinence or potentially from sitting on the area and getting pinched. LPN-A was observed to apply Remedy Calazime (a type of antifungal barrier ointment) around the open areas. LPN-A said the open areas on the scrotum would be reported to hospice and the director of nursing (DON), but did not indicate she would contact family regarding the change in status. On 3/13/14, at 7:56 a.m. R64 was assisted with cares by nursing assistant (NA)-D. The observation noted two open areas on the bottom of R64's scrotum; NA-D stated he had told the nurse about those. On 3/13/14, at 8:55 a.m. LPN-D was interviewed and reported any skin conditions should be documented on the wound flow sheet. LPN-D stated LPN-A had those documents. On 3/13/14, at 9:11 a.m. LPN-A said that R64's bath was scheduled yesterday and there should have been a skin audit done. LPN-A began flipping through a three-ring binder with the skin audit sheets, and commented to LPN-D that she needed to complete her documentation on the skin conditions. Several skin audit sheets were observed with LPN-D's signature but no documentation on the skin was recorded on the forms. On 3/14/14, at 10:34 a.m. the director of nursing (DON) observed R64's open areas with the surveyor. The DON stated they appear to be pressure related, and might be aggravated by incontinence. The DON would classify the sites as two separate stage II pressure ulcers (a type of pressure ulcer characterized by partial	F 157	Clinical record audits will be conducted for sampled resident R64 and for a random sampling of residents on a monthly basis for 6 months. The results of these audits will be reviewed by the DON and facility Administrator. Both will sign off on the audits. The audits will be reported to the QA committee monthly X6 for review and further intervention as found necessary. Responsible: Administrator, DON, licensed staff Compliance date: 4/28/2014	

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F 157	Continued From page 16 thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough - may also present as an intact or open/ruptured serum-filled or serosanguineous filled blister). Hospice LPN-F was also present at that time and concurred with the DON's impression. LPN-F confirmed that R64's brief was soiled with urine, and registered nurse (RN)-D stated the resident had not been repositioned since before breakfast. The DON stated the measurement of the first area was 2.5 cm x 1 cm with clearly defined borders that were irregular in shape. The second area had measurements of 1.5 cm x 2.4 cm. The wound bases were noted to be whitish in color, a change from the previous observation that morning. On 3/13/14, at 1:25 p.m. R64 was transferred by NA-A and NA-D into bed using the standing lift. R64 was noted to have two open areas on the scrotum; NA-D said he informed a nurse of the open areas last week. Review of the nursing progress notes and skin documentation worksheets for the previous week did not identify the open areas, or any physician or family contact regarding their presence or condition. On 3/13/14, at 1:32 p.m. LPN-D was informed of the skin areas by surveyor staff and looked at the sites. LPN-D said they thought they were from incontinence of bladder. Two distinct irregularly shaped, elongated open areas with a pinkish-red wound base were observed. There was a superficial loss of skin over the areas. Nursing progress notes for 3/13/14, revealed no documentation regarding LPN-D's observations of the area, or any follow up measures or assessment of the areas.	F 157		

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F 157	Continued From page 17 Nursing progress notes by LPN-A dated 3/14/14, at 8:06 a.m. revealed R64's hospice agency was informed of the open areas on R64's scrotum to inquire into treatment, but no notification was made to the family to update them of the change in condition or need to alter the treatment plan. Nursing progress notes by LPN-D dated 3/14/14, at 8:47 a.m. revealed an order was received for a physical therapy evaluation and treatment for proper transfers and a topical cream for R64's open areas. No notification was made to the family to update them of the new orders received. A skin audit sheet dated 3/14/14, (LPN-A indicated should have been dated 3/12/14) by LPN-C revealed R64's skin to the coccyx and perineum was intact. LPN-A said any areas other than pressure ulcers would be documented in the progress notes on the electronic chart. Review of R64's documentation lacked wound documentation or any progress notes indicating the presence of open areas on the scrotum. There was no documentation that the open areas had been reported to a physician or family. A policy regarding notification of significant changes in resident condition was requested at approximately 3:00 p.m. on 3/14/14, however none was provided.	F 157		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for	F 167	F 167 For all residents at the facility, the facility shall ensure that survey results including the plan of correction is readily available and positioned for easy access by wheelchair bound residents.	

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F 167	Continued From page 18 examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the most recent Federal and State survey results were posted in a prominent place accessible to be read by residents (including residents in wheelchairs), families and public visitors. This had the potential to affect all 84 residents residing in the facility. Findings include: On 3/10/14, at approximately 11:30 a.m. upon entrance to the facility, a yellow and white binder labeled State Survey Results, were observed to be stored behind the nurse staff posting (in a glass picture frame, leaning against the side of the binder), behind a basket, and behind a vase containing a bouquet of flowers. A maroon wing back chair was observed to be between the survey results and the surveyor and blocked direct access to the survey results. During random observations on 3/11/4, at approximately 1:00 p.m.; 3/12/14, at approximately 9:00 p.m.; on 3/13/14, at approximately on 3:30 p.m.; on 3/14/14, at approximately 10:00 a.m. the survey results binder was observed to be stored at the front receptionist desk in the same area, with the same environmental barriers in place. Although the survey results contained in the binder included the required survey information, the results were	F 167	The facility initiated a policy *"Posting of Survey Results"* to provide specific guidance to the facility related to this regulation. At resident council, the residents will be educated about the location of the survey and ensure they know how to access it. The minutes of this resident council meeting will be presented to the QA committee for review and further intervention as deemed appropriate. The administrator shall ensure the survey posting is place and report to the QA committee monthly X6, then quarterly after that. Responsible: Administrator and/or designee Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 167	Continued From page 19 not accessible to residents in wheelchairs or the public without asking facility staff for assistance. On 3/17/14, at 1:13 p.m. the director of nursing (DON) verified the Federal and State survey results were not accessible to residents in wheelchairs and could not be accessed without asking staff. The DON stated the facility lacked a policy for posting the most recent Federal and State survey results.	F 167		
F 174 SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY §483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. §483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 2 residents (R38) in the sample (but had the potential to affect 8 of 84 residents whose family did their laundry) reviewed for personal property whose clothing was not handled, not stored in a clean and sanitary manner. Findings include: On 3/12/14, at 12:42 p.m. family member (F)-A	F 174	F 174 For sampled resident R38 and for all residents that identify the facility to do the resident personal laundry, the facility shall ensure the laundry is done in a timely fashion. The laundry will be done in a manner to keep the clothes clean and well maintained. For sampled resident R38, the laundry issues was discussed. The facility offered to replace the damaged clothing and the family declined. A follow up meeting was held with the family. They estimated a cost of $177 to replace the clothing. The family was given a check for $177 to replace the damaged clothing.	

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F 174	Continued From page 20 approached the surveyors and stated he had been to the administrator office but had not seen anyone and wanted to show one of the surveyors something in R38's room. On 3/12/14, at 12:44 p.m. upon entering the R38's room there was an open clear plastic bag half filled with clothing sitting on the floor of the closet. As surveyor approached the closet there was a strong musty smell emanating from the plastic bag. -At 12:47 p.m. F-A stated he usually visited R38 one to two times per week and he was responsible for doing her laundry. He had been out of town due to other family issues and had asked licensed practical nurse (LPN)-A before leaving town in 1/23/14, to do R38's laundry while he was gone, but that was never followed up as requested even with phone calls when he was out of town to make sure R38 was taken care of. F-A added he had been out of town again in 12/13 and the same thing had happened. On 3/12/14, at approximately 1:00 p.m. F-A came to the surveyors carrying a clear plastic bag with clothing stated he wanted to show the surveyor how his mother's clothes that had not been laundered look. He opened and pulled the plastic bag back and in the bag was a pair of black slack and a pair of white socks. The clothing was observed to have multiple fuzzy white circular growths all over the black pants and both the stockings and pants had a strong musty smell. F-A stated, "Look at these clothes with all the mold growing in them." R38's care plan dated 9/27/11, identified R38 had an activity of daily living (ADL's) self-care performance deficit related to dementia, muscular	F 174	The facility has a policy titled *"Laundry Services."* The facility administrator, the laundry services staff, and the laundry manager shall ensure this policy is operational. Staff inservice will take place. These inservice records will be reviewed by the QA committee. At admission, the facility shall determine who will do the residents personal laundry. This record will be kept in a log book and reviewed and updated regularly by the laundry manager. This log book will be discussed at the QA committee monthly X6 for review and additional intervention as deemed necessary. The log will then be reviewed quarterly by the QA committee. Responsible: Administrator, laundry manager Compliance date: 4/28/2014	

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F 174	Continued From page 21 wasting, delusions, osteoarthritis, osteoporosis and indicated R38 was on hospice. Goal "Will have daily needs met..." The care plan directed nursing to provide cares, services according to resident needs and plan of care. In addition, R38's cognitive function identified R38 with an alteration in decision making, confusion, impaired thought processes, difficulty with decision making, impaired communication and indicated R38 required staff assistance with ADLs. Goal "R38 will have basic needs met on a daily basis..." R38's diagnoses included Alzheimer's disease, senile osteoporosis, muscular wasting and disuse atrophy, macular degeneration of retina, Parkinsonism, and cataract obtained from the Minimum Data Set (MDS) dated 1/29/14. In addition, the MDS indicated R38 required total physical dependence of one staff with ADLs. R38 was depicted as being totally incontinent of both bladder and bowel. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/10/14, identified R38 had decreased ability to make self-understood. The CAA for urinary incontinence dated 2/10/14, revealed R38 to be incontinent of both bowel and bladder and the plan was to "continue the same care." When interviewed on 3/14/14, at 8:48 a.m. LPN-A stated F-A had called stating he was out of town and had requested to have R38's laundry to be done by the facility until he returned. LPN-A was not sure about the exact date when F-A had requested. LPN-A acknowledged she had not documented the phone call in R38's medical record. LPN-A further stated she had gone to the	F 174		

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F 174	Continued From page 22 laundry supervisor (LS) and had told her to do the laundry and LS stated it was okay. -At 8:50 a.m. LPN stated one day she had realized LS was not working but had approached another laundry staff who had separated with the facility and had ask her to make sure she grabbed the laundry until further notice. LPN-A stated LS should have verified before stopping to do the laundry or should have continued until she had been told otherwise. LPN-A stated she was disappointed at how the whole situation had turned out. When interviewed on 3/14/14, at 2:38 p.m. LS stated she had been asked by LPN-A to do R38's laundry but had thought it was only one time and she never went back to check R38's room to see if the laundry was being done. She further stated "When I saw the clothes the other day they were moldy and I felt really bad and even I offered F-A to do the laundry but he declined." When interviewed on 3/17/14, at 8:12 a.m. the director of nursing (DON) stated there was miscommunication between laundry and when LPN-A had told LS as she thought it was a onetime thing only but never followed up before stopping to do it. She further stated when the laundry piled up someone should have said something or brought it to someone's attention.	F 174		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.	F 176	F 176 For sampled resident R36 and for all residents who wish to self-administer treatments and/or medication, the resident will be assessed for the safe ability to self-administer. The activity will be cared planned. Storage of supplies will be addressed.	

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F 176	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure self-administered medications were safely administered for 1 of 1 resident (R36) observed to self-administer medications (SAM). Findings include: On 3/11/14, at 9:36 a.m. during a random observation R36 showed surveyor he was holding his vitamin and potassium tablets (supplement replacements) in his hand. Upon looking, four and a half (4 1/2) tablets were observed in his left hand. When interviewed on 3/11/14, at 9:39 a.m. trained medication aide (TMA)-C stated R36 took the big ones back to his room to take with pop but the Lasix (medication used to treat excessive fluid accumulation and swelling of the body caused by heart failure) and Methadone (a narcotic pain medication) he took them in front of her. The quarterly Minimum Data Set (MDS) dated 2/18/14, identified R36 had diagnoses including hypertension, anemia, peripheral vascular disease (PVD), chronic pain and delirium/confusion state. In addition, the MDS indicated R36's Brief Interview for Mental Status (BIMS-tool used to measure cognition) had a score of 13 which noted cognitively intact. The care plan dated 6/14/12, indicated R36 had declined to self-medicate. The care plan directed "Nursing to store, administer and document all medications daily as ordered." In addition, the	F 176	The facility does have a policy titled "Self Administration of Treatment" that was effective 05/2012 and reviewed again on 05/2013. This policy shall be made operational for all residents in the facility. Additionally, the facility does have a policy titled "Self Administration of Medication" and has a specific self administration of medication form that was effective 05/2012 and reviewed again on 05/2013. These policies will be made full operational in the facility. All residents that engage in self-administration of treatments and/or medication will be assessed initially on admission and reassessed at least quarterly with MDS assessment and PRN based on clinical judgment and/or change in medical condition. Staff will be educated about the safe self-administration of treatments by residents and will ensure they are thoroughly aware of who does and does not self-administer treatments. This inservice will be reviewed by the QA committee.	

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F 176	Continued From page 24 care plan directed a self-medication assessment to be completed per facility policy. Physician's Orders dated 3/5/14, did not identify if R36 could SAM which included oral medications after set-up. The undated Assessment For Self-Administration Of Medications indicated R36 did not wish to self-administer medications and would not be set up with medications in envelop with designated dispensing times if he went on leave of absence. The Nursing Assessment Packet Review Quarterly reference period 2/12/ (no year), through 2/18/ (no year), under Self Administration of Medications had indicated "no" changes to SAM assessment. The Medication Administration Record (MAR) dated for March 2014, revealed R36 would have received the following medications during the observation: Methadone, Lasix, Certavite (Multivitamin), Potassium and Pantoprazole (used for short-term treatment of erosion and ulceration of the esophagus caused by gastroesophageal reflux disease). When interviewed on 3/14/14, 3:32 p.m. licensed practical nurse (LPN)-A stated she would expect a resident to have an assessment, a physician's order and an updated care plan if the resident had been determined to be able to self-administer medications. On 3/18/14, at 8:25 a.m. the director of nursing (DON) stated she expected staff to stay and watch all residents take their pills if they did not have an order to self-administer medications after	F 176	All resident who perform any self-administration of treatment and/or medication will have their clinical record audited monthly X6. The results of this audit will be reported to the QA committee for review and further action as necessary. Responsible: Administrator, DON, RCM, clinical staff Compliance date: 4/28/2014	

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F 176	Continued From page 25 set up. DON further stated if residents were considered to be appropriate to SAM that would be addressed in the care plan and an assessment would have been completed by the interdisciplinary team to reflect it all in the order which would be listed below the medication in the MAR. On 3/18/14, at 2:30 p.m. the policy was requested but was not provided.	F 176		
F 204 SS=D	483.12(a)(7) PREPARATION FOR SAFE/ORDERLY TRANSFER/DISCHRG A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency the State LTC ombudsman, residents of the facility, and the legal representatives of the residents or other responsible parties, as well as the plan for the transfer and adequate relocation of the residents, as required at §483.75(r). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 2 residents (R100) reviewed for admission, discharge, and transfer, was provided sufficient preparation and orientation prior to discharging from the facility. Findings include: R100 was admitted to the facility on 6/27/13, with	F 204	F 204 Sampled resident R100 is no longer a resident at the facility. For all residents who have anticipated discharges, the facility shall ensure sufficient preparation for discharge providing for a safe discharge plan. Additionally, the facility shall ensure that all discharge planning is thoroughly documented. For residents where a discharge is not anticipated, the facility shall ensure that a discharge summary is completed in a timely manner by the appropriate IDT members and placed in the closed record. The facility does have a policy titled, "Post-Discharge Planning" and "Discharge Summary." These policies shall be made operational in the facility.	

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F 204	Continued From page 26 diagnoses to include cellulitis and abscess of leg, diabetes, morbid obesity, history of alcohol abuse, homelessness and bipolar disorder which were obtained from the Discharge Health & Physical Progress Note dated 6/27/13. R100 was discharged from the facility of 10/30/13, to the homeless shelter where she had resided prior to the hospital admsission. The hospital History and Physical dated 6/25/13, noted R100 to be a type II diabetic that had poor insight to the disease process and was poorly controlled. R100 had fasting blood sugars over 200. The hospital indicated they were going to recheck the A1C (A1C is a test that measures a person's average blood glucose level over the past two to three months); however, no lab results for the A1C were found in the medical record from either the hosiptial or the facility. The Progress Notes for R100 were reviewed from admission to 10/30/13, only once did the facility try to explain the benefits of the blood sugars per the Progress Notes on 9/22/13. The Progress Notes lacked evidence of the risks versus benefits of taking all of the prescribed medication. The medical lacked evidence that R100 had been offered, provided orientation and facility staff reviewed discharge instructions with her prior to discharging her. Review of Physician Orders dated 6/27/13 through 10/29/13, lacked evidence that a physician's order had been obtained to discharge R100 from the facility. The Medication Administration record (MAR) dated 6/27/13 through 10/30/13, were reviewed. The MAR noted R100's blood sugars ranged from	F 204	Staff will be inserviced about the policies. These inservice records will be reviewed by the QA committee for further action as deemed appropriate. All new discharge records will be audited for sufficient discharge planning and documentation as well as the documentation of a discharge summary X6 months. The results of these audits will be reported to the QA committee for review and further action as deemed appropriate. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff, medical records Compliance date: 4/28/2014	

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F 204	Continued From page 27 112 to 275. The Nursing Comprehensive Assessment Packet Admission dated 6/28/13 through 7/1/13, revealed the facility did not assess R100's non-compliance with blood sugars and medications. The Nutritional Assessment 7/4/13 and 10/3/13, revealed the registered dietician only discussed the "risks of excess weight" and that "the resident expressed an understanding." R100's Physician's Orders Sheet dated 10/22/13, revealed R100 recieved Glipizide and Metformin (both diabetes medications) that were prescribed once and twice daily respectively and was to have the blood sugars checked at alternating times twice a day. R100's physician wrote an order for the staff to monitor her oral medication intake as R100 would spit out the medication. Staff were to ensure the resident had swallowed the medication and not spit out the medication. R100's medical record lacked evidence the facility had provided sufficient preparation, orientation on monitoring her blood sugars to be aware of signs and symptoms of hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar) and administering her medications. The medical record also lacked evidence of the staff informing R100 of the importance of taking all of her as prescribed medication to maintain blood sugar within the normal range. On 3/17/14, at 10:00 a.m. the director of nursing (DON) stated, "Discharge planning was not being done by designated social worker; she thought she only needed to call relocation services."	F 204	F 204 Sampled resident R100 is no longer a resident at the facility. For all residents who have anticipated discharges, the facility shall ensure sufficient preparation for discharge providing for a safe discharge plan. Additionally, the facility shall ensure that all discharge planning is thoroughly documented. For residents were a discharge is not anticipated, the facility shall ensure that a discharge summary is completed in a timely manner by the appropriate IDT members and placed in the closed record. The facility does have a policy titled, "Post-Discharge Planning" and "Discharge Summary." These policies shall be made operational in the facility. Staff will be inserviced about the policies. These inservice records will be reviewed by the QA committee for further action as deemed appropriate.	

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F 204	Continued From page 28 On 3/18/14, at 2:10 p.m. DON stated all the residents with pending discharge were supposed to have an order obtained for discharge from the physician which would be documented in the clinical record. DON stated discharge education including medications and treatments would be reviewed prior to discharge, the family or legal representative would be updated on the discharge and when discharging from the facility, the location of discharged would be documented in the clinical record. On 3/17/14, at 12:13 p.m. the policy for discharge was requested and not provided. The American Diabetes Association copyrighted 1995-2014, suggested the following targets for most non-pregnant adults with diabetes. Before a meal (preprandial plasma glucose): 70-130 milligrams/deciliter (mg/dL) one to two hours after beginning of the meal (Postprandial plasma glucose): Less than 180 mg/dl.	F 204	All new discharge records will be audited for sufficient discharge planning and documentation as well as the documentation of a discharge summary X6 months. The results of these audits will be reported to the QA committee for review and further action as deemed appropriate. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff, medical records Compliance date: 4/28/2014	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R89) was assessed for the restraint of having both wheelchair brakes locked and having the wheelchair placed flush against a table or desk; in	F 221	F 221 For sampled resident F89 and for all residents at the facility, the facility shall ensure that residents are assessed relative to the use of restrictive devices and that the least restrictive device is used.	

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F 221	Continued From page 29 addition, the facility failed to ensure the restraint was the least restrictive and clinical indications for the use of the restraint. Findings include: During the initial stage one observation on 3/10/14, at 6:09 p.m. R89 was observed to be in a wheelchair behind the nursing station with both brakes locked and the wheelchair arm rests push flush against the top of a desk (located directly in the center of the nursing station). The wheelchair was observed to be pushed against the desk, created a space R89 was observed to not be able to get out of. R89 was unable to answer surveyor initial probe questions at the time of the observation. R89 made nonsensical statements in response. R89 was observed to attempt to stand twice. Although a registered nurse (RN)-F was observed to be on the phone in direct line of sight of R89 at the nursing station and other staff was in and out of the area, no staff redirected or assisted R89 when she attempted to stand. R89's facial expression appeared to be troubled and anxious when she attempted to stand. R89 appeared unsteady with each attempt to stand. - At 6:12 p.m. a nursing assistant (NA)-N provided graham crackers to R89 and left the area. Four staff was observed in the area behind the nursing desk at that time. R89 sat and ate the crackers quietly. NA-N returned and then handed a glass of amber colored juice to R89 and stood next to her. R89's wheelchair brakes remained locked and the arm rests remained flush against the top of the desk. - At 6:15 p.m. RN-N left the nursing station and NA-N remained standing next to R89. R89 calmly drank juice, ate graham crackers and made not attempts to stand. At that time, three facility staff	F 221	The facility does have a policy titled, "Restrictive Device Management" and a "Restrictive Device Assessment Form and Consent" that were initiated 05/2012, reviewed 05/2013. This policy has been reviewed and revised. The revision now addresses locking a wheelchair as a restrictive device and it addresses the need for the care plan to articulate the frequently of releasing a restrictive device. Staff will be inserviced about the policy. These inservice records will be reviewed by the QA committee for further action as deemed appropriate.	

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 221	Continued From page 30 stood around R89. R89's brakes remained locked and the wheelchair remained pushed flush up to the desk. R89 was observed to make further standing attempts. With each attempt, R89 was noted to push back against the wheelchair. The wheelchair remained stationary, but moved back slightly about an inch each time. - At 6:18 p.m. the wheelchair was no longer flush with the desk (approximately three to four inches from the desk). NA-N remained standing next to R89, made no attempts to redirect R89 during her attempts to stand or when R89 pushed back on the wheelchair. Although NA-N remained directly next to R89, the wheelchair brakes remained locked. - At 6:23 p.m. NA-O unlocked both brakes and removed R89 from the area. - At 6:24 p.m. NA-O stated she unlocked both R89's brakes and stated she brought R89 to her room. At the time of the observations, R89 was observed to have a worried look on her face when she attempted to stand. R89 mumbled to herself nonsensical words. R89 appeared agitated with each attempt to stand. On 3/11/14, at 8:49 a.m. R89 was observed to be sitting in her wheelchair at a large breakfast table with approximately six other residents in the large dining room. R89's wheelchair was pushed up flush to the table. R89 was observed to attempt to eat independently. Licensed practical nurse (LPN)-G was observed to be at the opposite end of the table supervising and cueing another resident to eat. R89 was in direct line of sight of LPN-G. - At 8:55 a.m. LPN-G verified he was supervising the residents at the table "especially her [R89]." LPN-G stated R89 "stood up" and would attempt	F 221	All residents records with least restrictive devices in use will be audited monthly X6 for adherence to the facility policy. The results of these audits will be reported to the QA committee for review and further action as deemed appropriate. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff, medical records Compliance date: 4/28/2014	

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F 221	Continued From page 31 to walk a few steps and "fall." LPN-G explained R89 required supervision due to her attempts to walk and she would "lift up the whole table" when she attempted to stand. LPN-G explained staff needed to provide "one to one" with the resident at times and that was why staff needed to sit next to her. LPN-G further stated, "On my shift, I monitor her closely due to this." On 3/11/14, at 2:48 p.m. R89's guardian (O)-Q was contacted via telephone and verified she was the first contact for R89. When asked if R89 had been restrained, the guardian stated R89 was not restrained and verified she was not notified of any potential restraints. The guardian stated she was not aware of any recent falls. On 3/13/14, at 7:45 a.m. R89 was observed to be up and dressed, seated in a wheelchair near a medication cart in the hallway. R89 was confused and asked if she could "come with us." R89 attempted to raise herself partially in the wheelchair. Both brakes were locked and no staff was near the area. R89 rose slightly off wheelchair seat and immediately sat back down. - At 8:10 a.m. R89 was wheeled off the unit. - At 8:21 a.m. R89 was observed to be seated at the same long breakfast table and in the same spot at the table. Both R89's wheelchair brakes were locked, R89 was observed to make continuous attempts to stand by raising herself off the seat of the wheelchair, while pushing up with both hands against the armrests. The armrests were up against the top of the table and created a space R89 potentially could not get out of. - At 8:28 a.m. a divided plate with bowl was delivered by a cook (CK)-A to R89. Female staff (O)-R sat with R89 and assisted her to eat. The wheelchair brakes remained locked; R89	F 221		

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F 221	Continued From page 32 remained up to the table. - At 8:36 a.m. O-R stood and left R89, then approached the kitchen door, made a request and return to assisting R89. R89 made no attempts to stand. O-R interacted with R89 directly and appropriately. R89 remained in O-R's line of sight the entire time. - At 8:45 a.m. R89's brakes were unlocked and R89 was wheeled out of the dining area by O-R. At no time while R89 was supervised were R89's brakes unlocked. On 3/13/14, at approximately 9:50 a.m. NA-M stated since she has cared for R89, R89 had not fallen in her care. NA-M verified she locked the brakes on R89's wheelchair, even if she was sitting with the resident. NA-M stated, "When you're with her, you always have to lock the breaks." NA-M stated locking the brakes was a means to prevent falls and verified R89 was at times brought behind the nursing station, brakes locked and pushed up to the nursing desk. During monitoring observations on 3/15/14, at 10:21 a.m. R89 was observed to be in her wheelchair behind the nursing station. Both wheelchair brakes were locked and the wheelchair was pushed up flush to the desk in the center of the nurses' station. No staff was observed behind the desk. - At approximately 10:22 a.m. RN-B was observed to sit at a computer and type, and then answer the telephone. RN-B had their back to R89. R89 was noted to have nothing on the desk (such as a snack, fluids or a magazine); RN-B did not interact with R89. A restorative aide passed through the nursing station and stated "Hey [R89's name]!" and entered a door at the back of the nursing station. R89 lifted her bottom up off	F 221		

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F 221	Continued From page 33 the chair several times at irregular intervals. R89 stated, "Is he gonna come back? I gotta go home, I can't move this thing." R89 appeared anxious with a worried expression on her face, R89 pushed up with her hands and arms against the armrests and back against the wheelchair. RN-B made to attempts to assist or redirect R89. - At 10:25 a.m. the director of nursing (DON) came into the nursing station area and spoke with RN-B. Both had their backs turned to R89. DON then approached R89, patted her on the back and said, "Can I bring you to the lounge?" DON then stated to NA-A, "She [R89] shouldn't be back here." NA-A unlocked both brakes and wheeled R89 away from the desk, out of the nursing station area and into the lounge (the television (TV)/activity room off the South unit). The large TV was on and approximately five other residents were in the room. R89 was wheeled to the far wall near the window and faced towards the TV. Both brakes were locked and NA-A left the room. - At 10:33 a.m. RN-B was observed to be supervising the lounge and activity, adjusting positioning of legs of other residents in the lounge. R89 was observed to push herself up off of the wheelchair seat two times, and then sat and looked at the TV calmly, arms crossed across her chest. Both brakes remained locked. The Admission Nursing Assessment dated 12/23/13, identified R89 had no visual, or hearing impairments, and she was alert to person, place, family and self only. The assessment identified "right side weakness." Although the assessment identified R89 arrived to the facility in a wheelchair, the assessment did not identify the use of a wheelchair and had "N/A [non-applicable]" written by hand in the section. Review of the clinical record lacked evidence R89	F 221		

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F 221	Continued From page 34 was assessed for restraints. R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behavior concerns towards others. The MDS indicated R89 required limited physical assistance from staff to walk; extensive physical assistance from staff for transferring, bed mobility, locomotion and toilet use. The MDS identified R89 did not have steady balance when attempting to move from seated to standing position and R89 had impairment of the lower extremity on one side. The MDS did not identify R89 used a restraint. The Care Area Assessment (CAA) for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. R89's care plan identified R89 was at risk for falls related to confusion, dementia, psychotropic drug use and Picks disease. The care plan directed to provide a "safe environment for the resident." The	F 221		

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F 221	Continued From page 35 care plan did not identify or direct to lock R89's brakes, did not identify the use of a restraint and did not include direction to place R89 against a desk or table. The Admission Record dated 1/23/14, identified R89 had diagnoses to include difficulty walking, essential hypertension and Picks disease. On 3/15/14, at 1:00 p.m. DON and administrator were notified of observations of R89 restrained behind the nursing desk on 3/10/14 and on 3/15/14, as well as observations of R89 restrained at the meal table while supervised on 3/11/14 and on 3/13/14. DON stated residents should not be behind the nursing desk, and verified R89 should not have been restrained when attended/supervised by staff. DON verified R89 was at increased risk for injury and R89 should have been assessed for restraints. DON verified locking the brakes and pushing the wheelchair flush to a table or desk, and preventing R89 from moving away from the table or desk, would be considered a restraint. The facility's Restrictive Device Management Policy dated as reviewed 5/2013, identified residents should be assessed for the need for a restrictive device during the admission process and identified restrictive devices such as a lapbuddy and non-releasing seat belt. The policy did not identify other potential restrictive devices, such as the practice of locking the brakes, pushing a resident against a table or denying access to parts of the resident's body. The policy identified the "least restrictive" device should be used and identified a care plan should be developed by the interdisciplinary team to address the device. The policy indicated the DNS	F 221		

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F 221	Continued From page 36 (director of nursing services) or designee was responsible for ensuring residents were assessed for restrictive devices and for ensuring the device was checked each shift and released according to physician's orders. The policy lacked identification of release of restraint devices, such as to release the restraint every two hours, during supervised activities or while the resident was supervised at a meal.	F 221		
F 223 SS=J	483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 4 residents (R56) reviewed for resident to resident abuse, was free from verbal and physical abuse as R56 was not protected from the willful abusive actions of resident (R63) in the sample. The facility's failure to protect R56 from abuse constituted an immediate jeopardy (IJ) for R56. The IJ began on 3/9/14, when staff became aware of R63's threats to R56. The administrator and director of nursing (DON) were notified of the IJ on 3/12/14, at 5:00 p.m. The IJ was removed on 3/18/14, at 1:00 p.m. but noncompliance remained at scope and severity of a D, no actual	F 223	F 223 Resident R63 has been discharged from facility. R56 does not currently have a roommate and states she feels safe now that R63 has been discharged. Facility staff will immediately remove the resident who is abusing another resident and place them on one to one's until a plan can be established. The facility staff will immediately inform their supervisor who will notify DON and Administrator of any reports of abuse by staff or resident to resident. Staff will protect resident by calling 911 as needed. Vulnerability assessments will be reviewed/updated quarterly and as needed. Care plans will also be updated quarterly and as needed. Upon room changes, if a resident complains of being placed with a new roommate and states issues, staff will not place them in stated room.	

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F 223	Continued From page 37 harm with potential for more than minimum harm. Findings include: According to review of R56's medical record, and interview, R56 had reported to facility staff that R63 had caused emotional, physical and verbal abuse. However, the facility failed to investigate and intervene to protect R56 from the alleged physical, verbal and emotional abuse. R56 was observed and the following was noted: - On 3/11/14, at 1:54 p.m. R63 was observed to have yelled at R56 repeatedly and called her a liar. Registered nurse (RN)-B was immediately notified of R63 yelling at R56. He said "ok" and did not leave the desk. - On 3/11/14, at 4:00 p.m. R56 had to be approached five different times to get an interview completed due to R63 not allowing R56 talk without R63 becoming upset. R63 pointed at R56 and stated "You better not talk." - On 3/12/14, at 8:00 a.m. upon entering R56's room for an interview, R56 pointed towards R63 and stated to the surveyor, "Maybe you should come back." At that time R63 started to yell at R56 in a loud and angry tone of voice, "You're already here, I'm gonna leave!" R63 looked at R56 and said, "Oh, Girl you better keep your mouth shut!" R63's facial expression was angry and tone of voice was low and deep. R56 rolled her eyes and R56 recoiled back into the bed as if to guard herself at the time R63 made the verbal threat. - On 3/12/14, at 8:10 a.m. R56 stated during an interview with the surveyor, that her roommate (R63) was verbally abusive and caused her to be very afraid. R56 stated that on Sunday (3/9/14) R63 had slammed the foot of R56's bed with her	F 223	The facility has a policy "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property". This policy was effective May 2012 and reviewed May 2013. This policy covers procedure on investigating any allegation of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriation of resident property. The procedure also includes that the facility protects residents from harm during the investigation. The facility has a policy "Resident Abuse/Neglect follow up". This policy was effective May 2012 and reviewed May 2013. This policy covers procedure on assessing and evaluating for any negative outcomes to the resident following an allegation of abuse. Responsible: Social Services, Nursing and Administrator Compliance date: 4/28/2014	

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F 223	Continued From page 38 hand, and had told her she knew "what murder feels like." R56 stated the police had been called and came in. The resident said when she had reported the issue to the facility staff, they had told her to keep her stuff on her bed, and R56 said she tried not to make any noise. - Review of R56's record on 3/12/14, at 8:14 a.m. revelaed the facility still had not investigated or identified the emotional, physical or verbal abuse and threats towards R56 from R63. - On 3/12/14, at 8:23 a.m. R56 was again interviewed by the surveyor and R63 was out of the room. R56 stated, "I'm so glad she's (R63) not here." - On 3/12/14, at 1:53 p.m. R56 told the surveyor she "felt like s**t" when R63 verbally abused her and stated again that she was afraid of R63. - On 3/13/14, at 9:54 a.m. R56 was observed to be laying in bed in her room. R63 was also observed to by in the room on her own side. Maintenance staff was in the room setting up headphones for the television and the activity director was sitting outside the room. At the start of a conversation with R56, her roommate (R63) yelled with an angry voice "Oh God" and R63 got up and left the room. The activity director followed R63 down the hall. - On 3/14/14, at 8:12 a.m. R56 was observed to be laying in her bed. R56 stated to the surveyor, "they took her (R63) away last night." R56 said she felt safer now and reported she had been bedfast for the past one to two months. R56's Progress Notes were reviewed from 1/25/14, going forward to 3/14/14. On 3/14/14, the notes indicated the social services designee (SSD) had met with R56 "as a follow up to provide an ongoing support." There was no supporting evidence regarding what "ongoing	F 223		

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F 223	Continued From page 39 support" meant. The medical record lacked evidence of how the facility had intervened to keep R56 safe from R63's physical, verbal, and emotional abuse. The medical record lacked any evidence of the SSD having met with R56 prior to her becoming a roommate with R63 on 3/5/14, to discuss the new roommate and/or since to discuss any issues with adjustment to the room. R56's care plan dated 3/14/14, had a focus area initiated 3/6/13 indicating R56 had a "need for adjustment", with interventions in place to indicate R56 required social worker (SW) interventions due to her "recent admission to facility". The interventions noted the SW was to visit monthly and as needed (PRN), introduce self to others, encourage R56 to attend activities and the SW would make outside referrals to mental health professional(s) as needed. In addition there was another focus area initiated 3/6/13, with target date of 3/17/14, which indicated R56 was a "vulnerable adult related to physical limitations." The goal was to ensure R56 was "safe within Camden Care Center at all times" and the interventions included, "Nursing to provide cares, services according to resident needs, POS [Physician's orders] and POC [plan of care]," "Assistance in case of emergency" and "Vulnerable adult assessment per facility policy." The Vulnerable Adult Assessment (VAA) dated 11/21/13, indicated R56 had physical limitations which made the resident susceptible to abuse. The physical limitations include wheelchair (w/c) bound and history of hip fracture. The form also identified R56 did not "have a history of any type of abuse towards others or self-abuse." The VAA was updated on 2/20/14, and noted the VAA was still current with no changes.	F 223		

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F 223	Continued From page 40 R56's most recent Minimum Data Set (MDS) dated 2/20/14, identified R56 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R56 was totally dependent upon staff for transfers and bed mobility. behaviors directed towards staff only, no delusions, Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). R56's diagnoses included arthritis, cancer, and Parkinson's. The MDS also noted R56 received no antipsychotic medication. The Physician's Orders dated 3/5/14, indicated R56 had a lung mass was to see a pulmonologist. Also according R56's Physician's Orders R56 received Morphine Sulfate for pain twice a day, Lasix for edema twice a day, oral inhalers for breathing, and lactulose for liver disease. R63's record was reviewed. It was determined R63 was aware of the facility's policy for abuse as R63 had signed the Acknowledgement of Vulnerable Adult and Abuse Prevention Policies on 10/5/11. The Acknowledgement form read, "Camden Care Center strives to support and protect all of our residents. To ensure our resident's needs are met, we have established Vulnerable Adult and Abuse Prevention Policies. All residents have the right to report concerns or suspected abuse without fear of retaliation." R63's care plan last reviewed 2/16/14, included a focus area for R63 which indicated the resident needed an "opportunity to express feelings/ concerns regarding placement/life situations.	F 223		

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F 223	Continued From page 41 [R63] tends to keep to herself. [R63] has a dx [diagnosis] of depression." The interventions included encourage R63 to attend activities, refer to outside mental health professional(s), and remind R63 of the positives in life and to have the SW visit monthly and PRN. The care plan had not been updated with the room change and the addition of a roommate as of 3/5/14, nor was the care plan revised to reflect the physical, verbal and emotional abuse towards R56. A Care Conference Quarterly note dated 10/22/13, depicted R63 as having behaviors which included "becomes irritated with staff at times, barricades herself in her room with boxes, she also isolates her self [sic] in her room." The continued to note R63 "is very sensitive to noise and that causes 'nausea'." The note revealed R63 independent in ambulation to all destinations. R63's most recent quarterly MDS dated 1/8/14, noted R56's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a BIMS score of 15. R63's PHQ-9 was 10 which noted moderate depression. According to the MDS, R63 had trouble sleeping, had a poor appetite, had little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors. R63's last comprehensive assessment was dated 10/10/12. R63's medical record lacked a current comprehensive assessment that would have identified her current functional capacity and develop a current care plan with interventions to care for R63. R63's Progress Notes were reviewed from 9/27/13, going forward and the following was	F 223		

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F 223	Continued From page 42 noted: - On 3/9/14, at 5:34 a.m. noted staff was aware that R63 had threatened R56. "She [R63] stated 'I will kill you now', and she pounded very hard on her bed. This resident verbally attacked this writer for changing her room where she was having a good slumber. Updated the authority for a threatening comment directed towards coresident. We will continue to monitor the situation closely and vigilantly at this moment." - On 3/9/14, at 12:50 p.m. noted R63 was "not fine with present roommate and room environment. according to her [R63], her roommate is very in appropriate, like to put call light on, turn television loud, and calling nar [nursing assistant/registered] in the room to assist her with cares etc." The police had been called previously and resident needed to be separated before something happen [sic] beyond our reach." The note indicated the facility staff was going to monitor the situation every 15 minutes, however, the medical record lacked evidence of the monitoring. R63 was unavailable for interview related to the untoward behavior towards R56 as R63 was transferred out of the building on the evening of 3/13/14. On 3/12/14, at 1:50 p.m. the Minneapolis Police Department was called. In speaking with the support technician, he indicated no official report had been filed. The comments on a report made by the officer who came to the facility on 3/9/14, at 5:34 a.m. recommended the facility separate the two women (R56 and R63) as "they were irritable and could not tolerate each other." On 3/12/14, at 2:37 p.m. an interview was	F 223		

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F 223	Continued From page 43 conducted with the SSD (social services director). She indicated R56 and R63 became roommates on 3/5/14, as both women were private pay and could not afford to pay the private pay fee for a private room. The SSD indicated she was first made aware of the 3/9/14, altercation during the Monday morning report meeting on 3/10/14. The SSD revealed she did speak with R63 and stated, "[R63] is used to being in her own room. She did warn us, I would not be able to get along with a roommate. 'I was brought into a private room and will not be able to get along.'" The SSD was not aware of R63's "I now know what murder feels like." and was aware of the police being called on 3/9/14. The SSD expected the staff to inform her of any situation that needed her attention. SSD stated she did meet with R63 on 3/11/14, and R63 stated "things were getting better, they are avoiding communicating with each other and talking to each other." The SSD did not put any interventions into place for the altercations between the two roommates and she was unaware if nursing had put any interventions in place to prevent the emotional, physical and verbal abuse of R63 towards R56. The medical record lacked evidence of the communication between R63 and the SSD as the SSD did not document any of the follow up conversations. It could not be determined whether R63 had received the monthly SW visits as indicated on the care plan revised 4/18/12. R56 had not received the monthly visits by the SSD as directed by the care plan nor was R56's care plan revised to reflect a new roommate and the need for a new adjustment period for the new roommate. On 3/12/14, at 2:46 p.m. licensed practical nurse (LPN)-A and the administrator were interviewed	F 223		

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F 223	Continued From page 44 regarding the altercation between R56 and R63. The administrator was not aware of the incident that took place on 3/9/14, and was not aware that the police came. LPN-A was aware and stated she'd informed the SSD about the incident. Neither party was aware of the police recommendation to separate the women, and both acknowledged no interventions were put into place to protect R56 from R63. Neither party was aware of R63's comment on 3/11/14, "I now know what murder feels like." Both parties acknowledged they would have expected staff to report that incident to them. On 3/12/14, at 2:53 p.m. the DON was interviewed. The DON indicated she was not made aware of the 3/9/14, altercation between R56 and R63. She also indicated she did not know the police had come that morning or the recommendation of separating the women. The DON was unaware of the R63's abusive remark to R56 "I now know what murder feels like." The DON admitted there have been no interventions put into place since 3/9/14, to monitor R63's abusive verbal and emotional behavior towards R56. On 3/13/14, at 3:30 p.m. the DON reported she was not aware that R63 was verbally aggressive towards R56 during observations that a.m. She reported the facility had received an order for a 72 hour hold for R63. On 3/14/14, at 10:56 a.m. nursing assistant (NA)-B stated they had never heard of any altercations between R56 and R63. NA-B further commented R63 just moved to that room recently.	F 223		

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F 223	Continued From page 45 The undated Behavior Monitoring procedure directed staff to report all incidents of abusive behavior, such as physical, verbal, theft, etc. The staff was to report to the supervisor immediately. New behaviors were to be reported to the nurse for appropriate follow up. The procedure indicated the nurse and social worker were to review the information weekly and follow up as needed. The IJ that began on 3/9/14, was removed on 3/18/14, at 1:00 p.m., when the facility had implemented an IJ removal plan that included: review and revision of the abuse prevention plan, training was provided to all staff on each shift prior to resident contact, the facility initiated a thorough investigation of ongoing incidents that involved R56 and R63, and R63 was transferred to an inpatient acute care hospital for behavioral assessment. In addition, direct care staff and licensed nursing staff were interviewed and were able to explain their responsibility for identification of incidents of potential mistreatment; internal reporting; resident protection, investigation and external reporting as defined in the facility's revised Abuse Prevention Plan, the plan included how the facility would monitor for resident to resident physical, verbal and emotional abuse. Although the IJ was removed, noncompliance remained at the lower scope and severity (s/s) of a D.	F 223		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide	F 225		

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F 225	Continued From page 46 registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to immediately notify the administrator and the State agency (SA) of allegations of abuse, neglect and mistreatment for 2 of 4 residents (56, R63) for resident to	F 225	Sampled residents R21 and 63 are no longer at the facility. For sampled residents F56, 62, 71, 17 and for all residents at the facility, the facility shall ensure that allegations of abuse are investigated and reported. The facility administrator must be notified as well as the state agency and all other state and/or law enforcement agencies as directed by the Vulnerable Adults act. The facility has a policy titled "Abuse Neglect Prohibition" that was effective 05/2012 and reviewed 7/2013. Additionally, the facility has now written an additional policy titled "Vulnerable Adult Act – Camden Specific" to ensure the specifics of the MN VA Act are thoroughly addressed and part of the facility policies. Facility staff were educated about the policies and are able to verbalize their responsibilities during events of alleged/potential or real abuse. All incidents of abuse are reported and discussed at daily stand up meeting. For sampled resident R21, the facility will complete an Elopement assessment. The IDT will meet to develop a care plan for elopement based on this assessment.	

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F 225	Continued From page 47 resident abuse and for 4 of 5 residents (R21, R62, R71, R17) in the sample reviewed for abuse prohibition. These practices had the potential to affect all 84 residents residing in the facility. Findings include: The facility failed to immediately notify the administrator and the SA of allegations of abuse, neglect, and/or mistreatment for incidents involving R21, R62, R71, R17, R56 and R63. Review of the facility's Resident Accident/Incident Reports, as well as allegations of abuse/neglect and mistreatment reported to the SA and the individual resident clinical records indicated the following: NEGLECT - ELOPEMENT A Resident Accident/Incident Report dated 7/1/13, indicated at 12:00 a.m. the police were notified and a missing person report was filed regarding R21. R21 had not been seen since the "Pm [sic] (evening) shift" and was "not back at the facility before midnight." The report indicated staff had not "heard from [R21] until now (1:45am)." - At 2:54 a.m. a note attached to the form indicated the police came to the facility and left contact info and wanted to be updated when resident came back to facility. - At 9:11 a.m. a note indicated the police were notified R21 was in the facility. The report indicated R21 refused to have family notified and indicated the physician was notified. Although the report was checked that the administrator was notified, the report had no date or time of the notification. A copy of R21's incident report dated 7/1/13, was	F 225	The RCMs will randomly audit clinical records of residents identified at risk for elopement to ensure the assessment is accurate, the care plan is appropriate and that any incidents of elopement are identified, reported, documented and that appropriate follow up is completed. The results of these audits will be reported to the QA committee for review and further action as indicated. This process will be ongoing. For sampled resident R21 a vulnerable adult assessment was completed. The IDT developed/reviewed the care plan for appropriateness. Social services has done follow up to ensure there are no residual emotional, psychological, or physical issues related to the reported "mugging" incident. On an annual basis, staff will be educated/refreshed related to the abuse and the vulnerable adult policy. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff, social services, all staff Compliance date: 4/28/2014	

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F 225	Continued From page 48 requested from the facility, but not provided. The LOA (leave of absence) Safety Assessment dated 1/23/13, identified R21 did not have cognitive impairment and indicated R21 was assessed and "appropriate to leave the facility unsupervised." The signature section for R21 was blank. The Vulnerable Adult Assessment dated 1/23/13, identified R21 had a history of alcoholism, but contradicted the LOA Safety Assessment by identifying R21 as having cognitive deficits related to "Dementia & hx [history] of TBI [traumatic brain injury]." The quarterly Minimum Data Set (MDS) dated 7/24/13, indicated R21 had moderate cognitive impairment and was independent with most Activities of Daily Living (ADLs). A Resident Information form dated as printed 3/18/14, indicated R21's diagnoses included alcoholism, epilepsy with recurrent seizure, and dementia. A Minnesota Department of Health (MDH) Incident Report - Investigative Report Submission Completed form indicated a report was submitted to the SA on 7/2/13, for R21's elopement incident on 7/1/13. The report recapitulated R21 was identified on rounds to not be in the facility. The SA report also indicated the police department was notified and R21 returned to the facility on 1:45 a.m. The report indicated the SA was not notified until 7/2/13, the fax transmission verification report indicated fax was sent at 4:45 p.m. The clinical record lacked documentation of the elopement on 7/1/13. The interdisciplinary team (IDT) Progress Notes, contradicted the incident report and indicated a missing person report was filed on 7/2/13, and recapitulated the incident	F 225		

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F 225	Continued From page 49 identified on the Accident/Incident report form and MDH Incident Report on 7/1/13. The undated Investigation Follow Up CEP (Common Entry Point) Report had initials in the administrator notification section, but lacked a date or time when the administrator was notified of the elopement. Although the report identified an investigation was "completed" and reviewed by the administrator on 7/1/13, the SA was not notified until 7/2/13, at 4:45 p.m. Further review of R21's IDT Progress Notes indicated: - On 7/20/13, a note written at 12:55 p.m. indicated "At 12:55 a.m., police came to the facility to gather patient information and immediately after they left, resident returned to the building." The note indicated R21 "could not say where he went but repeatedly said I live here." The note indicated R21 was "drunk and also refused body audit to be done. Will continue to monitor." - At 10:37 p.m. the note indicated, "Okay to hold medications tonight, and resume tomorrow morning due to intoxication." - At 10:43 p.m. the note indicated R21 continued to appear "intoxicated" due to "slash speech," unsteady gait and "smell with alcohol." The note indicated the on-call physician was notified and orders were given to hold medications "until tomorrow." - At 11:45 p.m. the note indicated, "Resident was unaccounted-for during the shift head-count at 11:15 p.m. Search for the resident was initiated in and around the building but was unsuccessful. At 11:45 pm, 911 Call placed to report the resident missing. Writer was told during the previous shift report resident was intoxicated. Search for the	F 225		

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F 225	Continued From page 50 resident continues." - The next entry in the IDT Progress Notes was on 7/22/13, at 9:21 a.m. and was regarding R21's "insurance not covering" a medication. An entry regarding R21 actually being in the facility was not noted in the Progress Notes until 10/3/13. The clinical record lacked evidence of when and where R21 was located after he was identified to be missing on 7/20/13. The clinical record lacked evidence of the date, time, location of R21 when found, R21's mentation and status when located, the circumstances of R21 leaving the facility (such as R21's reason for leaving), immediate notification of the administrator and immediate reporting to the SA. In addition, the clinical record lacked evidence of further assessment of R21's LOA Safety, Vulnerability and assessment of R21's known behavior of drinking and intoxication after 7/20/13. ABUSE - MUGGING A facility Resident Accident/Incident Report for R21 dated 10/3/13, indicated time of incident "Unknown." The report indicated the location of the incident was "outside the facility." R21 reported the incident happened before lunch and "4 blackmen mugged him" when walking to the store to buy cigarettes. R21 sustained a skin tear to the bridge of his nose and the skin tear was cleansed and a Band-Aid was applied. Although R21 reported a crime, R21 "declined incident report to police." The report indicated the physician and family were notified (no date or time). The administrator was notified on 10/3/13 (no time of notification). A copy of the Resident Accident/Incident Report dated 10/3/13, was requested but not provided by the facility.	F 225		

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F 225	Continued From page 51 An IDT Progress Note dated 10/3/13, at 9:51 p.m. recapitulated the incident and indicated facility staff asked R21 "if the police need to be called and report, resident declined and said there is no need to report to the police." The note indicated the skin tear was "0.5 and 0.2 cm [centimeters]." The note indicated the administrator was notified, but lacked a time for the notification. The clinical record lacked evidence the SA was immediately notified of the incident. MISTREATMENT and/or ABUSE - RESIDENT TO RESIDENT Seperate Resident Accident/Incident Reports for R62 and R71, dated for 10/18/13 at 9:00 p.m., identified R62 was noted to "engage in an argument with roommate [R71]" and identified the argument was about R71 "bumping into her [R62's] bed" when R71 backed the wheelchair into her room space. The report indicated R62 "ended up hitting roommate [R71]" on the right cheek. R71 sustained no injuries. The immediate action taken section indicated, "Writer talked to both roommates to calm them." The report was checked to indicate the physician was notified, and checked to indicate the administrator was notified, but had no date of the notification. The report did not indicate the SA was notified. The 30-day MDS (minimum data set) assessment dated 10/2/13, identified R62 had moderate cognitive impairment, mood problems and no behavior problems. The MDS indicated R62 required limited assistance with walking and locomotion on the unit. R62's Resident Information sheet dated 1/14/14, indicated R62's diagnoses included memory loss and dementia. R71's quarterly MDS dated 7/31/13, identified	F 225		

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F 225	Continued From page 52 R71 was cognitively intact, had mood problems and physical behavior symptoms directed towards others occurring four to six days, but not daily. R71 was independent with locomotion, did not walk and required extensive assistance with all other ADLs. R71's Resident Information sheet dated 2/25/14, indicated R71's diagnoses included hemiplegia and depressive disorder. A MDH Incident Report - Investigative Report Submission Completed form indicated the SA was notified of the resident to resident abuse incident on 10/19/13 (the day after the incident). The report indicated both residents were "counseled" on sharing living space and agreed to get along in a more civilized manner. R71 was educated as to how to maneuver her wheelchair in a safe manner without bumping into furniture. The Investigation Follow Up CEP (common entry point) Report (undated), indicated the administrator was notified of the altercation on 10/19/13, in the "AM [no specific time]" by a "nurse at Videll [the facility]." Two Resident Accident/Incident Reports for R62 and R71 dated for 11/22/13, 9:30 a.m. indicated loud voices were heard coming from R62's room, "Writer saw this resident [R62] hitting her roommate [R71] in the face." The report indicated R71 sustained no injuries, both residents were separated and a "police report was done." The immediate action section of the report indicated, "Resident [R62] was moved to different room." The report was checked to indicate the physician and family were notified. The administrator notification section was not checked and indicated the administrator was not notified. The report did not indicate if the SA was notified. The clinical record lacked evidence the administrator	F 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 225	Continued From page 53 and the SA were notified of the altercation. According to medical record review, and interview, R56 had reported to facility staff that R63 had caused R56 emotional, physical and verbal abuse. However, the facility failed to investigate and intervene to protect R56 from the alleged physical, verbal and emotional abuse. R56 was observed and the following was noted: - On 3/11/14, at 1:54 p.m. R63 was observed to have yelled at R56 repeatedly and called her a liar. Registered nurse (RN)-B was immediately notified of R63 yelling at R56. He said "ok" and did not leave the desk. - On 3/11/14, at 4:00 p.m. R56 had to be approached five different times to get an interview completed due to R63 not allowing R56 talk without R63 becoming upset. R63 pointed at R56 and stated "You better not talk." - On 3/12/14, at 8:00 a.m. upon entering R56's room for an interview, R56 pointed towards R63 and stated to the surveyor, "Maybe you should come back." At that time R63 started to yell at R56 in a loud and angry tone of voice, "You're already here, I'm gonna leave!" R63 looked at R56 and said, "Oh, Girl you better keep your mouth shut!" R63's facial expression was angry and tone of voice was low and deep. R56 rolled her eyes and R56 recoiled back into the bed as if to guard herself at the time R63 made the verbal threat. - On 3/12/14, at 8:10 a.m. R56 stated during an interview with the surveyor, that her roommate (R63) was verbally abusive and caused her to be very afraid. R56 stated that on Sunday (3/9/14) R63 had slammed the foot of R56's bed with her hand, and had told her she knew "what murder feels like." R56 stated the police had been called	F 225		

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F 225	Continued From page 54 and came in. The resident said when she had reported the issue to the facility staff, they had told her to keep her stuff on her bed, and R56 said she tried not to make any noise. - Review of R56's record on 3/12/14, at 8:14 a.m. revelaed the facility still had not investigated or identified the emotional, physical or verbal abuse and threats towards R56 from R63. - On 3/12/14, at 8:23 a.m. R56 was again interviewed by the surveyor and R63 was out of the room. R56 stated, "I'm so glad she's (R63) not here." - On 3/12/14, at 1:53 p.m. R56 told the surveyor she "felt like s**t" when R63 verbally abused her and stated again that she was afraid of R63. - On 3/13/14, at 9:54 a.m. R56 was observed to be laying in bed in her room. R63 was also observed to by in the room on her own side. Maintenance staff was in the room setting up headphones for the television and the activity director was sitting outside the room. At the start of a conversation with R56, her roommate (R63) yelled with an angry voice "Oh God" and R63 got up and left the room. The activity director followed R63 down the hall. - On 3/14/14, at 8:12 a.m. R56 was observed to be laying in her bed. R56 stated to the surveyor, "they took her (R63) away last night." R56 said she felt safer now and reported she had been bedfast for the past one to two months. R56's Progress Notes were reviewed from 1/25/14, going forward to 3/14/14. On 3/14/14, the notes indicated the social services designee (SSD) had met with R56 "as a follow up to provide an ongoing support." There was no supporting evidence regarding what "ongoing support" meant. The medical record lacked evidence of how the facility had intervened to	F 225		

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F 225	Continued From page 55 keep R56 safe from R63's physical, verbal, and emotional abuse. The medical record lacked any evidence of the SSD having met with R56 prior to her becoming a roommate with R63 on 3/5/14, to discuss the new roommate and/or since to discuss any issues with adjustment to the room. R56's care plan dated 3/14/14, had a focus area initiated 3/6/13 indicating R56 had a "need for adjustment", with interventions in place to indicate R56 required social worker (SW) interventions due to her "recent admission to facility". The interventions noted the SW was to visit monthly and as needed (PRN), introduce self to others, encourage R56 to attend activities and the SW would make outside referrals to mental health professional(s) as needed. In addition there was another focus area initiated 3/6/13, with target date of 3/17/14, which indicated R56 was a "vulnerable adult related to physical limitations." The goal was to ensure R56 was "safe within Camden Care Center at all times" and the interventions included, "Nursing to provide cares, services according to resident needs, POS [Physician's orders] and POC [plan of care]," "Assistance in case of emergency" and "Vulnerable adult assessment per facility policy." The Vulnerable Adult Assessment (VAA) dated 11/21/13, indicated R56 had physical limitations which made the resident susceptible to abuse. The physical limitations include wheelchair (w/c) bound and history of hip fracture. The form also identified R56 did not "have a history of any type of abuse towards others or self-abuse." The VAA was updated on 2/20/14, and noted the VAA was still current with no changes. R56's most recent Minimum Data Set (MDS)	F 225		

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F 225	Continued From page 56 dated 2/20/14, identified R56 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R56 was totally dependent upon staff for transfers and bed mobility. behaviors directed towards staff only, no delusions, Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). R56's diagnoses included arthritis, cancer, and Parkinson's. The MDS also noted R56 received no antipsychotic medication. The Physician's Orders dated 3/5/14, indicated R56 had a lung mass was to see a pulmonologist. Also according R56's Physician's Orders R56 received Morphine Sulfate for pain twice a day, Lasix for edema twice a day, oral inhalers for breathing, and lactulose for liver disease. R63's record was reviewed. It was determined R63 was aware of the facility's policy for abuse as R63 had signed the Acknowledgement of Vulnerable Adult and Abuse Prevention Policies on 10/5/11. The Acknowledgement form read, "Camden Care Center strives to support and protect all of our residents. To ensure our resident's needs are met, we have established Vulnerable Adult and Abuse Prevention Policies. All residents have the right to report concerns or suspected abuse without fear of retaliation." R63's care plan last reviewed 2/16/14, included a focus area for R63 which indicated the resident needed an "opportunity to express feelings/ concerns regarding placement/life situations. [R63] tends to keep to herself. [R63] has a dx [diagnosis] of depression." The interventions	F 225		

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F 225	Continued From page 57 included encourage R63 to attend activities, refer to outside mental health professional(s), and remind R63 of the positives in life and to have the SW visit monthly and PRN. The care plan had not been updated with the room change and the addition of a roommate as of 3/5/14, nor was the care plan revised to reflect the physical, verbal and emotional abuse towards R56. A Care Conference Quarterly note dated 10/22/13, depicted R63 as having behaviors which included "becomes irritated with staff at times, barricades herself in her room with boxes, she also isolates her self [sic] in her room." The continued to note R63 "is very sensitive to noise and that causes 'nausea'." The note revealed R63 independent in ambulation to all destinations. R63's most recent quarterly MDS dated 1/8/14, noted R56's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a BIMS score of 15. R63's PHQ-9 was 10 which noted moderate depression. According to the MDS, R63 had trouble sleeping, had a poor appetite, had little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors. R63's last comprehensive assessment was dated 10/10/12. R63's medical record lacked a current comprehensive assessment that would have identified her current functional capacity and develop a current care plan with interventions to care for R63. R63's Progress Notes were reviewed from 9/27/13, going forward and the following was noted: - On 3/9/14, at 5:34 a.m. noted staff was aware	F 225		

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F 225	Continued From page 58 that R63 had threatened R56. "She [R63] stated 'I will kill you now', and she pounded very hard on her bed. This resident verbally attacked this writer for changing her room where she was having a good slumber. Updated the authority for a threatening comment directed towards coresident. We will continue to monitor the situation closely and vigilantly at this moment." - On 3/9/14, at 12:50 p.m. noted R63 was "not fine with present roommate and room environment. according to her [R63], her roommate is very in appropriate, like to put call light on, turn television loud, and calling nar [nursing assistant/registered] in the room to assist her with cares etc." The police had been called previously and resident needed to be separated before something happen [sic] beyond our reach." The note indicated the facility staff was going to monitor the situation every 15 minutes, however, the medical record lacked evidence of the monitoring. R63 was unavailable for interview related to the untoward behavior towards R56 as R63 was transferred out of the building on the evening of 3/13/14. On 3/12/14, at 1:50 p.m. the Minneapolis Police Department was called. In speaking with the support technician, he indicated no official report had been filed. The comments on a report made by the officer who came to the facility on 3/9/14, at 5:34 a.m. recommended the facility separate the two women (R56 and R63) as "they were irritable and could not tolerate each other." On 3/12/14, at 2:37 p.m. an interview was conducted with the SSD (social services director). She indicated R56 and R63 became roommates	F 225		

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F 225	Continued From page 59 on 3/5/14, as both women were private pay and could not afford to pay the private pay fee for a private room. The SSD indicated she was first made aware of the 3/9/14, altercation during the Monday morning report meeting on 3/10/14. The SSD revealed she did speak with R63 and stated, "[R63] is used to being in her own room. She did warn us, I would not be able to get along with a roommate. 'I was brought into a private room and will not be able to get along.'" The SSD was not aware of R63's "I now know what murder feels like." and was aware of the police being called on 3/9/14. The SSD expected the staff to inform her of any situation that needed her attention. SSD stated she did meet with R63 on 3/11/14, and R63 stated "things were getting better, they are avoiding communicating with each other and talking to each other." The SSD did not put any interventions into place for the altercations between the two roommates and she was unaware if nursing had put any interventions in place to prevent the emotional, physical and verbal abuse of R63 towards R56. The medical record lacked evidence of the communication between R63 and the SSD as the SSD did not document any of the follow up conversations. It could not be determined whether R63 had received the monthly SW visits as indicated on the care plan revised 4/18/12. R56 had not received the monthly visits by the SSD as directed by the care plan nor was R56's care plan revised to reflect a new roommate and the need for a new adjustment period for the new roommate. On 3/12/14, at 2:46 p.m. licensed practical nurse (LPN)-A and the administrator were interviewed regarding the altercation between R56 and R63. The administrator was not aware of the incident	F 225		

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F 225	Continued From page 60 that took place on 3/9/14, and was not aware that the police came. LPN-A was aware and stated she'd informed the SSD about the incident. Neither party was aware of the police recommendation to separate the women, and both acknowledged no interventions were put into place to protect R56 from R63. Neither party was aware of R63's comment on 3/11/14, "I now know what murder feels like." Both parties acknowledged they would have expected staff to report that incident to them. On 3/12/14, at 2:53 p.m. the DON was interviewed. The DON indicated she was not made aware of the 3/9/14, altercation between R56 and R63. She also indicated she did not know the police had come that morning or the recommendation of separating the women. The DON was unaware of the R63's abusive remark to R56 "I now know what murder feels like." The DON admitted there have been no interventions put into place since 3/9/14, to monitor R63's abusive verbal and emotional behavior towards R56. The DON verified R63's verbal, physical and emotional abuse was not immediately reported to the administrator nor was it thoroughly investigated, and R56 was not protected from R63's abusive behavior INJURY OF UNKNOWN ORIGIN A Resident Accident/Incident Report for R17 dated 12/14/13, at 5:00 a.m. indicated nursing assistant staff had "noted bruise on resident." The report identified R17 was "alert" and "oriented." The report indicated the bruise measured 5 centimeters (cm) by 4 cm, was "redden" in color and was located on the forehead. The report indicated the cause of the bruise was unknown.	F 225		

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F 225	Continued From page 61 R17 stated "I bumped it." The report was checked to indicate the physician and R17's daughter were notified. The administrator notification section was unchecked and indicated the administrator was not notified. The report did not indicate the SA was notified. Although the Resident Accident/Incident Report identified R17 was alert and oriented, the Quarterly MDS dated 12/12/13, indicated R17 was never rarely understood, could not complete the BIMS and had severe cognitive impairment. The MDS indicated R17 had no mood problems, experienced hallucinations and delusions, and required limited to extensive assistance from staff for all ADLs. The clinical record lacked evidence R17's injury was reported immediately to the administrator and the SA, and lacked evidence the injury was thoroughly investigated to rule out abuse, neglect or mistreatment. On 3/18/14, at 2:06 p.m. the DON verified the administrator should have been notified immediately for allegations of mistreatment, abuse, elopements, injuries of unknown origin, and alleged neglect. The DON verified either she or the administrator should notify the SA immediately when such reports were received. The Elopement policy dated as effective 5/2012, defined elopment as "'when a resident leaves the premises or a safe area without authorization (i.e., an order for discharge or leave of absence) and/or any necessary supervision to do so.'" The procedure identified residents were assessed at admission to identify risk for elopement and additional risk assessments at least quarterly	F 225		

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F 225	Continued From page 62 after. The procedure directed to impliment interventions immediately such as personal security devices or diversional activities. The policy directed the procedure for locating missing residents including notification of the administrator and DNS (director of nursing services), notification of the physician and notification of law inforcement in "30 minutes" if resident was not found. The policy directed procedure for assessment of the resident when they return to the facility which included: physical assessment, investigation of the event, complete/updated Elopement risk Evaluation, review/revise the care plan and to document the factual account. The policy directed for the administrator or designee to report the event to the appropriate State agencies. The Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated as reviewed 1/2013, identified each resident had the right to be free from mistreatment, neglect, involuntary seclusion and misappropriation of property. The policy identified appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. - The policy identified employees would be screened prior to their first day of employment including: license verification, registry search, criminal background check, reference checks. Screening for potentially abusive residents during the pre-admission process. The policy identified training would be provided to employees through orientation and ongoing, regarding abuse/neglect prevention, identification and recognition of signs/symptoms of abuse/neglect, protection, investigation, reporting and documentation of abuse/neglect. The policy indicated residents	F 225		

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F 225	Continued From page 63 would be educated at admission and during their stays on abuse/neglect. - The policy indicated reports would be made without fear of reprisal. The policy specifically directed to notify the administrator for injuries of unknown origin. - An addendum at the end of the policy indicated, "State of Minnesota" and, "The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations." The policy did not identify the office of health facility complaints (OHFC), online reporting or Common Entry Point (CEP).	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to operationalize the Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy and enforce a resident environment that was free from physical, verbal, and emotional abuse of residents for 2 of 4 residents (R56, R63) reviewed for resident to resident abuse; the facility failed to conduct screening for 6 of 6 newly hired employees (licensed practical nurse [LPN]-G, nursing assistant [NA]-A, LPN-F, NA-K, NA-D,	F 226		

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F 226	Continued From page 64 NA-I); failed to immediately report potential incidents of abuse, neglect and mistreatment to the administrator and the State agency (SA) for 4 of 5 residents (R21, R62, R71, R17) in the sample reviewed for abuse prohibition. In addition, the facility failed to report an investigation for an allegation of abuse in a timely manner to the SA for 1 of 1 resident (R117). These practices had the potential to affect all 84 residents in the facility. Findings include: The Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated as reviewed 1/2013, identified each resident had the right to be free from mistreatment, neglect, involuntary seclusion and misappropriation of property. The policy identified appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. - The policy identified employees would be screened prior to their first day of employment including: license verification, registry search, criminal background check, reference checks. Screening for potentially abusive residents during the pre-admission process. The policy identified training would be provided to employees through orientation and ongoing, regarding abuse/neglect prevention, identification and recognition of signs/symptoms of abuse/neglect, protection, investigation, reporting and documentation of abuse/neglect. The policy indicated residents would be educated at admission and during their stays on abuse/neglect. - The policy indicated reports would be made without fear of reprisal. The policy specifically directed to notify the administrator for injuries of unknown origin.	F 226	F 226 Sampled residents R21 and 63 are no longer at the facility. For sampled residents F56, 62, 71, 17, and 117 and for all residents at the facility, the facility shall ensure the Abuse Neglect Prohibition policy is fully operational. This includes, but is not necessarily limited to: • ensuring residents are protected from abuse, neglect, and misappropriation of property from any source • reporting of all allegations of abuse to the appropriate facility staff, state agencies, CEEP and all other state agencies and law enforcement as appropriate • ensuring the appropriate background checks are completed on newly hired employees All staff are educated in the Abuse Neglect Prohibition policy and are able to verbalize their responsibility as outlined in the policy.	

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 226	Continued From page 65 - An addendum at the end of the policy indicated, "State of Minnesota" and, "The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations." The policy did not identify the office of health facility complaints (OHFC), online reporting or Common Entry Point (CEP). ALLEGATION OF ABUSE According to medical record review, and interview, R56 had reported to facility staff that R63 had caused R56 emotional, physical and verbal abuse. However, the facility failed to investigate and intervene to protect R56 from the alleged physical, verbal and emotional abuse. R56 was observed and the following was noted: - On 3/11/14, at 1:54 p.m. R63 was observed to have yelled at R56 repeatedly and called her a liar. Registered nurse (RN)-B was immediately notified of R63 yelling at R56. He said "ok" and did not leave the desk. - On 3/11/14, at 4:00 p.m. R56 had to be approached five different times to get an interview completed due to R63 not allowing R56 talk without R63 becoming upset. R63 pointed at R56 and stated "You better not talk." - On 3/12/14, at 8:00 a.m. upon entering R56's room for an interview, R56 pointed towards R63 and stated to the surveyor, "Maybe you should come back." At that time R63 started to yell at R56 in a loud and angry tone of voice, "You're already here, I'm gonna leave!" R63 looked at R56 and said, "Oh, Girl you better keep your mouth shut!" R63's facial expression was angry and tone of voice was low and deep. R56 rolled	F 226	The facility will randomly conduct interviews with staff on duty to ensure they understand the Abuse Prohibition Policy and their responsibilities outlined in the policy. The results of these audits will be reported to the QA committee for review and further action as recommended. This is an ongoing process. For sampled employee files LPN-G and F, for NA-A, K, D, and I, the appropriate background checks will be completed prior to first day of employment. All new hire employee files will be audited monthly to ensure all the appropriate background and licensure/certification checks are completed. The results of this audit will be reported to the QA committee for review and further action as recommended. This is an ongoing process. The facility developed a policy "Vulnerable Adult Act – Camden Specific" to ensure that all aspects of the Minnesota VA Act are a part of the facility abuse prohibition protocol including completing and phoning in a CEEP report. Staff are educated in the policy and are able to verbalize their responsibilities as outlined in this policy.	

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F 226	Continued From page 66 her eyes and R56 recoiled back into the bed as if to guard herself at the time R63 made the verbal threat. - On 3/12/14, at 8:10 a.m. R56 stated during an interview with the surveyor, that her roommate (R63) was verbally abusive and caused her to be very afraid. R56 stated that on Sunday (3/9/14) R63 had slammed the foot of R56's bed with her hand, and had told her she knew "what murder feels like." R56 stated the police had been called and came in. The resident said when she had reported the issue to the facility staff, they had told her to keep her stuff on her bed, and R56 said she tried not to make any noise. - Review of R56's record on 3/12/14, at 8:14 a.m. revelaed the facility still had not investigated or identified the emotional, physical or verbal abuse and threats towards R56 from R63. - On 3/12/14, at 8:23 a.m. R56 was again interviewed by the surveyor and R63 was out of the room. R56 stated, "I'm so glad she's (R63) not here." - On 3/12/14, at 1:53 p.m. R56 told the surveyor she "felt like s**t" when R63 verbally abused her and stated again that she was afraid of R63. - On 3/13/14, at 9:54 a.m. R56 was observed to be laying in bed in her room. R63 was also observed to by in the room on her own side. Maintenance staff was in the room setting up headphones for the television and the activity director was sitting outside the room. At the start of a conversation with R56, her roommate (R63) yelled with an angry voice "Oh God" and R63 got up and left the room. The activity director followed R63 down the hall. - On 3/14/14, at 8:12 a.m. R56 was observed to be laying in her bed. R56 stated to the surveyor, "they took her (R63) away last night." R56 said she felt safer now and reported she had been	F 226	The facility will randomly conduct interviews with staff on duty to ensure they understand the Vulnerable Adult Act – Camden Specific Policy and their responsibilities outlined in the policy. The results of these audits will be reported to the QA committee for review and further action as recommended. This is an ongoing process. On an annual basis, staff will be educated/refreshed related to the abuse and the vulnerable adult policy. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff, social services, all staff Compliance date: 4/28/2014	

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F 226	Continued From page 67 bedfast for the past one to two months. R56's Progress Notes were reviewed from 1/25/14, going forward to 3/14/14. On 3/14/14, the notes indicated the social services designee (SSD) had met with R56 "as a follow up to provide an ongoing support." There was no supporting evidence regarding what "ongoing support" meant. The medical record lacked evidence of how the facility had intervened to keep R56 safe from R63's physical, verbal, and emotional abuse. The medical record lacked any evidence of the SSD having met with R56 prior to her becoming a roommate with R63 on 3/5/14, to discuss the new roommate and/or since to discuss any issues with adjustment to the room. R56's care plan dated 3/14/14, had a focus area initiated 3/6/13 indicating R56 had a "need for adjustment", with interventions in place to indicate R56 required social worker (SW) interventions due to her "recent admission to facility". The interventions noted the SW was to visit monthly and as needed (PRN), introduce self to others, encourage R56 to attend activities and the SW would make outside referrals to mental health professional(s) as needed. In addition there was another focus area initiated 3/6/13, with target date of 3/17/14, which indicated R56 was a "vulnerable adult related to physical limitations." The goal was to ensure R56 was "safe within Camden Care Center at all times" and the interventions included, "Nursing to provide cares, services according to resident needs, POS [Physician's orders] and POC [plan of care]," "Assistance in case of emergency" and "Vulnerable adult assessment per facility policy." The Vulnerable Adult Assessment (VAA) dated	F 226		

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F 226	Continued From page 68 11/21/13, indicated R56 had physical limitations which made the resident susceptible to abuse. The physical limitations include wheelchair (w/c) bound and history of hip fracture. The form also identified R56 did not "have a history of any type of abuse towards others or self-abuse." The VAA was updated on 2/20/14, and noted the VAA was still current with no changes. R56's most recent Minimum Data Set (MDS) dated 2/20/14, identified R56 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R56 was totally dependent upon staff for transfers and bed mobility. behaviors directed towards staff only, no delusions, Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). R56's diagnoses included arthritis, cancer, and Parkinson's. The MDS also noted R56 received no antipsychotic medication. The Physician's Orders dated 3/5/14, indicated R56 had a lung mass was to see a pulmonologist. Also according R56's Physician's Orders R56 received Morphine Sulfate for pain twice a day, Lasix for edema twice a day, oral inhalers for breathing, and lactulose for liver disease. R63's record was reviewed. It was determined R63 was aware of the facility's policy for abuse as R63 had signed the Acknowledgement of Vulnerable Adult and Abuse Prevention Policies on 10/5/11. The Acknowledgement form read, "Camden Care Center strives to support and protect all of our residents. To ensure our resident's needs are met, we have established	F 226		

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F 226	Continued From page 69 Vulnerable Adult and Abuse Prevention Policies. All residents have the right to report concerns or suspected abuse without fear of retaliation." R63's care plan last reviewed 2/16/14, included a focus area for R63 which indicated the resident needed an "opportunity to express feelings/ concerns regarding placement/life situations. [R63] tends to keep to herself. [R63] has a dx [diagnosis] of depression." The interventions included encourage R63 to attend activities, refer to outside mental health professional(s), and remind R63 of the positives in life and to have the SW visit monthly and PRN. The care plan had not been updated with the room change and the addition of a roommate as of 3/5/14, nor was the care plan revised to reflect the physical, verbal and emotional abuse towards R56. A Care Conference Quarterly note dated 10/22/13, depicted R63 as having behaviors which included "becomes irritated with staff at times, barricades herself in her room with boxes, she also isolates her self [sic] in her room." The continued to note R63 "is very sensitive to noise and that causes 'nausea'." The note revealed R63 independent in ambulation to all destinations. R63's most recent quarterly MDS dated 1/8/14, noted R56's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a BIMS score of 15. R63's PHQ-9 was 10 which noted moderate depression. According to the MDS, R63 had trouble sleeping, had a poor appetite, had little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors. R63's last comprehensive assessment	F 226		

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F 226	Continued From page 70 was dated 10/10/12. R63's medical record lacked a current comprehensive assessment that would have identified her current functional capacity and develop a current care plan with interventions to care for R63. R63's Progress Notes were reviewed from 9/27/13, going forward and the following was noted: - On 3/9/14, at 5:34 a.m. noted staff was aware that R63 had threatened R56. "She [R63] stated 'I will kill you now', and she pounded very hard on her bed. This resident verbally attacked this writer for changing her room where she was having a good slumber. Updated the authority for a threatening comment directed towards coresident. We will continue to monitor the situation closely and vigilantly at this moment." - On 3/9/14, at 12:50 p.m. noted R63 was "not fine with present roommate and room environment. according to her [R63], her roommate is very in appropriate, like to put call light on, turn television loud, and calling nar [nursing assistant/registered] in the room to assist her with cares etc." The police had been called previously and resident needed to be separated before something happen [sic] beyond our reach." The note indicated the facility staff was going to monitor the situation every 15 minutes, however, the medical record lacked evidence of the monitoring. R63 was unavailable for interview related to the untoward behavior towards R56 as R63 was transferred out of the building on the evening of 3/13/14. On 3/12/14, at 1:50 p.m. the Minneapolis Police Department was called. In speaking with the	F 226		

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F 226	Continued From page 71 support technician, he indicated no official report had been filed. The comments on a report made by the officer who came to the facility on 3/9/14, at 5:34 a.m. recommended the facility separate the two women (R56 and R63) as "they were irritable and could not tolerate each other." On 3/12/14, at 2:37 p.m. an interview was conducted with the SSD (social services director). She indicated R56 and R63 became roommates on 3/5/14, as both women were private pay and could not afford to pay the private pay fee for a private room. The SSD indicated she was first made aware of the 3/9/14, altercation during the Monday morning report meeting on 3/10/14. The SSD revealed she did speak with R63 and stated, "[R63] is used to being in her own room. She did warn us, I would not be able to get along with a roommate. 'I was brought into a private room and will not be able to get along.'" The SSD was not aware of R63's "I now know what murder feels like." and was aware of the police being called on 3/9/14. The SSD expected the staff to inform her of any situation that needed her attention. SSD stated she did meet with R63 on 3/11/14, and R63 stated "things were getting better, they are avoiding communicating with each other and talking to each other." The SSD did not put any interventions into place for the altercations between the two roommates and she was unaware if nursing had put any interventions in place to prevent the emotional, physical and verbal abuse of R63 towards R56. The medical record lacked evidence of the communication between R63 and the SSD as the SSD did not document any of the follow up conversations. It could not be determined whether R63 had received the monthly SW visits as indicated on the care plan revised 4/18/12. R56 had not	F 226		

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F 226	Continued From page 72 received the monthly visits by the SSD as directed by the care plan nor was R56's care plan revised to reflect a new roommate and the need for a new adjustment period for the new roommate. On 3/12/14, at 2:46 p.m. licensed practical nurse (LPN)-A and the administrator were interviewed regarding the altercation between R56 and R63. The administrator was not aware of the incident that took place on 3/9/14, and was not aware that the police came. LPN-A was aware and stated she'd informed the SSD about the incident. Neither party was aware of the police recommendation to separate the women, and both acknowledged no interventions were put into place to protect R56 from R63. Neither party was aware of R63's comment on 3/11/14, "I now know what murder feels like." Both parties acknowledged they would have expected staff to report that incident to them. On 3/12/14, at 2:53 p.m. the DON was interviewed. The DON indicated she was not made aware of the 3/9/14, altercation between R56 and R63. She also indicated she did not know the police had come that morning or the recommendation of separating the women. The DON was unaware of the R63's abusive remark to R56 "I now know what murder feels like." The DON admitted there have been no interventions put into place since 3/9/14, to monitor R63's abusive verbal and emotional behavior towards R56. The DON verified R63's verbal, physical and emotional abuse was not immediately reported to the administrator nor was it thoroughly investigated, and R56 was not protected from R63's abusive behavior.	F 226		

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F 226	Continued From page 73 The facility did not complete the required screening of new employees. The Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated as last reviewed on 1/2013, directed, "1. All potential employees will be screened prior to their first day of employment for a history of abuse, neglect, or mistreatment of residents or at risk elders." The policy indicated screening included, but was not limited to: license verification for licensed health care professionals, State and National registry search for all NAs, criminal background check, and a "minimum of 2 professional references." Review of the newly hired employee files indicated the following: - The New Hire and File Folder Set-up indicated a LPN-G was hired on 11/22/13. A Study Request was made on the date of hire, the Background Study Clearance (criminal background check) dated 11/25/13, and indicated LPN-G was cleared three days after hire. The Licensure Verification form indicated LPN-G's license was verified on 11/29/13, eight days after hire. A copy of the Background Study Clearance was requested from the facility, but not provided. - The New Employee Hire and File Folder Set-up indicated a NA-A was hired on 12/24/13. A Study Request Information form indicated the request for a background study was made on 12/24/13 (date of hire). The Background Study Clearance dated 12/26/13, indicated NA-A was cleared two days after hire. The Nurse Aide Registry form indicated a confirmation was requested on 12/24/13 (date of hire). The Reference Check form was blank. A copy of the Nurse Aide Registry form and reference check form were	F 226		

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F 226	Continued From page 74 requested from the facility, but not provided. - The New Hire and File Folder Set-up indicated LPN-F was hired on 3/6/14. A Study Request Information form and the Licensure Verification form both indicated the requests were made on the date of hire. There was no reference checks completed. - The New Employee Hire and File Folder Set-up indicated NA-K was hired on 3/6/14. The Study Request and Facility Inquiry form (for NA registry check) were both dated for the day of hire. The file lacked a Background Study Clearance form. The Reference Check form was blank. - The New Employee Hire and File Folder Set-up indicated NA-D was hired on 4/16/13. The Study Request was dated as submitted 4/17/13 (day after hire), and the Background Study Clearance indicated NA-D was cleared on 4/19/13 (four days after hire). The Facility Inquiry for nursing assistant registry check was made on 4/16/13. The Reference Checks form dated 4/17/13, indicated NA-D references were signed and dated as checked. NA-D's New Employee Orientation check list was half blank, incomplete and dated for 4/17/13 (the day after hire). - The New Employee Hire and File Folder Set-up indicated NA-I was hired on 5/1/13. The Background Study Clearance dated 5/6/13, indicated NA-I's background study was cleared five days after hire. Although the Reference Checks form was dated 4/18/13, the form lacked a signature of which staff checked the references. A copy of the Background Study Clearance was requested, but not provided by the facility. The employee screening indicated employee background check requests, licensure and registry checks were consistently submitted either the day of hire or submitted after the day of hire;	F 226		

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F 226	Continued From page 75 reference checks were inconsistently completed. All of the above staff had the capability to work on all units of the story facility. On 3/17/14, at 10:37 a.m. the director of nursing (DON) stated she was unclear which facility staff was delegated responsibility to ensure screening of new employees because the role had changed. DON stated her expectation was for new employee screening requests to be made prior to the date of hire. DON verified references should have been checked and stated she "recently noted" the new employees were "completing the reference check forms themselves" and verified the form was not completed by the facility staff. DON verified the form did not include a signature or date of when the reference(s) were actually checked or verified, confirmed the form did not identify who was completing the reference check, how the reference was checked (such as via telephone call or letter) and/or who was contacted. DON further verified the reference checks were "already stapled to the application" and "that was perhaps why" they were completed by the applicant. DON confirmed the date of hire was the first day of employment, the date of orientation was the first day of work and verified the facility policy was not followed. REPORTING The facility failed to immediately notify the administrator and the SA of allegations of abuse, neglect, and/or mistreatment for incidents involving R21, R62, R71, and R17 as directed by the policy. Review of the facility's Resident Accident/Incident Reports, as well as allegations of abuse/neglect and mistreatment reported to the SA and the	F 226		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 226	Continued From page 76 individual resident clinical records indicated the following: NEGLECT - ELOPEMENT A Resident Accident/Incident Report dated 7/1/13, indicated at 12:00 a.m. the police were notified and a missing person report was filed regarding R21. R21 had not been seen since the "Pm [sic] shift" and was "not back at the facility before midnight." The report indicated staff had not "heard from [R21] until now (1:45am)." Although the report was checked that the administrator was notified, the report had no date or time of the notification. A copy of R21's incident report dated 7/1/13, was requested from the facility, but not provided. A Minnesota Department of Health (MDH) Incident Report - Investigative Report Submission Completed form indicated a report was submitted to the SA on 7/2/13, for R21's elopement incident on 7/1/13. The SA report also indicated the police department was notified and R21 returned to the facility on 1:45 a.m. The report indicated the SA was not notified until 7/2/13, the fax transmission verification report indicated fax was sent at 4:45 p.m. The undated Investigation Follow Up CEP Report had initials in the administrator notification section, but lacked a date or time when the administrator was notified of the elopement. Although the report identified an investigation was "completed" and reviewed by the administrator on 7/1/13, the SA was not notified until 7/2/13, at 4:45 p.m. NEGLECT - ELOPEMENT	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 226	Continued From page 77 Further review of R21's interdisciplinary team (IDT) Progress Notes indicated: - On 7/20/13, a note written at 12:55 p.m. indicated "At 12:55 am, police came to the facility to gather patient information and immediately after they left, resident returned to the building." The note indicated R21 "could not say where he went but repeatedly said I live here." The note indicated R21 was "drunk and also refused body audit to be done. Will continue to monitor." - At 10:37 p.m. the note indicated, "Okay to hold medications tonight, and resume tomorrow morning due to intoxication." - At 10:43 p.m. the note indicated R21 continued to appear "intoxicated" due to "slash speech," unsteady gait and "smell with alcohol." The note indicated the on-call physician was notified and orders were given to hold medications "until tomorrow." - At 11:45 p.m. the note indicated, "Resident was unaccounted-for during the shift head-count at 11:15 p.m. Search for the resident was initiated in and around the building but was unsuccessful. At 11:45 pm, 911 Call placed to report the resident missing. Writer was told during the previous shift report resident was intoxicated. Search for the resident continues." - The next entry in the interdiscplinary team (IDT) Progress Notes was on 7/22/13, at 9:21 a.m. and was regarding R21's "insurance not covering" a medication. An entry regarding R21 actually being in the facility was not noted in the Progress Notes until 10/3/13. The clinical record lacked evidence of when and where R21 was located after he was identified to be missing on 7/20/13. The clinical record lacked evidence of the date, time, location of R21 when found, R21's mentation and status when located,	F 226		

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F 226	Continued From page 78 the circumstances of R21 leaving the facility (such as R21's reason for leaving), immediate notification of the administrator and immediate reporting to the SA. In addition, the clinical record lacked evidence of further assessment of R21's leave of absence (LOA) Safety, Vulnerability and assessment of R21's known behavior of drinking and intoxication after 7/20/13. ABUSE - MUGGING A facility Resident Accident/Incident Report dated 10/3/13, indicated R21 reported he was mugged outside the facility by "4 blackmen" when walking to the store to buy cigarettes. R21 sustained a 0.5 centimeter (cm) by 0.2 cm skin tear to the bridge of his nose and the skin tear was cleansed and a Band-Aid was applied. The report indicated the physician and family were notified (no date or time). The administrator was notified on 10/3/13 (no time of notification). A copy of the Resident Accident/Incident Report dated 10/3/13, was requested but not provided by the facility. An IDT Progress Note dated 10/3/13, at 9:51 p.m. indicated the administrator was notified, but lacked a time for the notification. The clinical record lacked evidence the SA was immediately notified of the incident. MISTREATMENT - RESIDENT TO RESIDENT ABUSE Two Resident Accident/Incident Reports for R62 and R71 dated for 10/18/13, at 9:00 p.m. identified R62 "ended up hitting roommate [R71]" on the right cheek. R71 sustained no injuries. The report was checked to indicate the physician was notified, and checked to indicate the administrator was notified, but had not date of the notification. The report did not indicate the SA was notified.	F 226		

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F 226	Continued From page 79	F 226		

A MDH Incident Report - Investigative Report Submission Completed form indicated the SA was notified of the resident to resident abuse incident on 10/19/13 (the day after the incident). The Investigation Follow Up CEP Report (undated), indicated the administrator was notified of the altercation also on 10/19/13, in the "AM [no specific time]."

Two Resident Accident/Incident Reports for R62 and R71 dated for 11/22/13, 9:30 a.m. indicated loud voices were heard coming from R62's room, "Writer saw this resident [R62] hitting her roommate [R71] in the face." The report indicated R71 sustained no injuries, both residents were separated and a "police report was done." The report was checked to indicate the physician and family were notified. The administrator notification section was not checked and indicated the administrator was not notified. The report did not indicate if the SA was notified. The clinical record lacked evidence the administrator and the SA were notified of the altercation.

ABUSE - INJURY OF UNKNOWN ORIGIN
A Resident Accident/Incident Report dated 12/14/13, at 5:00 a.m. indicated nursing assistant staff "noted bruise on resident [R17]." The report identified R17 was "alert" and "oriented." The report indicated the bruise measured 5 cm by 4 cm, was "redden" in color and was located on the forehead. The report indicated the cause of the bruise was unknown. R17 stated "I bumped it." The administrator notification section was unchecked and indicated the administrator was not notified. The report did not indicate the SA was notified.

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F 226	Continued From page 80 The clinical record lacked evidence R17's injury was reported immediately to the administrator, immediately reported to the SA and lacked evidence the injury was thoroughly investigated to rule out abuse, neglect or mistreatment. On 3/18/14, at 2:06 p.m. DON verified the administrator should have been notified immediately for allegations of abuse, elopements, injuries of unknown origin, and neglect. DON verified either she or the administrator should notify the SA immediately. DON verified the policy was not operationalized. TIMELY REPORTING AN INVESTIGATION TO SA: The facility failed to report an investigation to the SA for R117's allegation of witnessing another resident in the facility punched in the knuckles on 2/8/14. On 3/10/14, at 3:58 p.m. R117 stated he had seen another resident in the facility abused, punched in the knuckles over the weekend, the DON was notified and stated that story was familiar to her, but had happened prior to the last weekend. At 7:00 p.m. the DON provided the SA report, which indicated the alleged event had occurred on 2/8/14, was reported to the facility and the SA on 2/8/14, and was not able to be substantiated by the facility, by physical assessment, nor supported by the family. R117 was admitted to the facility on 1/21/14, with diagnoses of severe cardiomyopathy (weakened heart muscle), congestive heart failure (fluid buildup in the extremities or lungs), cardiac dysrhythmias (abnormally conducted heat beats), depression and anxiety.	F 226		

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F 226	Continued From page 81	F 226		
F 241 SS=D	The admission MDS dated 2/3/13, indicated R117 was cognitively intact and was independent in all cares. R117 was awaiting relocation services to find independent living placement. The final investigative report was submitted on 2/16/13, three days after the required five day deadline for submission on 2/13/14. 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services in a dignified manner for 1 of 2 residents (R38) whose living environment was permeated by an overwhelming urine odor from clothing soiled by urine and that was stored in the closet. Findings include: On 3/12/14, at 12:42 p.m. Family member (F)-A approached the surveyors and stated he had been to the administrator office but had not seen anyone and wanted to show one of the surveyors something in R38's room. F-A's facial expression was teary-eyed and had a look of disbelief. On 3/12/14, at 12:44 p.m. upon entering the R38's room observed an open clear plastic bag	F 241	F 241 For sampled resident F38 and for all residents at the facility, the facility shall ensure that cares and services are delivered in a dignified manner. Additionally, the facility shall ensure the residents do not experience a malodorous environment is free for prolonged periods of time. For sampled resident R38, the laundry issues was discussed. The facility offered to replace the damaged clothing and the family declined. A follow up meeting was held with the family. They estimated a cost of $177 to replace the clothing. The family was given a check for $177 to replace the damaged clothing. The facility has a policy titled "Laundry Services." The facility administrator, the laundry services staff, and the laundry manager shall ensure this policy is operational.	

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F 241	Continued From page 82 half filled with clothing sitting on the floor of the closet. As surveyor approached the closet there was a strong musty and ammonia smell emanating from the plastic bag. F-A stood by the closet and the bag of clothes. F-A threw his hands in the air, appeared distressed, weepy and his face was dripping of sweat as he stated "I just want them to treat my mother with dignity the facility gets paid a lot of money monthly and I expect her to receive quality care. She was a good mother and my mother was a clean woman and if she would be able to say something now she would be humiliated if she saw her clothes like this." -At 12:47 p.m. F-A stated he usually visited R38 once to twice per week and he was responsible for doing the her laundry but he had been out of town due to other family issues and had asked licensed practical nurse (LPN)-A before leaving town in 1/23/14, to do R38's laundry while he was gone but that was never followed up as requested even with phone calls when he was out of town to make sure R38 was taken care of. F-A added he had been out of town again in 12/13 and the same thing had happened. On 3/12/14, at approximately1:00 p.m. F-A came into the Parlor Room carrying a clear plastic bag with clothing stated he wanted to show the surveyors how R38's mothers clothes that had not been laundered looked. He opened and pulled the plastic bag back and in the bag was a pair of black slack and a pair of white socks. The black pants was observed to have multiple circular patches of fuzzy white growth build up with a strong ammonia smell emanating from the bag (the windows were immediately opened to diffuse the odor). F-A stated "Look at these clothes with all of the mold growing in them." F-A	F 241	Staff inservice will take place. These inservice records will be reviewed by the QA committee. At admission, the facility shall determine who will do the residents personal laundry. This record will be kept in a log book and reviewed and updated regularly by the laundry manager. This log book will be discussed at the QA committee monthly X6 for review and additional intervention as deemed necessary. The log will then be reviewed quarterly by the QA committee. Additionally, the facility has titled, "Housekeeping Services." The facility administrator and the housekeeping supervisor shall ensure this policy is operational. The facility has a policy titled, "Care Standards" and references national resources for these	

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F 241	Continued From page 83 appeared distress, weepy and shaky as surveyor assisted him to put the clothing in another clear plastic bag and was redirected to show the clothing to facility staff and stated he was going to show the clothing to the administrator but had been told she was not at the facility at the time. R38's care plan for cognitive function dated 9/27/11, identified R38 with an alteration in decision making, confusion, impaired thought processes, difficulty with decision making, impaired communication and indicated R38 required staff assistance with activities of daily living (ADLs). Goal "Will have daily needs met..." The care plan directed staff would provide supportive assistance that promotes resident comfort and dignity. R38's diagnoses included Alzheimer's disease, senile osteoporosis, muscular wasting and disuse atrophy, macular degeneration of retina, Parkinsonism, and cataract obtained from the Minimum Data Set (MDS) dated 1/29/14. In addition, the MDS indicated R38 required total physical dependence of one staff with ADLs. R38 was depicted as being totally incontinent of both bladder and bowel. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 2/10/14, identified R38 had decreased ability to make self-understood. The CAA for urinary incontinence dated 2/10/14, revealed R38 to be incontinent of both bowel and bladder and the plan was to "continue the same care." When interviewed on 3/14/14, at 8:48 a.m. LPN-A stated the F-A had called stating he was out of town and had requested to have R38's laundry to	F 241	standards. This policy was effective 05/2012 and was reviewed on 05/2013. Care and services provided in a dignified manner is addressed in these national resources. The facility also has a policy titled, "Activities of Daily Living." This policy was effective 05/2012 and was reviewed on 05/2013. The delivery of care and services provided in a dignified manner is addressed in this policy. Finally, the facility has a policy titled, "Dignity and Privacy" in the Social Services section of the policy and procedure manual. This policy was effective 6/2012 and was reviewed 05/2013. Staff will be inserviced about the policies. These inservice records will be reviewed by the QA committee for further action as deemed appropriate. The administrator, DON, RCM, or other designated leadership staff, shall randomly observe the delivery of care and services to ensure it is delivered in a dignified manner. These audits will be conducted weekly X6 months. The results of these audits will be reported to the QA committee for review and further action as deemed appropriate. Responsible: Administrator, DON, RCM, appropriate IDT members, clinical staff Compliance date: 4/28/2014	

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F 241	Continued From page 84 be done by the facility until he returned. LPN-A was not sure about the exact date when F-A had requested. LPN-A acknowledged she had not documented the phone call in R38's medical record. LPN-A further stated she had gone to the laundry supervisor (LS) and had told her to do the laundry and LS stated it was okay. -At 8:50 a.m. LPN-A stated one day she had realized LS was not working but had approached another laundry staff who had separated with the facility and had ask her to make sure she grabbed the laundry until further notice. LPN-A stated LS should have verified before stopping to do the laundry or should have continued until she had been told otherwise. LPN-A stated she was disappointed at how the whole situation had turned out. When interviewed on 3/14/14, at 2:38 p.m. LS stated she had been asked by LPN-A to do R38's laundry but had thought it was only one time and she never went back to check R38's room to see if the laundry was being done. She further stated "When I saw the clothes the other day they were moldy and I felt really bad and even I offered the F-A to do the laundry but he declined." Facility policy for dignity was requested on 3/17/14, at 9:00 a.m. but was not provided.	F 241		
F 247 SS=E	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced	F 247	F 247 Timely Notices of Roommate Assignment	

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F 247	Continued From page 85 by: Based on interview and document review, the facility failed to provide the appropriate notices of roommate changes for 3 of 4 residents (R36, R56, R9) who experienced changes. Findings include: R36 had a change in roommate on unknown date and was not provided prior notice. A review of R36's most recent Brief Inventory for Mental Status (BIMS-tool used to measure cognition) obtained from the quarterly Minimum Data Set (MDS) dated 2/18/14, noted a score of 13 indicating intact cognition. During interview on 3/11/14, at 11:16 a.m. when asked if he had received a notice prior to his current roommate moving in R36 stated he was never informed of R67 moving in which had been approximately six months ago. On 3/17/14, 2:20 p.m. the social service designee (SSD) stated when she had talked to R67 he had told her he had been in the room for six months. She verified the both R36 and R67 medical records lacked any documentation on notification for the roommate change. SSD stated there was a form filled out usually with all the room changes and the form would be signed by the director of nursing (DON) and administrator. The form would also be reviewed with the resident's involved who were involved and the form would be given to the director of facility operations who in turn assisted with re-locating the residents. SSD further stated she was not working at the facility and would not know where any one that information would be documented but there was a three-ring binder where all the forms would be kept in the	F 247	R36 followed up with on 4/16/2014 and R36 states satisfaction with roommate he received on 4/4/2014. R56 followed up with on 4/1614 and she currently does not have a roommate and states she feels safe now that R63 is no longer her roommate and has been discharged. The facility has a roommate notification policy. This policy will be followed with each resident room change. Each resident will be notified prior to receiving a new roommate and will be introduced to new roommate. This notification will be documented in Point Click Care in a progress note. Clinical audits will be completed to ensure proper notification of new roommates. Staff will randomly audit chart monthly for six months. Responsible: Social Services, Nursing and Administrator Compliance date: 4/28/2014	

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F 247	Continued From page 86 administrator's office she thought. R56 had a change in roommate on unknown date and was not provided prior notice. A review of R56's most recent BIMS obtained from the quarterly MDS dated 11/24/13, noted a score of 15 indicating intact cognition. During interview on 3/12/14, at 8:32 a.m. when asked if she received a notice prior to her current roommate moving in R63 stated she was never informed of R63 moving in which had been fairly recent. On 3/17/14, at 2:24 p.m. SSD verified there was no documentation in the R56's and R63's medical records in the chart and electronically that indicated R56 had been informed or notified of R63 moving in. On 3/17/14, at approximately 11:01 a.m. the director of facility operations stated R63 had been moved recently but was not sure of the date and prior she had been in a private room but was not able to pay for it. R9 had a change in roommate on 2/12/14, and was not provided prior notice. A review of R9's most recent BIMS obtained from the quarterly MDS dated 1/8/14, noted a score of 15 indicating intact cognition. During interview on 3/11/14, at 1:26 p.m. when asked if she received a notice prior to her current roommate moving in R1 stated "Never told me they just moved them in"	F 247		

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

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F 247	Continued From page 87 On 3/17/14, at 2:27 p.m. SSD verified there was no documentation in the R9's and R1's medical records in the chart and electronically that indicated R9 had been informed or notified of R1 moving in. On 3/18/14, at 9:23 a.m. the interim administrator was requested the three-ring binder where the notices were kept stated she was going to look for them but never provided the information. When interviewed on 3/18/14, at 1:50 p.m. licensed practical nurse (LPN)-A stated R1 had been recently been moved to the room and would check in the e-mail to verify then would get back to the surveyor. -At 2:07 p.m. LPN-A provided an e-mail dated 2/12/14, time stamped 1:09 p.m. from the director of facility operations indicating "Move complete" and that R1 had been moved in with R9. When interviewed on 3/18/14, at 2:10 p.m. DON stated her expectation was all resident's needed to be given a notice prior to being moved and or receiving a roommate, the notice was supposed to be filed in the resident chart and documented, if a resident was not okay with the move that would be addressed. DON further stated even the family or legal representative would be updated on the move if involved in resident care. The Room and/or Roommate Change policy dated December 2013, directed "Residents are notified in advance of a new roommate." The policy indicated the social service director or designee was responsible to ensure a resident was informed of a new roommate, documentation in the clinical record would be completed indicating reasons for the move, residents/family	F 247		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 247	Continued From page 88 input, agreement of resident/family, adjustment to the change in roommate would be monitored and documented in the clinical record and the residents care plan would be updated.	F 247		
F 250 SS=E	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE 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 observation, interview and document review, the facility failed to provide medically related social services related to discharge for 1 of 4 residents (R100) reviewed for abrupt/rapid discharge. In addition, the facility failed to provide medically related social services for 3 of 3 residents (R11, R56, R63) for refusals of care and to address roommate behaviors. Findings include: R100 was not provided medically-related social services for behavioral symptoms. R100 was admitted to the facility on 6/27/13, with admitting diagnoses bipolar disorder, history of alcohol abuse and homelessness obtained from the Discharge Health & Physical Progress Note dated 6/27/13. R100 was discharged from the facility of 10/30/13. When interviewed on 3/17/14, at 10:00 a.m.	F 250	F 250 Provision of Medically Related Social Service Resident R 100 has been discharged from the facility. The facility has a policy "Discharge Summary" effective May 2012, reviewed June 2013. This policy states that a discharge summary will be completed by the interdisciplinary team when a discharge is anticipated. Social services ensures that each member of the IDT completes a summary of the discharge plans. In the event that a discharge is not anticipated, each member of the IDT will complete a summary in a timely manner. Summaries may be completed on a discharge summary form or in PointClick Care. The administrator or designee will ensure that the facility follows the policy as applicable. The procedure includes: the discharge summary will include a recapitulation of the resident's stay and status; social services reviews the resident's social, emotional and mental status as well as any significant events or changes during their stay; social services will also address emotional issues and recommended interventions, community/ agency resources to be utilized after discharge, cognitive impairments (including resulting problems and means of supporting), and relationship issues and methods of addressing.	

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F 250	Continued From page 89 director of nursing (DON) stated "Discharge planning was not being done by social service designee (SSD); she thought she only needed to call relocation services." When interviewed on 3/18/14, at 2:10 p.m. DON stated all the residents with pending discharge were supposed to have an order obtained for discharge from the physician which would be documented in the clinical record, the family or legal representative would be updated on the discharge and when discharging from the facility the location of discharge would be documented in the clinical record. Behavioral Contract dated 9/24/13, indicated "R100 will not use derogatory language towards other residents while living at Videll Healthcare Camden. Resident will not call other residents or staff names. R100 will not threaten others and will not yell at roommate. If R100 does not comply with this behavior contract, she will be given a 30 day discharge notice, or if there are any immediate threats to the safety or health of other residents- R100 may receive an immediate discharge notice." On 9/30/13, R100 was given a letter to notify her she would be discharged from the facility effective 10/30/13, to a location of her choosing. The notice indicated "If you haven't chosen a residence by 10/30/13, you will be discharged to your previous residence..." The notice indicated R100 had no skilled nursing need; had behavior problems at the facility; she had signed a behavior contract that she did not comply with and R100 had been informed upon receiving and signing behavior contract that non-compliance would result in a 30 day discharge notice.	F 250	The facility has a policy "Post-Discharge Plan" effective May 2012, reviewed May 2013. This policy states that the post-discharge plan of care is developed and provided to the resident/family/ responsible party for all anticipated discharges. The procedure states: the post discharge plan is developed for all anticipated discharges to a private residence or another nursing care facility; the care plan is developed with the resident and family as appropriate (the family or responsible party should give the facility at least 72 hours notice to ensure an adequate discharge plan is developed); the post-discharge plan will include: description of the residents/family's preferences for care, description of how the resident/family will access and pay for services; description of how the care should be coordinated if continuing treatment involves multiple caregivers; a description of specific resident needs after discharge (including personal care, sterile dressings, PT/OT, etc.), and description of how the resident and family need to prepare for the discharge. Social service will review the plan with the resident/ family 24 hours before the discharge is to occur. A copy of the post-discharge plan is provided to the resident, the receiving facility, and a copy is maintained in the resident's clinical record.	

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F 250	Continued From page 90 During review of the Progress Notes dated 7/1/13 through 10/30/13, R100 had behavior episodes documented twenty one times. The medical record lacked follow up documentation that the SSD had followed up with R100's behaviors and arranged for necessary services to address the problem. During further Progress Notes review the following were revealed: -Progress Notes dated 10/4/13, indicated SSD had documented she had contacted a relocation agency that was assisting with housing for R100. In the Progress Notes, SSD had expressed concerns of R100's increase behaviors and the agency contact staff had stated that the agency had also suspected similar findings that R100 was on denial for her mental illness and was outright refusing to take medications to treat the mental illness diagnosis. -Progress Notes dated 10/30/13, indicated "Social Services has attempted over the last thirty days to work with resident and talk about progress, but she has refused all communications ..." No documentation in the medical chart as evidence for the attempts. Later the same day another Progress Note indicated "Resident observed leaving the facility with all her belongings." No documentation of location where R100 was going to or any attempts that may have been made to assist with discharge transfer. On 3/17/14, at 3:00 p.m. facility discharge policy was requested but was not provided. R11 was not provided medically related social services to address behaviors of refusal/rejection of cares, or calling staff derogatory names.	F 250	The facility has a policy "Against Medical Advice (AMA)-Discharge" effective May 2012, reviewed May 2013. This policy states that if a resident wishes to leave the facility against medical advice, the staff will immediately notify the physician and facility administrator. The procedure includes: the director of nursing or designee discussed the risks of leaving AMA with resident and/or resident representative and documents this discussion in the progress notes; the director of nursing or designee notifies the attending physician, Administrator, and social services director of request and reasons for self-discharge; the director of nursing or designee ensures the resident/legal representative signs the AMA form (if they refuse to sign, the DON or designee writes refused to sign and the form is signed by two clinical staff as witnesses); the AMA form is kept in the residents medical record; the director of nursing or designee completed the recapitulation of stay and it is mailed to the resident/responsible party. Audits will be completed monthly for 6months by social services, DON, or Administrator to ensure accurate documentation is completed for all discharges. Resident R11 has been discharged from the facility.	

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F 250	Continued From page 91 On 3/11/14, at 9:48 a.m. during the initial stage one interview R11 stated, "I don't like people" and his roommate "wakes him up at night screaming." R11 further verified he did not allow facility staff to assist him with activities of daily living, bathing or range of motion. R11 verified he had a contracture of his left hand. R11 stated he did not take showers "due to pain" on his left side and the facility staff did not offer bed baths. R11 explained he was not aware if he could take a tub bath. - At 10:12 a.m. surveyor asked to see R11's left hand. R11 was observed to have a contracture of the left arm, wrist and hand. R11 stated the contracture was due to an aneurysm and stroke. Stated he "didn't let them [facility staff] touch it" and only allowed staff he "trusted" to cut the nails (of the contracted hand). R11 stated he cleaned his left hand (inside the contracture, to prevent potential breakdown) under the faucet with running water, but was unclear on how frequently he cleaned the left hand. R11 verified he did not allow staff to monitor the skin of his hand for potential breakdown. - At 12:32 p.m. R11's hair was observed to be long, uncombed and appeared to be unwashed. R11 wore a dark colored baseball cap. R11's nails were long on the right hand with dark colored debris observed under the nails. R11 was observed to be wearing a dark colored coat, t-shirt and dark sweat pants. On 3/13/14, from 8:00 a.m. to 9:00 a.m. R11 was observed to be wearing the same baseball cap, t-shirt, dark colored sweat pants and coat as the initial interview. R11 appeared to have unwashed, uncombed hair. At no time during the observation were staff observed to approach R11 and offer	F 250	The facility has a policy "Resident Refusal of Medical Treatment" effective June 2012. Policy states that a residents right to refuse treatment will be respected. When a refusal occurs resident and their family member/contact/ guardian will be fully informed of the risk vs. benefit of such a refusal so they may make an informed decision. This discussion will be documented and will include: the residents condition; acknowledging that the facility provided comprehensive information regarding the residents condition and that everyone understands; comprehensive explanation of the benefits of the recommended treatment; comprehensive information regarding risk associated with refusal of recommended interventions; list of the risks, potential negative outcomes and impact on the health, well-being and quality of life of the resident; understanding of the risks and potential negative outcomes; informed decision; signature of the family member authorize to act on the resident's behalf, witness and date; and instructions regarding rescinding the refusal. Refusals will be reviewed at least quarterly. Audits will be completed monthly for 6months by social services, DON, or Administrator to ensure accurate documentation is completed for all formal refusals of medical treatment. Audits will be completed monthly for 6 months to ensure therapy documentation is complete.	

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F 250	Continued From page 92 assistance with grooming or range of motion. During the observations, R11 was observed to be in bed and fully dressed in the same clothing. On 3/13/14, at 9:42 a.m. a nursing assistant (NA)-M stated R11 "refuses everything." NA-M explained "today was [R11's] shower day" and stated R11 refused the shower. NA-M stated when staff approach R11, he was verbally abusive and verified he would make derogatory statements to staff. NA-M stated staff was expected to "reapproach" R11. "We usually come back and ask, but he always refuses." NA-M was unclear how R11 was bathed/cleaned and explained staff usually took care of R11 on the evening shift. On 3/13/14, at 10:00 a.m. NA-E stated R11 "refused all cares" and stated she went back to R11 to reapproach if there was a refusal. NA-E stated she offered all means of bathing (shower, bed bath, and tub bath) and R11 refused "all." NA-E explained she then reported refusals to the nurse and documented "refused" on the shower sheet. NA-E stated R11 refused the shower because it "hurt him." NA-E was unclear if risks of his frequent refusals were explained to R11. Review of R11's undated NA group sheet (an assignment sheet used by NA staff to identify individual resident care needs) indicated R11's "Bath Day" was Thursday morning, he required one staff assist for toileting and dressing; as needed assistance with grooming, was non ambulatory, independent with transfers and "Resident is prejudiced. Please alert Nurse if behaviors present." R11's Medicine Admission History and Physical	F 250	The facility has a policy "Behavior Management" effective November 2011, reviewed January 2013. The policy states that behavior management is an interdisciplinary process including: identifying residents whose behaviors may pose a risk to self or others; developing individual and practical care strategies based on assessed needs; implementing the behavior management program; and ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs. The procedure states that behavior assessment begins during the pre-admission process, the resident is assessed by a licensed nurse and/or social service director for behavior management issues during the admission/ re-admission process, the interdisciplinary team evaluates and documents the behavior(s) determining whether or not the behavior(s) rise to the level of being a "problem" requiring attention. The IDT evaluates the cause(s) of behaviors to minimize drug use as much as possible and when necessary. The IDT strives at all times to use the least amount of medication to help manage the behavior. Based on the IDT analysis of the behavior issues, an individualize care plan is developed to accommodate and/or manage the residents behavior. The director of nursing or designee is responsible to ensure behavior assessments are completed timely and that behavior care plans and nursing assistant care plans are	

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F 250	Continued From page 93 dated 12/31/13, included information regarding R11 prior to admission to the facility. The form identified R11 had a chronic problem with homelessness and R11 had "lost his medical respite bed at Harbor Lights [a shelter facility for the homeless] due to refusal to shower in their facilities." The form indicated R11's left sided spasticity was "Worse since he has not taken any of his medications since 12/24" and directed to resume baclofen. The Admission Record indicated R11 was admitted to the facility on 12/31/13. A Therapy Screening Form dated 1/2/14, indicated R11 was screened upon admission to the facility. The form indicated R11's activities of daily living (ADLs), and mobility were impaired. The cognition section was left blank; communication and swallowing were not impaired and none of the identified concerns were a "change" in R11's condition. The "Other Impairments" section of the form indicated R11 "denied" problems with pain, falls, pressure sores/open areas, and denied a "decline in ROM [range of motion]." The form indicated R11 "declines" splint/orthotic. The "Comments" section of the form indicated, "Pt [patient/R11] repeatedly declined offer of therapy services, stating he doesn't like people. Declines needing or wanting help for any ADL's, waiting for electronic scooter to arrive, is independent with manual w/c [wheelchair]. Requests not to have therapy services, no orders requested." The form indicated therapy services for physical therapy, occupational therapy, or speech therapy was "Refused." Although the form was dated 1/2/14, at the top of the form, the bottom of the form was signed by a therapist and dated for 3/11/14. The	F 250	reviewed at least quarterly. The director of nursing or designee is responsible to ensure a behavior tracking log is initiated on all behaviors identified for management. Audits will be completed monthly for 6months by social services, DON, or Administrator to ensure accurate documentation is completed for behavior management care plans and behavior management log. Audits will be completed monthly for six months to ensure that all range of motion assessments are complete. Audits will be completed monthly for six months by social services and nursing to ensure all care plans are complete and accurate. Resident R111 has been discharged from the facility. The facility has a policy "Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property." This Policy was effective May 2012. This policy covers procedure of	

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F 250	Continued From page 94 screening form indicated R11 was identified to refuse care and services shortly after admission. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 was cognitively intact, had a mood problem of feeling tired, and had no behavior problems. The MDS indicated R11 was independent with bed mobility, transferring, locomotion on the unit and eating; required supervision with locomotion off the unit, dressing and toilet use; R11 was identified as requiring extensive physical assistance from staff for personal hygiene. The Care Area Assessment (CAA) for nutrition dated 1/7/14, identified diagnoses of spastic hemiplegia on left side, history of alcohol abuse and congestive heart failure. The CAA identified R11 had "no upper teeth and few lower teeth" and, "He does not wish to receive a mechanically altered diet." The CAA for ADL Functional/Rehabilitation Potential dated 1/13/14, identified the CAA was triggered due to R11's need for supervision with ADLs. The CAA identified R11 had left sided hemiplegia due to a history of cerebrovascular accident (CVA, stroke). The CAA identified R11's other pertinent diagnoses to include altered mental status, and homelessness. The CAA identified R11 "was eval [evaluated] for therapy" and refused. The CAA identified R11 was continent of bowel and bladder, had no skin issues or falls. The CAA for falls and pressure ulcers (both dated 1/13/14), recapitulated the same data as ADL CAA. Although R11 initially refused therapies upon admission, and was identified to refuse therapy in the CAAs, the MDS and did not identify refusal of care behaviors. Although the behavior of refusing therapies was identified in the CAA, the clinical record lacked evidence R11 was assessed for refusals and interventions were developed to	F 250	educating staff and residents on abuse and neglect prevention, reporting, and facility follow up. The policy covers procedure on investigating any allegation of abuse, neglect, mistreatment, including injuries of unknown source, and/or misappropriate of resident property. The procedure also includes that the facility protects residents from harm during the investigation. The facility has a policy "Resident Abuse/Neglect follow up." This policy was effective May 2012. This policy covers procedure on assessing and evaluating for any negative outcomes to the resident following an allegation of abuse. The facility has a roommate notification policy. This policy will be followed with each resident room change. Each resident will be notified prior to receiving a new roommate and will be introduced to new roommate. This notification will be documented in point click care in a progress note. Clinical audits will be completed to ensure proper notification of new roommates. Staff will randomly audit chart monthly for six months.	

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F 250	Continued From page 95 address potential risks of associated with refusing therapy, such as but not limited to, the left sided contracture getting worse, or skin breakdown of the left hand. The Social Services Comprehensive Assessment Packet dated 1/13/14, included: a LOA (leave of absence) Safety Assessment, Smoking Assessment and Vulnerable Adult Assessment dated 1/2/14. No behaviors of refusing cares were identified in the assessments. The Vulnerable Adult Assessment appeared incomplete. Although R11 was identified to have refused to take showers at the homeless shelter (resulting in R11 losing a respite bed there) and R11 had behaviors of not taking medications such as baclofen, the assessment didn't identify R11 had any behaviors, such as calling staff derogatory names and refusal/rejection of cares. The clinical record did not identify a potential risk factor for R11 vulnerability. The Safety Risk (Fall) Assessment dated 1/4/14, indicated, "Resident does display behaviors calling staff 'Niggers', refuses cares and treatments. Nsg [nursing] to continue to monitor & update." Although the assessment identified abusive behaviors towards staff and refusals of care, the clinical record lacked evidence R11 was monitored for the behaviors. The undated Range of Motion Assessment identified "complete impairment" of R11's arm, hand, leg and foot on the left side. Review of R11's Weekly Audit (an evaluation of a residents' skin to identify potential changes, such as pressure ulcers or skin breakdown of the left contracted hand) form dated for both "12/31" and	F 250	Resident R56 reports that she is no longer afraid since R63 no longer lives at the facility. Resident R63 has discharged from the facility. Audits will be completed monthly for six months by social services to ensure that all vulnerable adult assessments and social service documentation is complete. Compliance Date: 4/28/2014 Responsible: Social Services, DON, Nursing, Administrator	

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F 250	Continued From page 96 "1/01" indicated "Refuses body audit." The audit dated 1/9/14, and 1/16/14, both indicated R11 refused his bath/shower. Although R11 was admitted to the facility on 12/31/13, and R11 was scheduled for showers/baths weekly, the clinical record lacked evidence facility staff attempted to reapproach R11 for bathing after 1/16/14. The clinical record lacked evidence R11 was evaluated/assessed by a nurse practitioner or physician within the required time frames. R11's care plan only had a focus for activities dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's concerns with roommate, refusals of care nor behaviors of calling staff derogatory names. The clinical record lacked evidence R11 had care plans developed (including goals and interventions) to address his clinically related social service needs, such as, but not limited to: R11's identified behaviors of refusals/rejection of cares, R11's identified behavior of calling staff derogatory names, and identification of R11's increased vulnerability due to physical limitations and individual psychosocial needs (such as a history of homelessness). In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming and skin assessments/evaluations and refusals of doctor visits. Review of the IDT Progress Notes from 12/31/13, through 3/17/13, indicated the following: - On 12/31/13, an admission note at 10:47 p.m.	F 250		

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F 250	Continued From page 97 identified R11 was admitted to the facility, identified R11 was cognitively intact, continent of bowel and bladder, and transferred independently. A note at 11:53 p.m. identified R11 was able to make changes in body position when in bed to "release pressure." Although R11 had left sided weakness and a contracture of left arm and lower leg, the note incorrectly identified R11 was "able to independently walk to and from toilet." - On 1/1/14, a Late Entry note at 3:43 a.m. indicated R11 refused three attempts at a "body audit" and indicated R11 stated, "'I do not have anything on my skin, no wound.'" At 1:43 p.m. a note identified R11 required one staff physical assist with ADLs. At 10:20 p.m. a note identified R11 "refused make change of clothes and went to bed with his street clothes." - On 1/2/14, at 6:29 a.m. a note identified, "Resident vehemently refused vital sign to be obtained, even when reapproached. Noted some blood show on his nares but he adamantly rejected nursing intervention, instead he placed a tissue papper [sic] in the nose, he refused to use 4x4 [gauze]. We will continue to encourage with care and support at this moment." At 10:13 p.m. a not indicated, "Resident refused cares and re-approached throughout the shift but he refused stating to be left alone." - On 1/4/14, a note at 10:40 p.m. indicated R11 refused "all attempts for the vital signs to be taken and cares to be provided." The note identified R11 "Requires help with ADLs but refuses." Although a behavior of refusing/rejecting cares was voiced by R11, the note indicated, "No behavioral problems noted." - On 1/20/14, at 3:16 p.m. a social services note indicated SSD met with R11 and discussed R11's discharge plan to remain in the facility "short term	F 250		

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F 250	Continued From page 98 [sic]." The note identified R11 had determined his stay was short-term and identified R11 "is homeless" but would "like to find placement." The note indicated SSD would assist with discharge planning. - On 2/4/14, at 12:54 p.m. a social services note indicated the county public health nurse and SSD met with R11 regarding relocation options. At this time the note indicated R11 would "like to return to the streets when it gets warmer outside." R11 refused assistance from both. The note identified SSD "explained the risks of returning to the streets." - On 2/5/14, at 11:01 p.m. R11 was identified to be abusive to staff "using N-word to the nursing staff." The note indicated staff attempted to speak with R11, but R11 cursed at staff, refused to allow staff to assist with cutting his nails "stating he [would] look for qualified person to cut his finger nails." - From 2/5/14, through 2/24/14, all notes indicated when R11 had nose bleeds or if no nose bleeds were noted. The notes identified period, but consistent refusals of assistance with nose bleeds. The notes did not indicate the physician was notified of potential nose bleeds. - On 2/25/14, at 3:17 p.m. a note from medical records indicated, "[R11] has refused all medical appt [appointments] since admit to include cardiology on 1-19-14. He has refused all offers of appts at the Indian Health Board for Primary care follow up. D.O.N. (director of nursing), clinical care manager and Admin [administrator] updated. Plan is for pt [patient] to be seen by the Medical Director." - From 2/25/14, through 3/17/14, notes address monitoring for nose bleeds. Although R11 was noted to refuse all cares, treatments, interventions and assistance, the	F 250		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 250	Continued From page 99 clinical record lacked evidence R11's refusals were assessed and clinically related social services were provided. The Follow Up Question Report for 3/1/14 - 3/13/14, identified the daily NA documentation from Care Tracker. The report indicated the following: - "Bathing: Self Performance - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower" was documented "Not applicable" daily. - NA's documented a behavior of both "Rejection of Care" and "Abusive Language" as "Yes" daily. - "Dressing: Self performance - How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis or TED hose (anti-embolism stockings). Dressing includes putting on and changing pajamas and housedresses" was documented "Resident Refused" for 16 out of 18 opportunities. - "Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (Excludes baths and showers)" indicated "Resident Refused" eight times, "Not applicable" two times, "Independent - No help or staff oversight at any time" eight times out of 18 opportunities. On 3/13/14, at 2:24 p.m. the licensed practical nurse (LPN)-D verified there was no monitoring for behaviors towards staff, such as inappropriate/derogatory name calling of staff. On 3/13/14, at 2:37 p.m. a facility staff member (O)-E verified there were no physician's visits for R11 in the clinical record. O-E stated R11 refused	F 250		

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F 250	Continued From page 100 referrals to "Indian services," cardiology and the medical director. O-E stated R11 had expressed he was in the facility until the weather warmed, then he "planned to return to the streets." On 3/13/14, at 2:40 p.m. LPN-D stated monitoring for refusal of care was in the NA "kiosks" and documented in "Care Tracker [a computer based data collection tool for the electronic medical record]" and should report the refusals of care to the nurse. LPN-D verified refusals should be documented in the clinical record. LPN-D was unclear on evaluation of the refusals. On 3/14/14, at 10:41 a.m. SSD stated she was not aware of R11 refusing any or all cares. SSD stated R11 was "easy to communicate with" and her first impression of R11 was he "wouldn't refuse." SSD further stated she "believes if [R11] was reapproached [when refusing]," R11 would "go for it." SSD stated facility staff should have been reporting the refusals to her and stated she would then have "approached and explained the risks and benefits" to R11. SSD stated she reviewed the (interdisciplinary team, IDT) progress notes, but stated the behaviors were not appropriately being documented in the clinical record. SSD stated "documentation was missing" and there "wasn't appropriate documentation [on behaviors]." SSD stated it was "very important for staff to document" and further stated she "relied heavily" on the documentation. SSD stated she was "not closely interactive with residents and staff." SSD verified she had access to "PCC [Point Click Care, the electronic medical record or EMR], and stated she did not know the NA staff documented R11's refusals daily "at the kiosks [in Care Tracker]." SSD stated she did not have access to the "kiosk" or Care Tracker. When	F 250		

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F 250	Continued From page 101 asked about R11's discharge plan, SSD stated, "When [R11] came, I did my psychosocial assessment, offered him services." Although SSD stated she was unaware of R11's refusal, R11 was "easy to communicate with" and R11 would "go for it" if reapproached during a refusal of a care or treatment, SSD stated, "He [R11] refused services and said he was going to back to the streets." SSD confirmed she was aware of R11's unsafe discharge plan and stated she "referred him to the county for relocation services." SSD further verified her awareness of R11's refusals and stated the "Public health nurse attempted to visit with him, he refused for the moment." The clinical record lacked evidence of SSD's psychosocial assessment. On 3/14/14, at 11:20 a.m. a physical therapist (PT)-J who provided a copy of R11's Therapy Screening Form verified the evaluation was "back dated" due to not being documented at the time of admission and problems with lost documentation. PT-J verified R11 refused therapy. PT-J stated risks and benefits were provided to R11, but were unclear on documentation of the risk/benefits. On 3/18/14, at approximately 2:05 p.m. the DON verified medically related social services were not provided for R11. R111 was not provided clinically related social services to address derogatory roommate behavior. On 3/10/14, at 6:38 p.m. during the initial stage one interview, when R111 was asked if there was a problem with a roommate or any other resident,	F 250		

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F 250	Continued From page 102 R111 stated his roommate called him a "nigger" and "we got into it." When ask if he reported the incident and what happened, R111 stated, "They [the facility staff] told me if I don't like it, I should have to move." R111 stated he "doesn't want to move" because he was admitted to the room first and R111 "didn't cause the problem." R111 stated he and his roommate were on "non speaking terms right now." R111 stated the incident occurred the prior week. R111 further stated "he [the roommate] came to move in here" and the roommate was the cause of the problem. R111 described feeling "penalized" for what "he did." Stated he feels like it's more of a "punishment" to have to move and to remain in the room with roommate and not a "solution." R111 stated he hoped it was the "last time" the roommate called him a name. R111's Admission Record dated 1/10/14, identified diagnoses to include head injury and depressive disorder. The admission MDS dated 12/23/13, indicated R111 was cognitively intact; had mood concerns of: feeling down/depressed, trouble falling asleep, trouble concentrating, and feeling tired. The MDS identified R111 had no behavioral concerns and required physical assistance from staff for transferring, toilet use, personal hygiene, dressing and locomotion on and off the unit. The CAA for pressure ulcers dated 12/26/13, identified R111's closed head injury was "following an assault." The CAA for ADL Functional /Rehabilitation Potential dated 12/27/13, identified R111 was able to voice his needs and identified R111's specific ADL needs. The CAA for psychotropic drug use dated 12/27/13, identified R111 had vision impairment due to diabetes mellitus diagnosis and from the assault. Review of R111's care plan revealed	F 250		

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

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F 250	Continued From page 103 appropriate care plan development. A copy of the care plan requested and not provided by the facility. Review of the IDT Progress Notes indicated on 3/6/14, at 12:06 a.m. a note identified R111 had "an argument with his roommate. According to his roommate the television (TV) was loud. He was very upset with his roommate for calling him the 'N' word. The nurse filled out an incident report. The administrator and DON were [sic] informed via text messag [sic]." Although the note identified an incident report, the facility lacked evidence of the notification or incident report. On 3/14/14, at 9:40 a.m. the LPN-A stated she was not aware of R111 being called derogatory name and stated "social services should be handling it." LPN-A stated room changes "are done by social services." When asked regarding determining who should move when roommates report behavioral problems, LPN-A stated staff report the behavior to the social service designee and determine "who is the best to move." LPN-A further stated, "Our policy has been, the complainer is the one to move." On 3/14/14, at 10:59 a.m. SSD stated she was aware of a verbal altercation and stated she was notified by night shift. SSD stated she "met with both" residents separately the next morning and offered for R111 to switch rooms. SSD stated R111 refused to change rooms due to his potential discharge "next week." SSD stated R111 expressed he would keep to himself and "avoid the roommate." SSD stated she spoke with the roommate and believed the residents were friends and was "shocked" that the altercation had occurred. SSD stated she believed the	F 250		

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F 250	Continued From page 104 roommate had just had a left below the knee amputation, was going through a rough time, lost all his belongings and he "took his frustrations out on [R111] due to the TV volume being too high." SSD stated she did not document the conversation and verified the roommate calling R111 a derogatory name would be considered verbal abuse. The Room and/or Roommate Change policy dated December 2013, directed "Residents are notified in advance of a new roommate." The policy indicated the social service director or designee was responsible to ensure a resident was informed of a new roommate, documentation in the clinical record would be completed indicating reasons for the move, residents/family input, agreement of resident/family, adjustment to the change in roommate would be monitored and documented in the clinical record and the residents care plan would be updated. R56 had verbalized to facility staff recurrent fear from R63, and the facility did not take adequate precautions to protect R56 from the alleged physical, verbal and emotional abuse. R56 was observed and the following was noted: - On 3/11/14, at 1:54 p.m. R63 was observed to have yelled at R56 repeatedly and called her a liar. Registered nurse (RN)-B was immediately notified of R63 yelling at R56. He said "ok" and did not leave the desk. - On 3/11/14, at 4:00 p.m. R56 had to be approached five different times to get the interview completed due to R63 would not let R56 talk without becoming upset. R63 pointed at R56 and stated "You better not talk." - On 3/12/14, at 8:10 a.m. R56 stated roommate	F 250		

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F 250	Continued From page 105 was verbally abusive. R63 stated R63 slammed the foot of R56's bed with her hand and told her she knew "what murder feels like." That incident had happened on 3/9/14, and the police were called. - On 3/12/14, at 8:11 a.m. when R56 reported the incident to facility staff they told her to keep stuff on her bed. R56 did not make noise. - On 3/12/14, at 8:14 a.m. the facility still did not investigate or identify the emotional, physical or verbal abuse towards R56 from R63. - On 3/12/14, at 8:23 a.m. R56 was again interviewed and stated "I'm so glad she's not here." - On 3/12/14, at 1:53 p.m. R56 reported she "feels like s**t" when R63 verbally abused her and reported she was afraid of R63. - On 3/13/14, at 7:40 a.m. observed in room 147A in bed. - On 3/13/14, at 9:54 a.m. resident observed in bed 147A. R63 was in 147B. Maintenance staff was in the room setting up headphones with the TV and the activity director was sitting outside the room. At the start of the interview with R56, roommate (R63) yelled with an angry voice "Oh God" and R63 got up and left the room. The activity director went down the hall with her. - On 3/14/14, at 8:12 a.m. R56 observed in her bed. R56 stated they took her (R63) away last night and felt safer now. R56 reported she had been bedfast for the past one to two months. The care plan dated 3/6/13, indicated R56 needed social services (SW) due to recent admission to facility. The interventions noted the SW was to visit monthly and as needed (PRN), introduce self to others, encourage R56 to attend activities and the SW would make outside referrals to mental health professionals as	F 250		

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F 250	Continued From page 106	F 250		

needed. The medical record lacked evidence of how the facility intervened on keeping R56 safe from R63's physical, verbal, and emotional abuse. The medical record lacked any evidence of the SSD meeting with R56 to discuss the new roommate and/or adjustment of the room.

The care plan revised 4/21/13, incorrectly identified R56 as short stay resident to the facility and identified R56 as a vulnerable adult related to (r/t) physical limitations. The goal was to ensure R56 was safe within Camden Care Center and the interventions included "Nursing to provide cares, services according to resident needs, POS [Physician's orders] and POC [plan of care]," "Assistance in case of emergency" and "Vulnerable adult assessment per facility policy."

The Vulnerable Adult Assessment (VAA) dated 11/21/13, indicated R56 had physical limitations which made the resident susceptible to abuse. The physical limitations include wheelchair (w/c) bound and history of hip fracture. The form also identified R56 did not "have a history of any type of abuse towards others or self-abuse." The VAA was updated on 2/20/14, and noted the VAA was still current with no changes.

R56's progress notes were reviewed from 1/25/14, going forward to 3/14/14. On 3/14/14, the social worker designee met with R56 "as a follow up to provide an ongoing support." There was no supporting evidence of as to what "ongoing support" meant.

R56's most recent MDS dated 2/20/14, identified R56 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R56 was totally dependent upon staff for transfers

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F 250	Continued From page 107 and bed mobility. behaviors directed towards staff only, no delusions, Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). R56's diagnoses included arthritis, cancer, and Parkinson's. R63 was aware of the facility policy for abuse as R63 had signed the Acknowledgement of Vulnerable Adult and Abuse Prevention Policies on 10/5/11. The form read, "Camden Care Center strives to support and protect all of our residents. To ensure our resident's needs are met; we have established Vulnerable Adult and Abuse Prevention Policies. All residents have the right to report concerns or suspected abuse without fear of retaliation." R63's care plan dated 4/18/12, noted R63 needed an "opportunity to express feelings/ concerns regarding placement/life situations. [R63] tends to keep to herself. [R63] has a dx [diagnosis] of depression." The interventions included encourage R63 to attend activities, refer to outside mental health professionals, and remind R63 of the positives in life and to have the social worker visit monthly and PRN. The care plan had not been updated with the room change and the addition of a roommate as of 3/5/14, and nor was the care plan revised to reflect the physical, verbal and emotional abuse towards R56. R63's Progress Notes were reviewed from 9/27/13, going forward and the following was noted: - On 3/9/14, at 5:34 a.m. noted staff was aware	F 250		

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F 250	Continued From page 108 that R63 had threatened R56. "She [R63] stated 'I will kill you now', and she pound very hard on her bed. This resident verbally attack this writer for changing her room where she was having a good slumber. Updated the authority for a threatening comment directed towards coresident. We will continue to monitor the situation closely and vigilantly at this moment." - On 3/9/14, at 12:50 p.m. noted R63 was "not fine with present roommate and room environment. according to her [R63] , her roommate is very in appropriate , like to put call light on, turn television loud, and calling nar [nursing assistant/registered] in the room to assist her with cares etc." The police had been called previously and 'resident needed to be separated before something happen [sic] beyond our reach." The note indicated the facilitystaff was going to monitor the situation every 15 minutes, however, the medical record lacked evidence of the monitoring. A Care Conference Quarterly note dated 10/22/13, depicted R63 as having behaviors which included "becomes irritated with staff at times, barricades herself in her room with boxes, she also isolates herself in her room." The continued to note R63 "is very sensitive to noise and that causes 'nausea'." The note revealed R63 independent in ambulation to all destinations. R63's most recent MDS dated 1/8/14, noted R56's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a BIMS score of 15. R63's PHQ-9 was 10 which noted moderate depression. According to the MDS, R63 had trouble sleeping, had a poor appetite, had	F 250		

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F 250	Continued From page 109	F 250		

little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors.

R63 was unavailable for interview for the untoward behavior towards R56 as R63 was transferred out of the building on the evening of 3/13/14.

On 3/12/14, at 2:37 p.m. an interview was conducted with the SSD. She indicated R56 and R63 became roommates on 3/5/14, as both women were private pay and could pay the private pay fee for the private room. The SSD indicated she was made aware of the 3/9/14, altercation in the Monday morning report meeting on 3/10/14. The SSD revealed she did speak with R63 and stated, "[R63] used to being in her own room. She did warn us, I would not be able to get along with a roommate. 'I was brought into a private room and will not be able to get along.'" The SSD was not aware of R63's "I now know what murder feels like." and was aware of the police being called on 3/9/14. The SSD expected the staff to inform her of any situation that needed her attention. SSD stated she did meet with R63 on 3/11/14, and R63 stated "things were getting better, they are avoiding communicating with each other and talking to each other." The SSD did not put any interventions into place for the altercations between the two roommates and she was unaware if nursing had put any interventions in place to prevent the emotional, physical and verbal abuse of R63 towards R56. The medical record lacked evidence of the communication between R63 and the SSD as the SSD did not document any of the follow up conversations. It could not be determined if R63 received the monthly SW visits as indicated on the care plan

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F 250	Continued From page 110 revised 4/18/12, nor could it be determined if R63 adjusted to the new room and roommate as the medical record lacked evidence any SW intervention for the adjustment other than one visit on 3/11/14. On 3/17/14, at 10:00 a.m. the DON stated discharge planning was not done by SSD, she thought she only needed to call relocation services. - At 11:40 a.m. The administrator and corporate interim administrator (CIA) were interviewed regarding the SSD: what training/orientation was provided so that she could successfully carry out the job? The administrator stated, "When I started here with SSD, I asked CIA if she was being supervised." CIA stated, "I told you she was, because the corporate social workers (CSW) was going to mentor her." The administrator stated, "When corporate came into town on 2/11/14, both of the two (facility owner and CSW) were here, and I asked when are you going to counsel SSD? The CSW acted like she did not know what was happening and stated, 'I can't supervise her.' The facility owner stopped the conversation and stated 'you will supervise her.' It was very alarming to me, a new social worker (without a mentor)." CIA stated, "When I got here in November she was already hired and here." The administrator stated a social worker was so essential to proper discharge planning, and "I was downright angry that she was not supervised, and mentored. My regional administrator stated he had hired her with the understanding that CSW was going to be her supervisor." The undated Social Services/Social Work job description identified, "The social worker will work	F 250		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 250	Continued From page 111 with residents in the facility by identifying their psychosocial, mental and emotional needs along with providing, developing, and/or aiding in the access of services to meet those needs." The job description indicated, "Advocacy 1. Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident. Prevent and address resident abuse as mandated by law and professional licensure." The job description identified clinical responsibilities of the social worker to be: complete social history and psychosocial assessment for each resident, develop a written plan of care for each resident that identified the needs from the assessment, ensure therapeutic interventions were provided to assist with coping in transition to the facility, provide support and education to residents/family, provide clinical interventions to address "catastrophic events" that occur during the resident's stay, and coordinate discharge planning.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 4 residents (R11, R36, R10, R93) reviewed for environmental concerns, had their wheelchairs maintained in clean and good repair.	F 253	F 253 Sampled residents R11 no longer resides at the facility. For sampled resident R10, 36, and 93 and for all residents at the facility, the facility shall ensure that resident wheelchairs are kept in good repair and are clean.	

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F 253	Continued From page 112 Findings include: R11's motorized wheelchair was observed to be in ill repair. On 3/11/14, at 10:15 a.m. R11's motorized wheelchair was observed to have vinyl ripped and a large chunk of foam exposed on the back left side of the seat and the left side of the head rest. The back aspect of the left arm rest was observed to be peeling up. R11 stated the motorized wheelchair and standard wheelchair next to the bed were his personal property. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 had intact cognition, had functional limitation of the lower extremity on one side, R11 was identified as un-steady and needed assist of one for surface to surface transfers, which included transfers from bed to wheelchair. On 3/17/14, at 10:03 a.m. during the environment tour the director of facility operations (DFO) verified the findings and stated the motorized wheelchair was R11's personal property. DFO stated he had not been informed the wheelchair needed any maintenance follow up. DFO stated because the motorized wheelchair was R11's property, the designated social worker should work with the outside vendor to repair it. DFO stated he was going to let the social worker know immediately. R36's wheelchair was not kept clean. On 3/11/14, at 4:20 p.m. R36's entire wheelchair frame was observed to be heavily soiled. R36's quarterly MDS dated 12/18/14, indicated	F 253	All wheelchairs used by residents in the facility will be cleaned and inspected for maintenance. A record of this cleaning and maintenance inspection will be reported to the QA committee for review and further recommendation as indicated. Weekly audits for maintenance and cleanliness will be conducted on random wheelchairs in use. This audit will be done for 6 months. The results of these random audits will be reported to the QA committee for review and further recommendation as indicated. A record of wheelchair cleaning will be kept in a log. This log will be reviewed by the facility administrator on a weekly basis. The log will be presented to the QA committee for review and further recommendation as indicated. Responsible: Administrator, Maintenance Compliance date: 4/28/2014	

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F 253	Continued From page 113 R36 had intact cognition and needed assist of one for transfers, identified R36 used a wheelchair and walker for mobility. On 3/17/14, at 10:55 a.m. DFO verified the wheelchair was soiled and stated, "Very dirty needs to be cleaned." DFO verified he was not notified of the soiled wheelchair. R10's wheelchair was observed to be in ill repair On 3/13/14, at 7:33 a.m. R10's left wheelchair armrest was observed to be ripped with foam padding exposed and coming out of the rip. The right armrest vinyl was observed to be chipped which exposed the mesh underneath, making it an uncleanable surface. R10's quarterly MDS dated 2/11/14, indicated R10 had intact cognition and needed assist of one for transfers and used wheelchair for mobility. On 3/17/14, at 11:34 a.m. with DFO and surveyor present, R10 stated, "I have been asking you for a long time for another wheelchair." DFO acknowledged R10 had asked him this before and stated he would replace the armrests at least. R93's was observed to be not cleaned and in ill repair. On 3/11/14, at 1:21 p.m. R93's wheelchair was observed to be heavily soiled with food spatters, the plastic part of the left foot pedal was broken off, leaving a sharp edge. R93's quarterly MDS dated 2/6/14, indicated R10	F 253		

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F 253	Continued From page 114 had moderately impaired cognition, needed assist of one for transfers, and used a wheelchair for mobility. On 3/10/14, at 10:22 a.m. DFO verified the findings, stated he had just gotten the wheelchair washer machine fixed about two months ago and the night shift was doing all the wheelchair cleaning. DFO stated he was not sure of the current cleaning schedule, but stated before maintenance would have collected the wheelchairs and cleaned them by hand. DFO further stated he would replace the foot rest for R93. The February and March 2014 Maintenance Request log was reviewed. The log lacked evidence the ill repaired wheelchairs had been identified or documented. The wheelchair cleaning schedule and policy were requested, but were not provided. The Maintenance Request Log policy and procedure dated as revised April 2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs and will document identified repairs in log." Facility records lacked evidence the administrator completed audits. The Home Like Environment policy dated August 2013, directed "Videll Healthcare, LLC facilities shall provide a safe, clean, comfortable, and homelike environment."	F 253		
F 257 SS=D	483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS The facility must provide comfortable and safe	F 257	F 257 For sampled residents R1 and 9 and for all residents at the facility, the facility shall ensure	

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F 257	Continued From page 115 temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain comfortable room temperatures for 2 of 9 residents (R1, R9) in the sample reviewed with complaints of cold rooms. Findings include: R1 and R9, roommates in the same room, expressed concerns with the room temperature and comfort. R1 was interviewed on 3/11/14, at 11:31 a.m. and stated, "It's either too hot or cold. It's [the temperature] not well regulated." R1's most recent Brief Interview for Mental Status (BIMS-tool used to measure cognition) dated 3/4/14, noted a score of 15 indicating R1 was cognitively intact. R9 was interviewed on 3/11/14, at 1:20 p.m. and stated, "It is too hot or too cold sometimes." R9's most recent BIMS dated 1/8/14, noted a score of 15 indicating R9 was cognitively intact. On 3/17/14, at 11:22 a.m. upon entering room with the surveyor, the director of facility operations (DFO) verified the room felt cold and stated the temperature was set at 55 degrees Fahrenheit (°F). On 3/17/14, at 11:23 p.m. DFO stated the heat	F 257	that resident room temperatures are kept between 71 and 81 degrees F. Maintenance identified to the surveyor during the survey the fan control was not functioning in the room where residents R1 and R9 reside. The fan control will be repaired or replaced. Will be done B/4 4-28-14 A digital temperature gun was purchased by the facility and ambient temperatures will be checked randomly by maintenance. This random check will be done weekly on all 4 hallways. A log of this random ambient temperature check will be kept. This log will be reviewed by the administrator. Additionally, this log will be reviewed by the QA committee regularly for additional recommendation as necessary. Responsible: Administrator, Maintenance Compliance date: 4/28/2014	

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F 257	Continued From page 116 control was working, but not the fan control. DFO stated he was not aware of the problem, and verified it was not identified or logged in the maintenance log. DFO unscrewed the part and further stated the bracket was not working and added, "It needs a new whole control." The Home Like Environment policy dated August 2013, directed "Videll Healthcare, LLC facilities shall provide a safe, clean, comfortable, and homelike environment."	F 257		
F 258 SS=D	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure comfortable sound levels were maintained for 2 of 5 residents (R113, R36) who lived in different hallways. In addition, the facility failed to ensure comfortable sound level concerns brought up at the Resident council Meetings which had the potential to affect all 84 residents residing at the facility. Findings include: R113 on 3/11/14, at 9:03 a.m. during interview expressed there was a noise problem especially at night from some residents yelling and staff being loud either across or down the hallways. R113 further stated "Maybe that is how they are I just shut the door."	F 258	F 258 For sampled residents R113 and 36 and for all residents at the facility, the facility shall ensure the noise level is comfortable. Comments in the Resident Council Minutes about noise issues will be responded to timely by the facility administrator. During shift change, facility leadership will be visible to ensure staff attend to shift change activities and that noise levels are comfortable. Staff will be educated regarding their responsibility to maintain comfortable noise levels in the facility at all times. Documentation of this education will be provided to the QA committee for review and further recommendation as indicated.	

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F 258	Continued From page 117 On 3/17/14, at 11:34 a.m. R113 stated the noise level was fine at the time but at times was an issue and he knew better to shut the door. R113's most recent Brief Inventory for Mental Status (BIMS-tool used to measure cognition) obtained from the significant Minimum Data Set (MDS) dated 2/14/14, noted a score of 15 out of possible 15 which indicated intact cognition. R36 On 3/11/14, at 10:40 a.m. during interview R36 stated "At around 2:30 p.m. by the medication cart about seven aides would be standing and they were loud. It was also noisy at night a couple of aides and residents won't stop talking." R36's most recent BIMS obtained from the quarterly MDS dated 2/18/14, noted a score of 13 which indicated intact cognition. On 3/17/14, at 10:59 a.m. when asked about the noise R36 stated there was noise in the hallway was worse especially during the afternoon shift change. On 3/17/14, at 11:01 a.m. the director of facility operations stated the noise concern had been brought up on the stand up meetings several times and thought director of nursing (DON) and administrator were the two handling it as some residents had been very vocal about the noise levels on numerous occasion including some that had been discharged from the facility. During review of the Resident Council Meeting Minutes the following was revealed: -Meeting Minutes dated 10/28/13, indicated staff	F 258	The facility administrator shall ensure that issues raised by the Resident Council about noise levels are addressed timely and that follow up is given back to the Resident Council. This will be ongoing. Complaints risen at Resident Council about noise levels will be reported to the QA committee for review and further recommendation as indicated. This will be ongoing. Responsible: Administrator and all facility staff Compliance date: 4/28/2014	

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F 258	Continued From page 118 were loud between shifts, talked between themselves, ignored the residents and sat in the halls around 9:00 p.m. and 10:20 p.m. -Meeting Minutes dated 11/25/13, indicated staff was being loud between shifts and talked between themselves continued to be a problem. Also the staff continued to seat in the halls around 9:00 p.m. and 10:20 p.m. - Meeting Minutes dated 12/16/13, indicated staff being loud between shifts, talking between themselves and sitting in the halls continued to be a problem. -Meeting Minutes dated 1/20/14, indicated staff being loud between shifts continued to be a problem, talking between themselves and staff sat in the halls around 9:00 p.m. and 10:20 p.m. During further document review, it was revealed a Resident Council Action Form dated 11/15/13, indicated "Talked to supervisors to educate PM staff to stop this behavior. Supervisor will take charge." In addition, attached was undated postage sign which addressed many other resident complaints including staff not sitting and talking with their peers at the medication carts. There was lack of documentation in all subsequent Resident Council Meetings on how the noise/sound level was addressed by the facility as it was being brought up on every one of the meetings in the five months. The Home Like Environment policy dated August 2013, directed "Videll Healthcare, LLC facilities shall provide a safe, clean, comfortable, and homelike environment."	F 258		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272		

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F 272	Continued From page 119 The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F 272 For sampled resident R91 and for all residents at the facility, the facility shall ensure assessments are completed. These assessments will be thorough and accurate. Assessments will be completed at the time of admission as outlined in the MDS manual, according to PPS protocol, and at the discretion of the clinical staff based on clinical observations and/or change in medical status. Behavior assessments are part of this assessment process. The facility has a policy titled, "Behavior Management" that was effective 11/2011 and reviewed 01/2013. This policy addresses the specific need for behavior assessments. As outlined in the facility policy, after assessments are completed, the IDT will meet to discuss the assessment and create a care plan. If behavior management is a part of that care planning process, target behaviors that are identified will be tracked on a behavior tracking sheet/log.	

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F 272	Continued From page 120 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not comprehensively assess behaviors1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Findings include: On 3/13/14, at 9:00 through 9:47 a.m. R91 was observed resting in bed with covers on her. R91 was being delivered supplemental oxygen to her through a nasal cannula. R91 nodded off during conversation with surveyor and did not respond to some questions. R91 flinched her shoulders twice and reported she had a lot of pain in her knees. R91 reported she was very depressed from living at the facility and wanted to go home. R91 explained she felt no one cared for her at the facility because, even though she was sick and in pain, no one came to check on her. R91 explained she had been prescribed antibiotics and pain medications by a physician yesterday but she did not take them because she did not trust the physician knew her well enough to prescribe meds to her. R91 recounted how she was upset because a staff member lied to her yesterday about canceling a ride to the store for her. R91 reported it made her "angry" and "rude" when staff lied to her. R91 reported she planned on spending the rest of the day resting in bed and did not think any staff would assist her with any cares today. R91's admission Minimum Data Set (MDS), dated 10/15/13, indicated the potential for moderate depression due to self-reported symptoms of little interest or pleasure in doing things, feeling down	F 272	Sampled resident R91 will be assessed related to behavior management issues. The IDT will meet to review the assessment and a behavior management care plan will be initiated. Identified target behaviors will be tracked on a behavior tracking sheet/log. This behavior management assessment and the behavior management care plan will be reviewed/revised at least quarterly with the MDS process. New behaviors that are problematic will be assessed immediately and appropriate care plan interventions identified as indicated. The DNS and/or RCM will audit sampled resident R91 monthly X6 to ensure behavior management assessments and target behavior	

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F 272	Continued From page 121 depressed or hopeless, trouble falling asleep or sleeping too much, feeling tired or having little energy and poor appetite or overeating. The MDS revealed R91 displayed verbal and physical aggression one to three days during the seven day observation period. R91's quarterly MDS, dated 1/9/14, indicated a potential for mild depression, with R91 reporting the same symptoms in addition to moving or speaking slow or being fidgety. The MDS noted verbal and physical aggression towards others occurred four to six days during the seven day observation period. Both the 10/15/13 and 1/9/14, MDS indicated R91 rejected evaluation or care on one to three days during the seven day observation period. R91's Brief Interview for Mental Status (BIMS) on her admission and quarterly MDS dated 10/15/13 and 1/9/14 indicated she was cognitively intact. R91's Care Area Assessments, dated 10/22/13, for Mood, Cognitive Loss/Dementia, Behavior, and Psychosocial Well Being included the same summary statement under the Care Plan Considerations section: "Resident has some behavior r/t [related] medical Dx [diagnosis]. Staff will monitor her behavior and ensure pt [patient] needs are met and she is safe." The sections for input from resident and family or representatives for resident were all left blank; despite R91's BIMS score indicating she was cognitively intact. Each care area assessment noted a referral to another discipline in the health care team (such as social services, medical or mental health professionals) was not necessary. The assessment did not include a thorough analysis including: specific behaviors exhibited by R91, what medical or mental health concerns would	F 272	tracking is being completed as outlined in the care plan. Additionally the medical record will be audited for thoroughness and accuracy of the behavior assessment. The results of this audit will be reported to the QA committee for review and further recommendation as indicated. The DNS/RCM will randomly audit 6 resident records who are receiving behavior management intervention and targeted behavior tracking to ensure assessments are completed and that behavior tracking is being completed. These audits will be done for 6 months. The results of these audits will be reported to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DNS, RCM, Social Services Compliance date: 4/28/2014	

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F 272	Continued From page 122 impact care, triggers to behaviors, events immediately prior to behavior, consequences of behavior or tactics known to decrease or minimize behavior. R91's current care plan, last reviewed 1/30/14, did not include problems, goals or interventions related to R91's mood, rejection of evaluation or care and verbal and physical aggression. On 3/14/14, at 2:14 p.m. the social service designee (SSD) reported the care area assessments for R91 were completed prior to her employment at the facility. SSD reported the care area assessments were not comprehensive, did not identify what behaviors were occurring, causative factors or how best to help. SSD reported she was not aware R91 exhibited verbal and physical aggression or rejection of cares. Surveyor requested any other documentation of behavior or mood assessments, not included in the care area assessments. None was provided. SSD confirmed R91's care plan did not address her aggressive behaviors or rejection of evaluation or care. On 3/14/14, at 3:53 p.m. R91's nursing assistant (NA)-G reported R91 rejected cares because she valued her privacy and wanted to do as much as she could herself. NA-G reported R91 at times cussed at staff, called them unkind names or threatened to get them fired. NA-G reported R91 has said unkind statements to her roommates. NA-G explained R91 could be intrusive to her roommate's privacy during cares because she thought her roommate was her daughter. NA-G explained R91's behavior varied throughout the day and that at times she was very kind. NA-G was not aware of any physical aggression	F 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 272	Continued From page 123 towards other residents from R91.	F 272		
F 275 SS=D	483.20(b)(2)(iii) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not comprehensively assess 1 of 1 resident (R63) who required a comprehensive assessment at 366 days. Findings include: R63's most recent Minimum Data Set (MDS) dated 1/8/14, noted R63's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a Brief Interview for Mental Status (BIMS - a tool used to determine cognitive levels) score of 15. R63's Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). According to the MDS, R63 had trouble sleeping, had a poor appetite, had little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors. However, looking at R63's MDS history it was noted that R63 had four consecutive quarterly MDS and the medical record lacked evidence of	F 275	F 275 Sampled resident R63 is no longer at the facility. The facility uses PointClick Care for MDS scheduling, tracking, and completion. The MDS due in October 2013 showed in PCC that it was "ACCEPTED". Communication from CMS to the facility indicated the initial submission was not accepted. The facility opened the MDS and resubmitted the MDS which was then accepted by CMS. A validation report is available for review. For all residents at the facility, the facility shall ensure that MDS assessments are completed and submitted according to timelines outlined in the MDS manual. Validations reports of submission and CMS acceptance will be kept by the MDS coordinator. These validation reports will be presented to the QA committee regularly for review and further recommendation as indicated. Responsible: Administrator, MDS coordinator Compliance date: 4/28/2014	

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 275	Continued From page 124 an annual comprehensive assessment that had been completed which would have identified the resident's functional capacity and health status. R63's MDS history was as follows: - Annual comprehensive assessment completed on 10/10/12, and - quarterly assessment completed 1/9/13, 4/10/13, 7/11/13, and 1/8/14. The October 2013 MDS manual revision directed "each facility must use its State-specified RAI [resident assessment instrument] (which includes the MDS, utilization guidelines and the CAAs [Care Area Assessments]) to assess newly admitted residents, conduct an annual reassessment and assess those residents who experience a significant change in status. The facility is responsible for addressing all needs and strengths of residents regardless of whether the issue is included in the MDS or CAAs. The scope of the RAI does not limit the facility's responsibility to assess and address all care needed by the resident." The comprehensive assessment was to be completed done within 366 calendar days of the last comprehensive assessment. R63 went 522 days (at time of exit) without a comprehensive assessment that would have identified her current functional capacity and develop a current care plan with interventions to care for R63. On 3/12/14, at 3:01 p.m. an interview with the director of nursing (DON) was conducted. The DON revealed assessments were not accurate and update and so we have started to redo all of them. Only six to seven residents have been completed. We have not been able to get the whole team together to talk about all of it.	F 275		

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F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive plan of care (POC) for 1 of 1 resident (R11) to include refusals of cares, psychosocial needs, vulnerability, social service needs, discharge planning, pertinent diagnoses, contracture of the left side including hand and wrist, dental status and actitivies of daily living (ADL) requirements; the facility failed to develop a comprehensive POC for 1 of 1 resident (R111) care plan did not address the respiratory interventions for use of a continuous positive airway pressure (CPAP-breathing machine that	F 279	F 279 Sampled resident R11 is no longer at the facility. For sampled residents R103, 111, 117 and for all residents the facility shall ensure that comprehensive care plans are developed addressing all assessed needs. Comprehensive care plans shall be developed according to OBRA and MDS timelines. For sampled residents R103, 111, and 117 the clinical record and MDS will be reviewed to ensure all assessments have been completed. IDT shall meet to develop a comprehensive care plan that addresses all of the residents needs including but not necessarily limited to CPAP use, ADLS, dental care, behavior management, psychotropic drug management, refusal of care, social and psychosocial needs, falls, nutrition, contractures, and CAAs. The comprehensive care plans for R103, 111, and 117 will be audited monthly to ensure they remain current and up to date. The results of these audits will be reported to the QA committee for review and further recommendation as indicated.	

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F 279	Continued From page 126 provides a continuous supply of air which is positively pressurized); the facility failed to develop a comprehensive POC for 1 of 1 resident (R117) to include lacked a comprehensive care plan related to the Care Area Assessments (CAA) areas triggered of falls, dental care and psychotropic drug use; the facility failed to develop a comprehensive POC for 1 of 1 resident (R103) to include interventions for urinary incontinence, ADLs, psychosocial wellbeing, and pain; the facility failed to develop a comprehensive POC for 1 of 1 resident (R1) to include interventions for ADLs and sleep medications. Findings include: The facility did not develop a care plan to address R11's refusals of cares, psychosocial needs, vulnerability, social service needs, discharge planning, pertinent diagnoses, contracture of the left side including hand and wrist, dental status and ADL requirements. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 was cognitively intact, had a mood problem of feeling tired, and had no behavior problems. The MDS indicated R11 was independent with bed mobility, transferring, locomotion on the unit and eating; required supervision with locomotion off the unit, dressing and toilet use; R11 was identified as requiring extensive physical assistance from staff for personal hygiene. The CAA for nutrition dated 1/7/14, identified diagnoses of spastic hemiplegia on left side, history of alcohol abuse and congestive heart failure. The CAA identified R11 had "no upper	F 279	Additionally a random sampling of comprehensive care plans shall be audited monthly to ensure they are current and up to date based on the current assessments. The results of these audits will be reported to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DNS,MDS coordinator, RCM, Clinical Liaison Compliance date: 4/28/2014	

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F 279	Continued From page 127 teeth and few lower teeth" and, "He does not wish to receive a mechanically altered diet." - The CAA for ADL Functional/Rehabilitation Potential dated 1/13/14, identified the CAA was triggered due to R11's need for supervision with ADLs. The CAA identified R11 had left sided hemiplegia due to a history of cerebrovascular accident (CVA, stroke). The CAA identified R11's other pertinent diagnoses to include altered mental status, and homelessness. The CAA identified R11 "was eval [evaluated] for therapy" and refused. The CAA identified R11 was continent of bowel and bladder, had no skin issues or falls. - The CAA for falls and pressure ulcers (both dated 1/13/14), recapitulated the same data as ADL CAA. R11's care plan only had a focus for activities dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's concerns with roommate, refusals of care nor behaviors of calling staff derogatory names. The clinical record lacked evidence R11 had care plans developed (including goals and interventions) to address his clinically related social service needs, such as, but not limited to: R11's identified behaviors of refusals/rejection of cares, R11's identified behavior of calling staff derogatory names, and identification of R11's increased vulnerability due to physical limitations and individual psychosocial needs (such as a history of homelessness). In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming	F 279		

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F 279	Continued From page 128 and skin assessments/evaluations and refusals of doctor visits. R111's care plan did not address the respiratory interventions for use of a CPAP. On 3/11/14, at 6:34 p.m. R111 indicated to surveyor the staff did not clean the machine "CPAP." On 3/13/14, at 11:30 a.m. the CPAP mask and tubing were observed lying on the floor next to R111's bed with creamy white build up in the inside of the mask and around the seams. On 3/14/14, at 11:28 a.m. the CPAP mask and tubing were both again observed lying on the floor slightly under the bed but visible. The mask observed to have a thick creamy build up on the inside and the seams. R111's Admission Record dated 1/10/14, identified diagnoses to include head injury and depressive disorder. The admission MDS dated 12/23/13, indicated R111 was cognitively intact and had a diagnoses of asthma. The CAAs did not identify the use of a CPAP machine. The clinical record lacked a comprehensive care plan to address the use of the CPAP, including monitoring of respiratory status, cleaning. A copy of the care plan was requested, but not provided by the facility. R117 was admitted to the facility on 1/21/14, per the Admission Sheet, with diagnoses of severe cardiomyopathy (weakened heart muscle),	F 279		

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F 279	Continued From page 129 congestive heart failure (fluid buildup in the extremities or lungs), cardiac dysrhythmias (abnormally conducted heat beats), depression and anxiety. R117's admission MDS dated 1/27/14, indicated R117 was cognitively intact and was independent in all activities of daily living. R117 was awaiting relocation services to find independent living placement. R117 was observed on 3/10/14, at 3:30 p.m. to self-isolate in his room, listen to loud music and not interact with others in the facility, he did not greet peers or staff. On 3/11/14, at 2:00 p.m. R117 was observed outside smoking, he did not join the group that was outside on the designated smoking patio, but instead choose to isolate himself by sitting on the planter by the front door (not a designated smoking area). On 3/12/14, at 10:30 a.m. R117 was observed to sit on the planter and smoke (not a designated smoking area), he stared at the ground and did not interact or socialize with the residents on the nearby designated smoking patio. On 3/13/14, at 9:29 a.m. the resident went out to smoke, he had the cigarette and lighter in his hand, he lit the cigarette immediately when he went out the door (not a designated smoking area, and sat on the planter by the drive way (not a designated smoking area). A review of the medical record revealed that R 117 had triggered the CAAs for falls, dental care, and psychotropic drug use. The falls CAA identified R117 received an antidepressant, a diuretic, had cardiac problems, psychiatric problems, anxiety disorder, impaired cognition and depression. The facility identified the falls	F 279		

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F 279	Continued From page 130 would be addressed on the care plan. The dental CAA noted R117 had broken or loosely fitting, full or partial denture and decreased mobility. The facility identified the dental would be addressed on the care plan. The psychotropic drug use CAA identified R117 was on psychotropic medications for treatable medical conditions of heart disease. The facility identified the psychotropic drug use would be addressed on the care plan. The temporary care plan dated 1/21/14, was requested and not provided. The care plan dated 2/16/14, was requested and not provided, but upon review of the electronic care plan indicated lacked a comprehensive care plan related to the CAA areas triggered of falls, dental care and psychotropic drug use. On 3/11/14, at 8:00 a.m. the director of nursing (DON) was interviewed and stated R117 did not have a comprehensive care plan. R103 was admitted to the facility 7/29/13, discharged to the hospital on 1/2/14, and was re-admitted on 1/3/14, with diagnoses related to injuries from a motor vehicle accident (MVA), lung contusion (a bruise of the lung tissue from impact), Open fractures of left femur (hip bone) (a fractured bone that protrudes through the skin), right femur, left tibia (leg bone), right tibia, right forearm per the Admission sheet. The quarterly MDS dated 1/16/14, revealed a Brief Interview of Mental Status (BIMS) score of 15/15 indicated R103 was cognitively intact. A Patient Depression Questionnaire (PHQ9) score of 7, indicating mild depression, R103 required supervision and physical assist of one for bed	F 279		

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F 279	Continued From page 131 mobility and transfers, dressing and toilet use; required supervision and set up for locomotion on the unit and off the unit; was independent in personal hygiene, ambulating in room and in hallway and eating. CAAs dated 8/9/13, triggered for ADLs, urinary incontinence, psychosocial wellbeing, activities, dental care and pain. All of the areas identified were to be care planned. The care plan dated 8/9/13, was created by the MDS nurse. The care plan only addressed R103's dental needs. The care plan lacked evidence of interventions for urinary incontinence, ADLs, psychosocial wellbeing, and pain. R1 did not have a comprehensive developed since admission. R1 was admitted to the facility on 11/30/13, per the Admission sheet, with diagnoses including Insomnia, chronic pain, arthritis, osteoporosis, depression, chronic obstructive pulmonary disease (COPD), hypertension, cardiovascular disease, neuropathy in diabetes, bladder spasms, gastric esophageal reflux disease, muscle spasms, and diabetes mellitus obtained from the MDS dated 12/6/13. Physician's Orders dated 2/26/14, indicated R1 received the following medications: -Trazodone 300 milligrams (mg) by mouth at bedtime (HS) for insomnia -Effexor 150 mg by mouth daily for depression -Ambien 5 mg by mouth at HS as needed (PRN) for insomnia -Benadryl 25 mg 2 capsules (caps) by mouth every 4 to 6 hours prn for itching -Atarax 25 mg 2 caps by mouth every 6 hours prn for itching	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 132 -Oxycodone 30 mg by mouth three times a day (TID) prn for pain -Methadone 100 mg by mouth daily for pain -MS Contin 15 mg by mouth at HS for muscle spasms (MS) -Neurontin 800 mg TID by mouth for neuropathy related to diabetes mellitus -Lisinopril 10 mg daily for hypertension (Blood pressure medication) -Metformin hydrochloride 1000 mg two times daily for diabetes -Lantus 12 units subcutaneous at bedtime for diabetes -Detrol LA (long acting) 4 mg daily at bedtime for bladder spasm During further review of the medical record to determine whether there was regular monitoring for efficacy/side effects and sleep patterns it was noted there was no comprehensive care plan developed for the R1. In addition, no comprehensive or temporary care plans had been developed for R1 to direct staff of her care and monitoring. When interviewed on 3/13/14, at 9:23 a.m. registered nurse (RN)-C stated she was the only one doing all the MDS assessments for all the residents in the building and she had not developed a nursing care plan for R1 which included non-pharmacological, pharmacological interventions, medications R1 was taking and side effects that staff were to monitor and report/update to the medical provider. RN-C stated "The temporary care plan is supposed to be completed a few days after admission and the comprehensive care plan one by twenty one days after a resident is admitted to the facility." RN-C verified the only care plans developed in R1's	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 133 record were for activities and nutrition. When interviewed on 3/14/14, at 8:14 a.m. the DON stated every resident should have a temporary care plan until the main care plan was developed. She verified R1 lacked a temporary care plan and that the care plan in the record dated 3/13/14, had been developed two days after a concern had been brought to the facility attention. On 3/13/14, at 4:24 p.m. the DON stated the facility was aware assessments and care plans were not done well or at all. DON stated the facility had started to get everyone together to work on the care plans. The DON verified that many of the care plans were not developed properly, or not developed at all, or were overdue. The DON stated, "The process was to print out everyone's care plan, circled and made notes on what doesn't seem right on the care plan. every department was supposed to go back to their department and review. After a portion was done, we realized we needed to narrow our focus to get the work done, so we focused on residents who elope from the facility or smoke first. We re-did a safety assessment, the originals are in the chart, but I have not yet had time to cut and paste into the care plans. yet. Right now we are trying to get them back into the chart. Currently the care plans are kept in the nursing office, so right now none of the nurses on the floor write on care plans, we are attempting to get them back into the charts, so staff can update them."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be	F 280	F 280 Sampled resident R75 is no longer a resident at the facility.	

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F 280	Continued From page 134 incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan to implement smoking interventions for 1 of 3 residents (R36) reviewed for unsafe smoking and non-placement of a Wanderguard (an alert system to notify staff when a resident had left the building); and the facility failed to revise the care plan for 1 of 1 resident (R75) who received Hospice services. Findings include: Smoking: R36 was observed to have multiple cigarette burn holes on his clothing on 3/11/14. The facility did not revise the care plan or identify the burn holes in his clothing, nor other smoking safety concerns	F 280	For sampled resident R36 and for all residents the facility shall ensure care plans are updated according to OBRA and MDS timeliness and PRN as care planning needs are identified by facility staff. For sampled residents R36 the clinical record and MDS will be reviewed to ensure all assessments have been completed. IDT shall meet to review and/or revise the comprehensive care plan to ensure the care plan appropriately addresses all of the residents needs including but not necessarily limited to smoking and smoking safety, use of a Wander Guard bracelet, and hospice service. The comprehensive care plans for R36 will be audited monthly to ensure it remains current and up to date or is revised as necessary. The results of these audits will be reported to the QA committee for review and further recommendation as indicated.	

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 280	Continued From page 135 related to R36 smoking unsupervised and independently. R36's smoking observations were as follows: - On 3/10/14, at 1:00 p.m. R36 was observed to be smoking unsupervised in the front designated smoking area. R36 was observed to propel his wheelchair (w/c) independently, while smoking. No smoking apron was observed on R36 or in the smoking area. -On 3/11/14, at 11:18 a.m. R36 reported he was assessed for smoking, stated the staff came and watched him light up and watched him smoke. R36 stated the burn hole in his new glove was from a month ago. R36 stated he had never needed a smoking apron or any other smoking interventions. - At 1:27 p.m. R36 was observed to be smoking unsupervised in the front designated smoking area. R36 was observed to propel his w/c independently while smoking with an approximately one inch long cigarette ash. No smoking apron was observed in the area. R36 was observed to have burn holes on his left glove, on the left chest of the coat and the right thigh of R36's pants. R36 stated the burn occurred "one month ago [2/2014]" from "sleeping" with the cigarette in his hand. R36 further stated the gloves were newly purchased and the burn hole on the pants was "old." R36 stated, "I'm getting careless." - On 3/12/14, at 7:45 a.m. R36 was observed to be propelling the w/c to enter the building of the facility from the front designated smoking area while holding a cigarette in his mouth. The cigarette was observed to have an approximate one inch long ash. R36 was observed to notice	F 280	Additionally a random sampling of comprehensive care plans shall be audited monthly to ensure they are current and up to date based on the current assessments and that appropriate revisions are made as indicated. The results of these audits will be reported to the QA committee monthly x 6 months for review and further recommendation as indicated. Responsible: Administrator, DNS, MDS coordinator, RCM, Clinical Liaison Compliance date: 4/28/2014	

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F 280	Continued From page 136 the ash, flick the ash off and extinguish the cigarette in the ash tray. No staff was observed in the smoking area and no smoking apron was observed. - At 1:58 p.m. R36 was observed to be smoking unsupervised in a front designated smoking area. R36 was observed to dozing in the w/c while the cigarette was lit. The cigarette was observed to be nearly burnt out and was held over the previous burn hole in R36's sweat pants. R36 awakened and discarded the cigarette on the pavement. The cigarette was extinguished. No smoking apron was observed. - At 2:28 p.m. R36 reported he retrieved his own clothes in the morning and dressed independently. R36 reported burn holes in coat are from being "careless" and stated the was new to the facility within the last six months. - On 3/13/14, at 9:42 a.m. R36 was noted to be with the facility administrator in a front designated smoking area with a smoking apron on. R36 was observed to have papers in his hand. - At 9:50 a.m. R36 was overheard by the surveyor to inform another resident the facility gave him [R36] a copy of the smoking policy. - At 9:54 a.m. R36 took off the smoking apron, threw it to the ground while stating "F###!" loudly. R36 immediately lit a cigarette. - At 10:04 a.m. R36 picked up the smoking apron and wheeled back into the building. In a loud voice R36 stated, "Here! I'm going to give that to you [and threw the smoking apron on the reception desk]." R36 then stated, "I cannot safely roll with that on." - At 3:35 p.m. R36 was observed to be in the front designated smoking area without the smoking apron on and unsupervised. The smoking apron was lying next to R36. R36 had a lit cigarette with	F 280		

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F 280	Continued From page 137 an inch long ash. R36 was sleeping in the w/c. The director of nursing (DON) was summoned by the surveyor and notified of the observation. DON immediately started a conversation with R36, picked up the smoking apron and folded it. R36 was finished smoking at that time. R36's Admission Record dated 5/26/12, indicated R36 diagnoses included respiratory abnormalities, altered mental status and muscle weakness. A Camden Care Center Smoking Contract dated 5/31/12, was signed by R36's guarantor and read as follows: - "I have received a copy of the Camden Care Center Smoking Policy/Procedure and agree to comply with all the rules set by this policy." - "I understand that smoking is NEVER allowed in resident rooms or anywhere inside the building." - "I understand that smoking is ONLY allowed in designated smoking areas." - "I understand that failure to comply with the Camden Care Center Smoking Policy/procedure may result in a 30 day discharge notice from the facility." The care plan lacked evidence the smoking interventions were ever put into place. R36's Smoking Evaluation dated 5/28/13, was completed by social services. Although the evaluation indicated R36 had a history of unsafe smoking practices, the evaluation lacked explanation as to what those unsafe practices were. The evaluation indicated R36 was cognitively intact, and had no behaviors. Although the evaluation had identified unsafe smoking practices in the past, the evaluation indicated R36 understood the safe storage of smoking	F 280		

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F 280	Continued From page 138 materials, understood where smoking was allowed, and was deemed an independent smoker. R36's three consecutive Smoking Evaluations dated 8/29/13, 11/17/13, and for 2/18/14, all noted no changes from the Smoking Evaluation on 5/28/13. The unsafe smoking history still remained undetermined and all four assessments indicated R36 was deemed an safe smoker. The Nursing Assessment Packet Review for the reference period of 2/12/ (no year) through 2/18/ (no year) lacked any documentation of the safety risks regarding R36's smoking. A behavior contract was signed on 6/6/13, which indicated R36 would not drink alcohol while residing in the facility and would follow all policies in the facility. The contract specified the smoking policy and identified R36 would "only smoke on the back patio of the facility." The care plan was not revised for the smoking contract as R36 smoked in the front of the building unsupervised. The Camden Care Center Quarterly Care Conference summary for R36 was noted to be written by nursing and dated 9/17/13. The summary indicated R36 was assessed by the licensed nurse and deemed to be an independent smoker, risks versus benefits were explained, and R36 refused a smoking cessation program. However, a care conference summary written by social worker designee indicated, "[R36] requires supervision with smoking; however he does not follow it. [R36] has had difficulty following facility policy for smoking in designated area of back patio of facility, but over the last quarter he has improved greatly." The Camden Care Center Quarterly Care Conference summary dated	F 280		

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F 280	Continued From page 139 11/26/13, documentation was unchanged from the 9/17/13, care conference note. - During the survey, R36 was never observed to be smoking in the supervised smoking area on the back patio. R36 was always observed to smoke in the designated "unsupervised" smoking area in the front and to the side of the building. It could not be determined if R36 was deemed a safe smoker as the summary from nursing conflicted with the summary from the social worker. R36's most current quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 had no behaviors and had a Brief Interview for Mental Status (BIMS) score of 13 which noted R36 was cognitively intact. The MDS also indicated R36 received one person assist with transfers, dressing, hygiene, and R36 used a wheelchair for mobility. The smoking care plan dated 2/18/14, identified R36 as an independent smoker, and indicated R36 would remain safe while smoking and would follow all guidelines regarding smoking. The care plan also identified R36 was directed to smoke only in the designated areas and would not smoke around those with oxygen. The care plan conflicted with the social worker designee's summary dated 2/18/14, which indicated R36 was an unsafe smoker and needed supervision. On 3/12/14, at 3:01 p.m. DON and administrator were interviewed. DON verified she was aware of the burn holes in R36's coat. DON stated she was told in the interdisciplinary team (IDT) "all that stuff is old that's he's got." The administrator stated, "He has new gloves in his closet, glove burn happened one month ago." and verified she	F 280		

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F 280	Continued From page 140 was informed "the aides know about it." The administrator stated R36 just liked the old coat and stated the new coat was "just put on." The administrator stated R36 was given a discharge notice in June of last year. The administrator verified assessments were not accurate or up to date and stated the facility had started to redo all of the assessments. The administrator indicated the social worker designee (SWD) was not trained on how to do the assessments and no plan had been identified to ensure R36's safety. On 3/13/14, at 2:17 p.m. during an environmental tour the administrator verified the facility had two resident smoking areas. The administrator verified the area in the front of the building to the left of the entrance to the facility was designated as unsupervised. The second resident smoking area was located adjacent to the dining room and designated as the supervised smoking area. Wanderguard: R36's guardian requested a Wanderguard be applied to R36 "to prevent him from leaving the facility." The care plan printed 2/16/14, indicated on 5/27/13, R36's guardian requested a Wanderguard be applied. R36's Wanderguard applied was on 11/28/12. On 6/2/13, the Wanderguard was "cut off" by R36 and he refused it. The care plan still noted the Wanderguard as an intervention and the Wanderguard was "not effective at this time." R36's care plan was not revised to indicate R36 did not have a personal alert system to alert staff	F 280		

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F 280	Continued From page 141 when he left the building. R75's care plan regarding Hospice and resuscitation status after Hospice was initiated on 5/3/13 was not revised. The care plan reflected neither enrollment in Hospice, nor coordination of Hospice care. The Admission Sheet dated 10/15/11, indicated R75 was admitted to the facility on the same day with diagnoses to include end stage chronic obstructive pulmonary disease (COPD) with 10 to 15 liters of continuous oxygen, chronic pain, and methadone use for history of drug dependence. The Care Area Assessments (CAA) for nutrition dated 5/12/13, indicated R75 had a recent hospitalization for COPD and was currently on Hospice care for end stage COPD. The nursing care plan dated 9/2/13, indicated R75 was a full code and would receive all life sustaining measures in case of medical emergency. The care plan indicated nursing was to implement all life sustaining measures in case of medical emergency. The care plan lacked coordination of Hospice cares that were identified in the CAAs dated 5/12/13. A quarterly Minimum Data Set (MDS) dated 2/17/14, indicated R75 was cognitively intact, mildly depressed, and required an extensive one person physical assist for bed mobility, transfers, dressing, toileting, and personal hygiene. A review of the Physician Orders signed 3/10/14, indicated physician order for R75's advanced directives to be Do Not Resuscitate (DNR), Do	F 280		

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F 280	Continued From page 142 Not Intubate (DNI) and R75 was enrolled as a Hospice care patient. On 3/13/14, at 4:24 p.m. the director of nursing (DON) verified the care plan for R75 was not revised to include the change in R75's advanced directives, Hospice enrollment and coordination of R75's Hospice care. The policy for care planning was requested and not provided.	F 280		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor for target behaviors for the use of Zyprexa as directed by the care plan for 1 of 1 resident (R89); the facility failed to ensure self-administered medications were safely administered for 1 of 1 resident (R36) observed to self-administer medications (SAM); the facility failed to ensure 1 of 3 residents (R41) who did not receive medications as care planned for six days; the facility failed to ensure 1 of 3 residents (R64) was not provided assistance with repositioning, transfers and nail care as directed by the care plan. Findings include:	F 282	F 282 For sampled residents R89, 36, 41, 64 and for all residents the comprehensive care plan will be followed as initiated, reviewed, and/or revised by the IDT. For sampled resident R89 and for all residents with target behaviors, the target behaviors will be tracked as outlined in the comprehensive care plan. All care plans for residents with target behaviors will be reviewed/audited by the appropriate IDT member for appropriate target behavior identification and comprehensive care plan interventions. Updates and/or changes will be made based on current evaluation of the effectiveness of the interventions.	

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F 282	Continued From page 143 R89 was not monitored for target behaviors as directed by the care plan. R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. Review of the clinical record indicated R89 was not monitored for target behaviors. On 3/13/14, at 2:24 p.m. the licensed practical nurse (LPN)-D verified there was no target behavior monitoring for Zyprexa and stated there "should be." LPN-D was unclear on what target behaviors to monitor for R89. On 3/14/14, at approximately 9:40 a.m. the geriatric nurse practitioner (GNP) stated she would expect the facility to monitor for efficacy of the medication and be looking for things like increased somnolence, decreased delusions. When asked if she directed the facility to monitor	F 282	Additionally, the facility has a policy titled, "C.A.R.E. Team Meeting: Clinical At Risk Resident Evaluation Team Meeting." This policy was effective 05/2012 and reviewed 05/2013. It outlines weekly meetings that are to be held to review specific residents at risk. Behavior Management is an area of clinical risk. These meetings are now initiated again at the facility and once every month residents with targeted behaviors are reviewed by the IDT. During this meeting target behaviors are reviewed, interventions evaluated for effectiveness, and care plans are reviewed and revised/updated. A log will be kept from each CARE meeting related to behavior management. This log will be presented to the QA committee for review and further recommendation as indicated. This will be an ongoing audit and QA review process. For sampled resident R36, the IDT will review the self-administration of medication assessment to ensure it is current and accurate. The IDT will review and revise as appropriate	

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F 282	Continued From page 144 for behaviors or gave suggestions of target behaviors, GNP stated she did not direct monitoring for target behaviors because "they were usually identified on behavior sheets." On 3/14/14, at 10:51 a.m. the director of nursing (DON) verified target behaviors should have been monitored as directed by the care plan. SAM: On 3/11/14, at 9:36 a.m. during a random observation R36 showed surveyor he was holding his vitamin and potassium tablets (supplement replacements) in his hand. Upon looking, four and a half (4 1/2) tablets were observed in his left hand. When interviewed on 3/11/14, at 9:39 a.m. trained medication aide (TMA)-C stated R36 took the big ones back to his room to take with pop but the Lasix (medication used to treat excessive fluid accumulation and swelling of the body caused by heart failure) and Methadone (a narcotic pain medication) he took them in front of her. The care plan dated 6/14/12, indicated R36 had declined to self-medicate. The care plan directed "Nursing to store, administer and document all medications daily as ordered." in addition the care plan directed a self-medication assessment to be completed per facility policy. The care plan was not followed for R36's SAM. Physician's Orders dated 3/5/14, did not identify if R36 could SAM which included oral medications after set-up. The undated Assessment For Self-Administration Of Medications indicated R36 did not wish to self-administer medications and would not be set up with medications in envelop with designated dispensing times if he went on	F 282	the comprehensive care plan related to the self-administration of medication and ensure the care plan is implemented. The Resident Care Manager(s) or DON will do a monthly audit x6 of residents who self-administer medication to ensure the assessments are present and accurate and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. For sampled resident R64, the resident MDS section related to ADLs and mobility will be reviewed to ensure it is accurate. The IDT will review the MDS and make appropriate referrals to PT/OT as indicated to improve mobility. The IDT will formulate a comprehensive care plan and ensure that it is implemented. For all residents with mobility issues, the care plans will be audited to ensure they reflect an accurate assessment. Referrals to PT/OT will be made if appropriate to improve ADL function. The IDT will formulate a comprehensive care plan and ensure that it is implemented.	

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F 282	Continued From page 145 leave of absence. In addition, the Nursing Assessment Packet Review Quarterly reference period 2/12/ (no year), through 2/18/ (no year), under Self Administration of Medications had indicated "no" changes to SAM assessment. When interviewed on 3/14/14, 3:32 p.m. LPN-A stated she would expect a resident to have an assessment, a physician's order and an updated care plan if the resident had been determined to be able to self-administer medications. On 3/18/14, at 8:25 a.m. the DON stated she expected staff to stay and watch all residents take their pills if they did not have an order to SAM after set up. DON further stated if residents were considered to be appropriate to SAM that would be addressed in the care plan and an assessment would have been completed by the interdisciplinary team to reflect it all in the order which would be listed below the medication in the Medication Administration record (MAR). On 3/18/14, at 2:30 p.m. the policy was requested but was not provided. The facility failed to ensure R41 received medications as care planned for six days. The current physician orders, dated 2/4/14, directed staff to administer "Morphine Sulfate ER Tablet [Extended Release] 30MG [milligrams] Give 30MG orally at bedtime for pain give at HS only" R41's pain care plan, dated 2/17/14, informed staff "Pain: has chronic pain r/t [related to] osteoarthroses, peripheral neuropathy, Chronic	F 282	The Resident Care Manager(s) or DON will do a monthly audit x6 of residents who have mobility issues to ensure the assessments are present and accurate and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. For sampled resident R41 the care plan will be reviewed related to the administration of medications. The IDT will ensure that appropriate diagnoses exist for all prescribed medications. The IDT will ensure the care plan is initiated relative to these medication interventions. The Resident Care Manager(s) or DON will do a monthly audit x6 of residents who have medications identified in the care plan to ensure the medication regimen is still ordered and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DON, RCM, IDT Compliance date: 4/28/2014	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 282	Continued From page 146 Physical Disability, PVD [peripheral vascular disease]" The goal was "[R41] will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through review date." The care plan directed staff " Administer analgesia Percocet and Morphine as ordered." The narcotic administration record for February and March 2014, indicated no morphine administered on 3/5, 3/6, 3/7, 3/8, 3/9, and 3/10. The March 2014, medication administration notes indicated medications were not available on 3/5, 3/6, 3/8, 3/9, and 3/10. On 3/13/14, at 8:50 a.m. R41 reported he had not received his scheduled morphine for about a week recently. R41 reported his pain increased related to not receiving his scheduled dose of morphine. On 3/13/14, at noon, the narcotic administration record and medication administration record with TMA-A. TMA-A confirmed the narcotic administration record for February and March 2014 indicated no morphine administered on 3/5, 3/6, 3/7, 3/8, 3/9, and 3/10. On 3/14/14, at 8:15 a.m. R41 reported "It took them more than a few days to get the meds. It took a few days for them to take action on it. I got the lady at the desk to order some new ones. They had to have the house doctor prescribe a new order for morphine." On 3/14/14, at 10:00 a.m. the medical records staff [MR] reported R41 reported he was out of morphine so she wrote out the form for the medical director to sign. MR reported the process was for TMAs or nurses to order refills from	F 282		

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F 282	Continued From page 147 pharmacy. The pharmacy sends back a form for the prescriber to fill out and renew the refill order for controlled substances. When MR received the fax she gave it to the nurse. MR reported "the process does not work" and further added "this is inexcusable" yet "happens all the time." MR reported the facility should be reordering medications earlier. On 3/14/14, at 11:42 a.m. LPN-D, confirmed R41 did not have scheduled morphine available from 3/5/14 through 3/10/14. On 3/14/14, at 11:42 a.m. the DON reported R41's scheduled medications should have been available to him as prescribed. R41 not having a prescribed medication available from 3/5/14 through 3/10/14 did not meet her expectations. The Videll Healthcare LLC Pain Management Policy, last reviewed 1/2013, directed staff: "The goal of any pain management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify pain and develop an effective management program." "8. A comprehensive care plan is developed by the interdisciplinary team that addresses pain and an individualized pain management program based on individualized assessed need. a. The pain management program may address the following: i. Scheduled use of pain medication" R64 was not provided assistance with nailcare, repositioning, and transfers as directed by the care plan. R64's current diagnoses according to the face	F 282		

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F 282	Continued From page 148 sheet, dated 1/14/14, included senile dementia uncomplicated, diabetes, essential hypertension, senility without mention of psychosis, muscle weakness generalized and difficulty in walking. R64 was admitted on 1/5/10. Nailcare: On 3/12/14, at 7:52 a.m. R64 was noted to have approximately ½ inch long fingernails on both hands. On 3/13/14, at 7:56 a.m. nursing assistant (NA)-D was completing a.m. cares on R64. - At 8:23 a.m. NA-D stated he would tell the nurse if a resident had long nails and the resident was diabetic. He said R64 was diabetic. - At 8:31 a.m. R64 was wheeled out into the hallway and taken to the dining room for breakfast. - At 9:11 a.m. LPN-A said that diabetic resident nails should be trimmed on bath days. LPN-A said R64's bath was yesterday and nurses should be checking R64's fingernails on the bath day. - At 9:18 a.m. LPN-B viewed R64's fingernails. LPN-B said they were "very long." When surveyor staff asked about the procedure for cutting R64's nails, LPN-B replied "Well, the daughter is here every day, I don't know if she didn't see that or what." Surveyor staff asked to clarify if it would be the daughter's responsibility to cut R64's nails, LPN-B replied "Like I said she is here every day." R64 was not provided with assistance to complete grooming (trimming of fingernails) as directed by the care plan. An observation of a.m. cares on 3/14/14, at 7:22 a.m. revealed LPN-A told NA-D he needed to cut R64's nails today, R64 was "not diabetic." R64 was noted to be cooperative throughout that	F 282		

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F 282	Continued From page 149 episode of care and began to verbalize a little with staff towards the end of the observation. During interview on 3/14/14, at 8:47 a.m. the DON said nails should be trimmed on bath days by either a nurse or an aide. The ADL care plan dated 11/14/11, indicated R41 was to have assist of one with grooming and hygiene. A policy regarding nail care was requested, none was provided. Repositioning/Transfers: On 3/13/14, at 7:56 a.m. nursing assistant (NA)-D was completing a.m. cares on R64. - At 8:19 a.m. NA-B entered the room to assist NA-D to transfer R64 with the use of the EZ-stand (a mechanical device to stand a resident). R64 was not holding onto the EZ-stand, NA-D repeatedly tried to reapply R64's hands to the lift. The safety strap (a waist belt) on the EZ-stand harness was loosely secured about R64's waist. - At 11:00 a.m. surveyor staff spoke with LPN-B to inform them R64 needed assistance with repositioning. - At 11:05 a.m. (two hours and 46 minutes after R64 was last repositioned), NA-C and NA-B attempted to lift R64 out of his wheelchair for repositioning with the EZ-stand. During the transfer, R64 pulled their hands away from the EZ- stand handles, with the left hand becaming wedged between handle of the EZ- stand and the frame on the left side. NA-C and NA-B lowered R64 back down into the wheelchair. NA-B stated the resident does that (would not hold onto the lift) a lot. NA-B and NA-C tried to manually place R64's hands on the handles and R64 was unable.	F 282		

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F 282	Continued From page 150 NA-B and NA-C said R64 was unsafe in anything else but the EZ-stand. - At 11:10 a.m. NA-B and NA-C obtained LPN-B to assist. LPN-B came to the room, placed R64's hands on the handles, and covered R64's left hand with his hand to maintain placement. NA-B and NA-C began to stand R64 and R64 began to slide out of the EZ stand harness, surveyor staff intervened and asked NA-B and NA-C to place the wheelchair underneath R64 to prevent them falling onto the floor. The belt of the EZ-stand sling was noted to be very loose around R64's waist. - At 11:17 a.m. NA-B and NA-C stated they used the resident group lists for special information about residents, however neither NA staff member had the group list on their person at this time. NA-B and NA-C were unable to state R64 could use a Hoyer lift for transfers if they were resistive, as directed by the care plan. - At 1:25 p.m. NA-A and NA-D were attempting to transfer R64 into bed from the wheelchair using the standing lift. NA-D began to lift the resident, and surveyor staff intervened to tell NA-A and NA-D the resident was not hooked to the lift on one side. Additionally, R64 was not holding onto the lift handles at first, and began to hang onto the lift frame and not the handles. NA-A and NA-D completed the remainder of the transfer with the EZ-stand. NA-D said the usual practice was to lie R64 down after lunch, the usual practice was not to reposition R64 every two hours, as the care plan directed. NA-D did not follow the care plan for safe transfers. The plan of care dated 11/14/11, indicated R41 was at risk for falls and needed assist with transfers. The interventions directed the staff to follow the falls/safety policy and protoclol.	F 282		

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F 282	Continued From page 151 The goal was that R41 would be safe and not sustain an injury. Also, R41 was to have appropriate use of adaptive equipment to increase mobility. R41's care plan directed the staff to turn and reposition every two hours. The plan of care was not follwed for R41's transfers and repositioning. During interview on 3/14/14, at 10:34 a.m. registered nurse (RN)-D said R64 typically does not lie down until after lunch and stayed in their wheelchair until then. RN-D said R64 had not been back to bed for repositioning since he had gotten up for breakfast (three hours and 12 minutes earlier). The facility staff's usual practice of lying R64 down after lunch was in conflict with the care plan directions to reposition R64 every two hours.	F 282		
F 283 SS=E	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to complete a discharge summary and capitulation of stay for 15 of 18 discharged residents (R78, R32, R107, R42, R108, R48, R109, R114, R82, R110, R79, R106, R87, R66,	F 283	F 283 For closed record review sampled residents R78, 32, 107, 42, 108, 48, 109, 114, 82, 110, 79, 106, 87, 66, 100 and for all discharged residents going forward at the facility, the facility shall ensure that a recapitulation of stay (discharge summary) is completed by the IDT timely.	

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F 283	Continued From page 152 R100) reviewed for closed records. Findings include: During the stage one closed record review the discharged resident records did not contain a recapitulation of the residents' stay, or summary of resident cares and treatments while in the facility. Discharges occurred between 10/31/14, through 2/14/14, were as follows: R78 was admitted to the facility 11/26/13, and discharged to the community 12/20/13. R32 was admitted to the facility 10/30/13, and discharged to the community 11/18/13. R107 was admitted to the facility 10/17/13, and discharged to the community 1/17/14. R42 was admitted to the facility 9/26/13, and discharged to the community 10/15/13. R108 was admitted to the facility 10/30/13, and discharged to the community 11/13/13. R48 was admitted to the facility 11/4/13, and discharged to the community 11/26/13. R109 was admitted to the facility 10/31/13, and discharged to the community 11/22/13. R114 was admitted to the facility 12/27/13, and discharged undocumented 1/31/14. R82 was admitted to the facility 11/08/13, and had a quarterly review on 2/13/14, eloped on 3/10/14, returned on 3/13/14, collapsed and was taken to acute care hospital. Discharges and readmissions were not reflected in the Minimum Data Set (MDS) entry/discharge records. R110 was admitted to the facility 11/15/13, and discharged to the community 12/30/13. R79 was admitted to the facility 1/23/14, and discharged to the community 2/14/14	F 283	The facility has a policy titled, "Transfer Discharge" that was effective 05/2012, reviewed 05/2013, and is now revised as of 04/2014. The revision clearly directs that a transfer/discharge recapitulation (discharge summary) shall be completed by the IDT with anticipated and/or unanticipated discharges timely. This revised policy is available to the facility on the facilities remote desktop. Additionally, the facility has a policy titled, "Nursing Documentation" that was effective 05/2012 and reviewed on 05/2013. This policy has direction to refer to AHIMA as an authoritative resource for all aspects of documentation in the long term care setting. All clinical records for anticipated and/or unanticipated discharges shall be audited by the Resident Care Manager and/or DON for completeness. This audit is completed weekly on all discharges for the previous week. The results of this audit are reviewed by the administrator. The audit results are reported to the QA committee for review and further recommendation as appropriate. These audits will be ongoing.	

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F 283	Continued From page 153 R106 was admitted to the facility 10/16/13, and discharged to the community 12/04/13. R87 was admitted to the facility 10/07/13, and discharged to the community 10/31/13. R66 was admitted to the facility 9/26/13, and discharged to acute care status 10/18/13, readmitted on 10/28/13 and discharged to acute hospital 1/03/14. R100 was admitted to facility 6/27/13, and discharged to the community 10/30/13. On 3/12/14, at 4:24 p.m. the director of nursing (DON) stated, "I am not surprised there are no discharge summaries, there was really no system in place."	F 283	For resident R82, ...we need to address the missing MDS issues is possible. Responsible: Administrator, Maintenance Compliance date: 4/28/2014	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide six days worth of physician ordered and care planned pain medications for 1 of 3 residents (R41) in the sample reviewed for pain. Findings include: R41's current physician orders dated 2/4/14,	F 309	F 309 For sampled residents R41 and for all residents with care plans for pain and pharmacological pain management, the facility shall ensure that medications are administered as care planned and that the pain regimen is effective to allow the resident to function at their highest practicable level. For resident R41, a pain assessment shall be completed and the IDT will review the care plan for both pharmacological and non-pharmacological pain interventions. The IDT will review the interventions for effectiveness and revise the comprehensive care plan for pain management as indicated.	

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F 309	Continued From page 154 directed staff to administer "Morphine Sulfate ER Tablet Extended Release 30MG [milligrams] Give 30MG orally at bedtime for pain give at HS [hour of sleep] only." R41's Care Area Assessment [CAA] for pain dated 2/17/14, identified R41 experienced pain frequently over the past five days and his pain had an adverse affect on his mood. R41's CAA noted, "Resident c/o [complained of] pain he has scheduled Neurontin MS [Morphine Sulfate] and Percocet for pain It has been effective at time he did not use any PRN [as needed medication]. Resident is at risk fro [sic] increase pain, dependence and falls." R41's care plan for pain dated 2/17/14, informed staff, "Pain: has chronic pain r/t [related to] osteoarthroses, peripheral neuropathy, Chronic Physical Disability, PVD [peripheral vascular disease]" The goal was, "[R41] will verbalize adequate relief of pain or ability to cope with incompletely relieved pain through review date." The care plan directed staff, "Administer analgesia Percocet and Morphine as ordered." R41's Narcotic Administration Record for February and March 2014, indicated no doses of morphine were administered to R41 on 3/5, 3/6, 3/7, 3/8, 3/9, and on 3/10. The March 2014 Medication Administration notes indicated medications were not available on 3/5, 3/6, 3/8, 3/9, and on 3/10. During a standardized initial interview on 3/10/14, at 5:30 p.m. R41 responded "yes" to the question, "Do you have any discomfort now or have you been having discomfort such as pain, heaviness, burning or hurting with no relief?" R41 reported	F 309	Additionally, the facility has a policy titled, "C.A.R.E. Team Meeting: Clinical At Risk Resident Evaluation Team Meeting." This policy was effective 05/2012 and reviewed 05/2013. It outlines weekly meetings that are to be held to review specific residents at risk. Pain management is an area of clinical risk. Sampled resident R41 will be reviewed during a CARE Team Meeting to ensure pain management is effective. The facility also has a policy titled, "Pain Management" that was effective 05/2012 and reviewed 05/2013. The facility shall ensure this policy is operational for sampled resident R41 and for all residents with pain. Any resident with pain management issues may be reviewed in a CARE Team Meeting. All care plans for residents with pain will be reviewed/audited by the appropriate IDT member for appropriateness of pharmacologic and non-pharmacologic pain interventions. Updates and/or changes will be made based on current evaluation of the effectiveness of the interventions.	

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F 309	Continued From page 155 his pain was related to neuropathy. On 3/13/14, at 8:50 a.m. R41 reported he had recently not received his scheduled morphine for about a week. R41 reported his pain increased from not receiving his scheduled dose of morphine. On 3/13/14, at 12:00 p.m. the Narcotic Administration Record (NAR) and Medication Administration Record (MAR)were reviewed with the Trained Medication Aide (TMA)-A. TMA-A confirmed the NARs and MARs for February and March 2014 indicated no morphine was administered to R41 on 3/5, 3/6, 3/7, 3/8, 3/9, and on 3/10. On 3/14/14, at 8:15 a.m. R41 stated to the surveyor that it took a few days to feel an increase in pain after he stopped receiving his scheduled morphine and then his pain was "way worse." R41 stated pain made it more difficult for R41 to sleep. R41 would have preferred to receive his scheduled morphine every night. R41 reported, "It took them more than a few days to get the meds. It took a few days for them to take action on it. I got the lady at the desk to order some new ones. They had to have the house doctor prescribe a new order for morphine." On 3/14/14, at 10:00 a.m. the Medical Records staff (MR) stated R41 reported he was out of morphine so she wrote out the form for the medical director to sign. MR reported the process was for TMAs or nurses to order refills from the pharmacy. MR stated the pharmacy sends back a form for the prescriber to fill out and renew the refill order for controlled substances. When MR received the fax, MR stated she gave it to the	F 309	A log will be kept from each CARE meeting related to pain management. This log will be presented to the QA committee for review and further recommendation as indicated. This will be an ongoing audit and QA review process. The Resident Care Manager(s) or DON will do a monthly audit x6 of residents have comprehensive care planning for pain management ensure the pain assessments are present and accurate and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DON, RCM, IDT Compliance date: 4/28/2014	

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F 309	Continued From page 156 nurse. MR stated, "The process does not work" and further added "this is inexcusable" yet "happens all the time". MR reported the facility should be reordering meds earlier. On 3/14/14, at 11:42 a.m. the nurse manager (LPN)-D confirmed R41 did not have morphine available from 3/5/14 through 3/10/14. On 3/14/14 at 11:42 a.m. the director of nursing (DON) reported R41's scheduled medications should have been available to him as prescribed. R41 not having a prescribed medication available from 3/5/14 through 3/10/14 did not meet her expectations. The Videll Healthcare LLC Pain Management Policy dated as last reviewed on 1/2013, directed staff: "The goal of any pain management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify pain and develop an effective management program." "8. A comprehensive care plan is developed by the interdisciplinary team that addresses pain and an individualized pain management program based on individualized assessed need. a. The pain management program may address the following: i. Scheduled use of pain medication"	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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.	F 312	F 312 For sampled resident R61 and for all residents assessed as need any level of assistance with ADLs, the facility shall ensure the assessed level of assists is provided for ADLs.	

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F 312	Continued From page 157 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with nail care for 1 of 3 residents (R64) in the sample who was dependent on staff for grooming. Findings include: On 3/12/14, at 7:52 a.m. R64 was noted to have approximately ½ inch long fingernails on both hands. An observation of a.m. cares on 3/14/14, at 7:22 a.m. revealed licensed practical nurse (LPN)-A told nursing assistant (NA)-D he needed to cut R64's nails today, R64 was "not diabetic." R64 was noted to be cooperative throughout that episode of care and began to verbalize a little with staff towards the end of the observation. An observation on 3/14/14, at 3:19 p.m. (at the end of NA-D's shift) revealed R64 had not yet been assisted with nail care and R64's fingernails were still untrimmed. R64's care plan, dated 11/14/11, revealed R64 had a self-care performance deficit and required extensive assistance of one for grooming. R64's current diagnoses according to the face sheet, with a revised date of 1/14/14, included senile dementia uncomplicated, diabetes, essential hypertension, senility without mention of psychosis, muscle weakness generalized and difficulty in walking. R64 was admitted on 1/5/10.	F 312	The facility has a policy titled, "Activities of Daily Living." This policy was effective 05/2012 and was reviewed 05/2013. The policy does address hygiene but has now been revised to specifically address nail care and nail care for the diabetic resident. For sampled resident R61, finger nail hygiene and length will be assessed during scheduled baths. Since the resident is diabetic the finger nails will be filed rather than clipped. The comprehensive care plan for sampled resident R61 will be reviewed to ensure it contacts accurate direction related to the level of ADL assist required for nail care and all ADL areas. The assessed level of assist required for ADLs will be reviewed at least quarterly based on the MDS schedule. Additionally the comprehensive care plan will be reviewed and revised as indicated on this same time line. At the discretion of the clinical staff additional assessments related to ADL assist will be carried out based on clinical judgment and/or change in medical condition. Comprehensive care plans will be reviewed and revised based on these discretionary assessments.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 312	Continued From page 158 R64's most current Minimum Data Set (MDS), dated 1/30/14, revealed R64 was extensive assistance of one staff for grooming. During interview at 8:23 a.m. NA-D stated he would tell the nurse if a resident had long nails. He said R64 was diabetic. On 3/13/14, at 9:11 a.m. LPN-A said that diabetic resident nails should be trimmed on bath days. LPN-A said R64's bath was yesterday and the nurse's should be checking R64's fingernails on the bath day. - At 9:18 a.m. LPN-B viewed R64's fingernails. LPN-B said they were "very long." When asked about the procedure for cutting R64's nails, LPN-B replied "Well, the daughter is here every day, I don't know if she didn't see that or what." When asked to clarify if it would be the daughter's responsibility to cut R64's nails in his care plan, LPN-B replied "Like I said she is here every day." During interview on 3/14/14, at 8:47 a.m. the director of nursing (DON) said nails should be trimmed on bath days by either a nurse or an aide. A policy regarding nail care was requested, none was provided.	F 312	All care plans for residents with ADL assist required for nail care will be reviewed/audited by the appropriate IDT member for appropriateness of interventions X6 months. Updates and/or changes will be made based on current evaluation of the effectiveness of the interventions. The results of this audit will be reviewed by the facility Administrator and then reported to the QA committee for review and further recommendation as appropriate. Responsible: Administrator, DON, RCM, IDT Compliance date: 4/28/2014	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having	F 314	F 314 For sampled resident R64 and for all residents assessed at risk for the development of pressure sores, the facility shall ensure that avoidable pressure sores do not develop.	

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F 314	Continued From page 159 pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Findings include: R64's current diagnoses according to their face sheet, revised 1/14/14, revealed senile dementia uncomplicated, diabetes, essential hypertension, senility without mention of psychosis and lack of coordination. R64 was admitted on 1/5/10. R64's annual Minimum Data Set (MDS) dated 1/30/14, identified that a Brief Interview for Mental Status (BIMS-tool used to measure cognition) score was unable to be completed. R64's cognitive skills for daily decision making were severely impaired and R64 was rarely/never understood. R64's transfer ability was scored as a total dependence with a two person assist. R64 did not have any existing pressure ulcers recorded on the MDS.	F 314	The facility has a policy titled, "Skin Integrity Management" that was effective 05/2012 and was reviewed 05/2013. Additionally the facility has a policy titled, "CARE Team Meeting" that was effective 05/2012 and reviewed 05/2013.. Both of these policies will be made operational at the facility. For sampled resident R66, a thorough and complete skin assessment shall be completed. Based on this assessment, the IDT shall develop a comprehensive care plan related to skin integrity management. Additional skin integrity assessments for sampled resident R66 will be done at least quarterly based on MDS schedule or more frequently at the discretion of the clinical staff based on clinical judgment and/or change in medical condition. Skin Integrity Management is an area of clinical risk. These meetings are now initiated again at the facility and once every month residents with skin integrity issues are reviewed by the IDT. During this meeting comprehensive care plan interventions are evaluated for effectiveness, and care plans are reviewed and revised/updated. Sampled resident R66 shall be reviewed at CARE Team Meeting until the Stage II pressure areas are healed and then PRN based on clinical assessment and the judgment of the IDT.	

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F 314	Continued From page 160 R64's Care Area Assessment (CAA) for pressure ulcers dated 2/11/14, revealed the resident was at risk for pressure ulcers due to pressure, needs special mattress or seat cushion to reduce or relieve pressure, immobility, altered mental status, cognitive loss, poor nutrition, incontinence, diagnoses of diabetes and cerebrovascular accident, functional limitation in range of motion, and newly admitted or readmitted. Care plan considerations included resident had no changes, will continue with the same care plan. R64's Skin Care Plan, dated 11/14/11, revealed R64 had no skin impairment. R64's Pressure Ulcer Care Plan, dated 11/14/11, revealed potential for pressure ulcers related to decreased sensory perception, incontinence, chairfast, immobility, at risk for shear and friction, cognitive impairment and requires assistance with activities of daily living (ADLs) pain, psychotropic drug use and aspirin therapy, atrial fibrillation, hypertension (HTN) and dementia. Goals included R64 would have intact skin, free of redness, blisters or discoloration through next review date. Interventions included weekly skin checks per facility policy, turning and repositioning every two hours and pressure redistributing device on bed and chair. R64's ADL Self-care Performance Care Plan, dated 11/14/11, identified R64 required assistance of two staff and an EZ-stand (a type of standing lift) for transfers and a Hoyer (full body lift) if the resident was weak or combative to be moved. Review of R64's electronic and hard copy clinical record dated 3/14/14, going back three months, lacked wound documentation or any progress notes indicating the presence of open areas on	F 314	All residents will have a skin review with each scheduled bath. Any skin issues are to be reported to the RCM and/or DON immediately for further assessment and intervention as indicated. A record of this reporting will be made in the resident clinical record. All clinical records for active residents in the facility will be audited for skin integrity assessments. This audit will ensure the skin integrity assessment is completed at least quarterly based on the MDS schedule. All care plans for residents with skin integrity issues will be reviewed/audited by the appropriate IDT member for appropriateness of interventions X6 months. Updates and/or changes will be made based on current skin integrity assessment and the effectiveness of the interventions. The results of this audit will be reviewed by the facility Administrator and then reported to the QA committee for review and further recommendation as appropriate. All facility acquired pressure areas shall be reported to the QA committee for review and further action as deemed appropriate. This reporting to the QA committee will be ongoing.	

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F 314	Continued From page 161 the scrotum. There were no documentation notes that the open areas had been reported to a physician or family. In addition, the chart lacked assessment documentation to define risk factors for development of pressure ulcers and the rationale for the current repositioning schedule. The facility nursing assistant (NA) worksheet for the south hallway, undated, indicated R64 should be checked and changed every two hours and PRN (as needed). Additionally, the worksheet indicated R64 was an EZ-stand with assistance of two staff, OK to use Hoyer lift if resistive; wheelchair, non-ambulatory. On 3/13/14, at 7:56 a.m. R64 was observed to have been assisted with cares by nursing assistant (NA)-D. The surveyor observed two open areas on the bottom of R64's scrotum. NA-D stated during the observation that he had told the nurse about the openings. After the surveyor inquired about the open areas, NA-D applied Remedy Calazime (a type of antifungal barrier cream) to the sites. NA-D applied a clean incontinent brief. NA-D proceeded to dress R64's lower extremities and left the room briefly to obtain assistance to transfer R64 into their wheelchair. On 3/13/14 at 8:19 a.m., R64 was observed to be assisted by NA-D and NA-B into their wheelchair, which was observed to have a thin cloth covering over a mesh-webbing type seat. NA-D and NA-B used a standing lift to complete the transfer. No pressure redistribution cushion was present in R64's wheelchair. Continuous observations of the resident from the time of the transfer into their wheelchair at 8:19 a.m. through 11:00 a.m. on 3/13/14, revealed that R64 was not	F 314	Responsible: Administrator, DON, RCM, IDT Compliance date: 4/28/2014	

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F 314	Continued From page 162 repositioned by facility staff. During interview with licensed practical nurse (LPN)-D on 3/13/14, at 8:55 a.m., LPN-D reported that any skin conditions should be documented on the wound flow sheets and stated LPN-A had those documents. At 9:11 a.m. LPN-A was interviewed and stated that R64's bath was scheduled yesterday and that there should have been a skin audit done. At that time, LPN-A began flipping through a three-ring binder with the skin audit sheets, and commented to LPN-D (also present) that she needed to complete her documentation on the skin conditions. Several skin audit sheets were observed with LPN-D's signature but no documentation of the skin condition was recorded on the forms. A skin audit sheet dated 3/14/14 by LPN-C, (LPN-A stated this should have been dated 3/12/14), indicated R64's skin to the coccyx and perineum was intact. LPN-A said any areas other than pressure ulcers would be documented in the progress notes on the electronic chart. On 3/13/14, at 11:00 a.m. LPN-B was observed to ask two nursing assistants, NA-C and NA-B, to reposition R64. At 11:05 a.m., two hours and 46 minutes after R64 had last been transferred into his chair, NA-C and NA-B attempted to assist R64 into bed utilizing the standing lift. R64 was unable to hold onto the lift handles and pulled his hands away from the lift. LPN-B entered the room and attempted to assist, however staff were unsuccessful as R64 could not hang onto the standing lift handles. R64 remained in the wheelchair. During an additional observation, at 1:25 p.m. on 3/13/14 NA-A and NA-D again attempted to	F 314		

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F 314	Continued From page 163 transfer R64 into bed using the standing lift. R64 initially had difficulty holding onto the lift handles and then began to hold onto the lift frame long enough for R64 to be moved from the wheelchair into bed. R64 was noted to have two open areas on the scrotum. NA-D told the surveyor he had seen the open areas and informed a nurse of the areas, stating this had happened a week ago. NA-D further said the usual facility practice was not to reposition R64 every two hours, but that R64 was usually laid down after lunch. At 1:32 p.m., the surveyor informed LPN-D of the open areas on R64's scrotum. LPN-D went with the surveyor to observe the areas, and said she thought they were from incontinence of bladder. Two distinct irregularly shaped, elongated open areas with a pinkish-red wound base were observed. There was a superficial loss of skin over the areas. On 3/14/14, at 7:22 a.m. licensed practical nurse (LPN)-A was observed to measure the open areas on R64's scrotum. LPN-A identified them as a single 4 centimeter (cm) x 2 cm superficial area, LPN-A said they were two areas that looked like they had merged into one large area. LPN-A felt they were related to incontinence or potentially from sitting on the area and getting pinched. LPN-A was observed to apply Remedy Calazime (a type of antifungal barrier ointment) around the open areas. A skin audit sheet documented by LPN-C dated 3/14/14, (which LPN-A indicated should have been dated 3/12/14), indicated R64's skin on the coccyx and perineum was intact. LPN-A said any areas other than pressure ulcers would be documented in the progress notes on the electronic chart. Review of R64's progress note documentation identified a lack of wound documentation or any progress	F 314		

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F 314	Continued From page 164 notes indicating the presence of open areas on the scrotum. A progress note entered by LPN-A dated 3/14/14, at 8:06 a.m. revealed R64's hospice agency had been informed of the open areas to R64's scrotum to inquire into treatment. Nursing progress notes by LPN-D dated 3/14/14, at 8:47 a.m. revealed an order was received for a physical therapy evaluation and treatment for proper transfers and a topical cream for R64's open areas. On 3/14/14, at 10:34 a.m. the director of nursing (DON) observed R64's open areas with the surveyor. The DON stated the open areas appeared to be pressure related, and might be aggravated by incontinence. The DON stated she would classify the sites as two separate stage II pressure ulcers (a type of pressure ulcer characterized by partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough - may also present as an intact or open/ruptured serum-filled or serosanguineous filled blister). The DON stated the measurement of the first area was 2.5 cm x 1 cm with clearly defined borders that were irregular in shape. The second area had measurements of 1.5 cm x 2.4 cm. The wound bases were noted to be whitish in color, a change from the previous observation that morning. Hospice LPN-F was also present at that time and concurred with the DON's impression. LPN-F confirmed that R64's brief was soiled with urine, and registered nurse (RN)-D who was also in the room, stated the resident had not been repositioned since before breakfast. RN-D confirmed that R64 typically does not lie down until after lunch and stayed in the wheelchair until	F 314		

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F 314	Continued From page 165 then. The DON asked hospice LPN-F about the resident's wheelchair cushion, indicating it felt "pretty firm." LPN-F said she thought the chair was pressure redistributing, but would check on the literature from the manufacturer. The DON said R64 needed to be repositioned at a minimum now of hourly and new assessments needed to be started. The hospice agency medical supplier's information on the wheelchair, entitled Benefits of the "Judy" Chair, undated, indicated the wheelchair provided superior pressure mapping to that of similar wheelchairs, however did not specify the seat of the chair in and of itself constituted a pressure redistribution device. The facility policy entitled Skin Integrity Management, dated 5/12, directed skin integrity risk assessments should be completed on admission and at least quarterly. The policy further directed that the director of nursing services (DNS) was responsible to ensure a valid skin at risk tool is used (Braden Scale or Norton Plus Pressure Scale is required). The policy further identified the goal of any skin integrity process is to provide safe and effective care to prevent and/or treat pressure sores or skin issues, maintain function and improve quality of life.	F 314		
F 319 SS=D	483.25(f)(1) TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.	F 319	F 319 For sampled resident R91 and for all residents assessed at risk for depression and aggressive behavior, the facility shall ensure a healthy adjustment to living in a facility is achieved.	

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F 319	Continued From page 166 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Findings include: On 3/13/14, at 9:00 through 9:47 a.m. R91 was observed resting in bed with covers on her. R91 was being delivered supplemental oxygen to her through a nasal cannula. R91 nodded off during conversation with surveyor and did not respond to some questions. R91 flinched her shoulders twice and reported she had a lot of pain in her knees. R91 reported she was very depressed from living at the facility and wanted to go home. R91 explained she felt no one cared for her at the facility because, even though she was sick and in pain, no one came to check on her. R91 explained she had been prescribed antibiotics and pain medications by a physician yesterday but she did not take them because she did not trust the physician knew her well enough to prescribe meds to her. R91 recounted how she was upset because a staff member lied to her yesterday about canceling a ride to the store for her. R91 reported it made her "angry" and "rude" when staff lied to her. R91 reported she planned on spending the rest of the day resting in bed and did not think any staff would assist her with any cares today. R91's admission Minimum Data Set (MDS), dated	F 319	The facility has a policy titled, "Behavior Management" that was effective 05/2012 and was reviewed 05/2013. Additionally the facility has a policy titled, "CARE Team Meeting" that was effective 05/2012 and reviewed 05/2013. Both of these policies will be made operational at the facility. Behavior Management is an area of clinical risk. These meetings are now initiated again at the facility and once every month residents with targeted behaviors, such as depression and aggressive behaviors, are reviewed by the IDT. During this meeting target behaviors are reviewed, comprehensive care plan interventions evaluated for effectiveness, and care plans are reviewed and revised/updated. A log will be kept from each CARE meeting related to behavior management. This log will be presented to the QA committee for review and further recommendation as indicated. This will be an ongoing audit and QA review process.	

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F 319	Continued From page 167 10/15/13, indicated the potential for moderate depression due to self-reported symptoms of little interest or pleasure in doing things, feeling down depressed or hopeless, trouble falling asleep or sleeping too much, feeling tired or having little energy and poor appetite or overeating. The MDS revealed R91 displayed verbal and physical aggression one to three days during the seven day observation period. R91's quarterly MDS, dated 1/9/14, indicated a potential for mild depression, with R91 reporting the same symptoms in addition to moving or speaking slow or being fidgety. The MDS noted verbal and physical aggression towards others occurred four to six days during the seven day observation period. Both the 10/15/13 and 1/9/14, MDS indicated R91 rejected evaluation or care on one to three days during the seven day observation period. R91's Brief Interview for Mental Status (BIMS) on her admission and quarterly MDS dated 10/15/13 and 1/9/14 indicated she was cognitively intact. R91's Care Area Assessments, dated 10/22/13, for Mood, Cognitive Loss/Dementia, Behavior, and Psychosocial Well Being included the same summary statement under the Care Plan Considerations section: "Resident has some behavior r/t [related] medical Dx [diagnosis]. Staff will monitor her behavior and ensure pt [patient] needs are met and she is safe." The sections for input from resident and family or representatives for resident were all left blank; despite R91's BIMS score indicating she was cognitively intact. Each care area assessment noted a referral to another discipline in the health care team (such as social services, medical or mental health professionals) was not necessary. The	F 319	For sampled resident R91, a thorough and complete behavior management assessment shall be completed. Additionally, a thorough and complete Social Services assessment shall be completed. Based on these assessments, the IDT shall develop a comprehensive care plan related to behavior management and the resident's ability to make a healthy adjustment to living in a facility. Additional behavior management assessments for sampled resident R91 will be done at least quarterly based on MDS schedule or more frequently at the discretion of the clinical staff based on clinical judgment and/or change in medical condition. The Resident Care Manager(s) or DON will do a monthly audit x6 of residents with behavior management issues to ensure the assessments are present and accurate and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated.	

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 319	Continued From page 168 assessment did not include a thorough analysis including: specific behaviors exhibited by R91, what medical or mental health concerns would impact care, triggers to behaviors, events immediately prior to behavior, consequences of behavior or tactics known to decrease or minimize behavior. R91's current care plan, last reviewed 1/30/14, did not include problems, goals or interventions related to R91's mood, rejection of evaluation or care and verbal and physical aggression. On 3/14/14, at 2:14 p.m. the social service designee (SSD) reported the care area assessments for R91 were completed prior to her employment at the facility. SSD reported the care area assessments were not comprehensive, did not identify what behaviors were occurring, causative factors or how best to help. SSD reported she was not aware R91 exhibited verbal and physical aggression or rejection of cares. Surveyor requested any other documentation of behavior or mood assessments, not included in the care area assessments. None was provided. SSD confirmed R91's care plan did not address her aggressive behaviors or rejection of evaluation or care. On 3/14/14, at 3:53 p.m. R91's nursing assistant (NA)-G reported R91 rejected cares because she valued her privacy and wanted to do as much as she could herself. NA-G reported R91 at times cussed at staff, called them unkind names or threatened to get them fired. NA-G reported R91 has said unkind statements to her roommates. NA-G explained R91 could be intrusive to her roommate's privacy during cares because she thought her roommate was her daughter. NA-G	F 319	Social Services shall conduct a monthly audit X6 of residents with behavior management issues to ensure they are making a healthy adjustment to facility living. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DON, RCM, Social Service, IDT Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 319	Continued From page 169 explained R91's behavior varied throughout the day and that at times she was very kind. NA-G was not aware of any physical aggression towards other residents from R91.	F 319		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 3 of 28 residents (R36, R1, R22) who currently smoked unsupervised in the facility, and failed to ensure they utilized mechanical devices in a safe manner for transfers for 1 of 2 residents reviewed (R64). The facility's failure to provide supervision and a safe environment to prevent potential burns from unsafe smoking practices constituted an Immediate Jeopardy (IJ) for R36, R1, and R22. In addition, the facility's failure to safely utilize a mechanical lift constituted an IJ for R64. The immediate jeopardy began on 3/12/14, and the administrator and director of nursing (DON) were notified of the IJ on 3/12/14, at 5:00 p.m. In addition, the facility did not ensure the safe use of a mechanical stand lift (a mechanical device used	F 323	**SMOKING Tag 323** Effective 3/13/14, the facility designated two specific smoking areas for residents. Between the hours of 7am and 9pm, residents must smoke on the patio west of the front entrance. Between the hours of 9pm and 7am, residents must use the enclosed patio area outside of the main dining room. A smoking monitor assignment was created to ensure the safety of all smokers. See attached for details of this assignment. A smoking monitor is dedicated to this assignment 24 hours per day, beginning 3/13/2014. The facility will contact the Local ombudsman, issue a 30 day notice and seek discharge orders from the resident's physician for consistently refusing to abide by the smoking policy. Residents who require supervised smoking include but not limited to those who have burn holes in clothing and/or evidence of careless smoking. Smokers who do not wish to comply with individual smoking assessments will be assessed for discharge potential and alternative placement sought.	4/28/14

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F 323	Continued From page 170 for transfers) for 1 of 2 residents (R64) in the sample. This practice resulted in an IJ which was identified on 3/13/14, and the administrator and DON were notified of this IJ on 3/13/14, at 1:50 p.m. Although the IJ was removed on 3/16/14, at 12:17 p.m. non-compliance remained at the lower scope and severity (s/s) of an E. Findings include: R36 was observed with multiple cigarette burn holes on his clothing on 3/11/14. The facility did not identify that or other safety concerns related to the resident independently smoking unsupervised. R36 was observed to smoke unsafely on 3/11/14, 3/12/14, and on 3/13/14. R36's smoking observations were as follows: On 3/10/14, at 1:00 p.m. R36 was observed to be smoking unsupervised in the front designated smoking area. R36 was observed to propel his wheelchair (w/c) independently, while smoking. No smoking apron was observed on R36 or in the smoking area. On 3/11/14, at 11:18 a.m. R36 was interviewed and he reported he had been assessed for smoking. He stated the staff came and watched him light up and watched him smoke. R36 stated the burn hole in his new glove was from a month ago. R36 stated he had never needed a smoking apron or any other smoking interventions. On 3/11/14 at 1:27 p.m. R36 was observed to be smoking unsupervised in the front designated smoking area. R36 was observed to propel his w/c independently while smoking with an approximately one inch long cigarette ash. No smoking apron was observed in the area. R36	F 323	Members of the Interdisciplinary team (IDT) provided additional staff training on the new smoking monitor to staff 3/14/2014. Staff that were not present for this training will not assume any smoking monitor responsibilities until documented training is provided by a member of the IDT. The IDT members include the Administrator, DON, Care Managers, Director of Dietary, MDS Coordinator, Social Worker, or corporate staff. The IDT reviewed smoking assessments and related care plans for all residents by 3/15/2014. Inaccurate or incomplete assessments and documentation were completed or revised, then reviewed by the IDT by 3/15/2014. Care plans were updated accordingly by 3/15/2014. Updated information regarding smokers has been made available to staff, including the smoking monitor.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 171 was observed to have burn holes on his left glove, on the left chest of the coat and the right thigh of R36's pants. R36 stated the burn in his glove had occurred "one month ago [2/2014]" from "sleeping" with the cigarette in his hand. R36 further stated the gloves were newly purchased and the burn hole on the pants was "old." R36 stated, "I'm getting careless." On 3/12/14, at 7:45 a.m., R36 was observed to be propelling the w/c to enter the building of the facility from the front designated smoking area while holding a cigarette in his mouth. The cigarette was observed to have an approximate one inch long ash. R36 was observed to notice the ash, flick the ash off and extinguish the cigarette in the ash tray. No staff was observed in the smoking area and no smoking apron was observed. On 3/12/14 at 1:58 p.m. R36 was observed to be smoking unsupervised in a front designated smoking area. R36 was observed to be dozing in the w/c while the cigarette was lit. The cigarette was observed to be nearly burnt out and was held over the previous burn hole in R36's sweat pants. R36 awakened and discarded the cigarette on the pavement. The cigarette was extinguished. No smoking apron was observed. On 3/12/14 at 2:28 p.m. R36 stated during interview, that he retrieved his own clothes in the morning and dressed independently. R36 reported the burn holes in his coat were from being "careless" and stated he was "new to the facility within the last six months". On 3/13/14, at 9:42 a.m. R36 was observed to be with the facility administrator in a front designated	F 323	The Administrator and corporate consultants Met with facility residents 3/14/2014 to review The corporate smoking policy and revisions, which were effective immediately. Residents KC and RA have been assessed to need wear a smoking apron and be supervised while smoking. Both of the affected residents were directly informed of the smoking policy, expectations, and consequences of violating the terms of the policy 3/13/2014. Any unsafe smoking behaviors observed will be immediately reported to the licensed nurse. The licensed nurse will be responsible for documenting these incidents in the medical record and following up as indicated. All smoking log notes will be reviewed during quarterly QA meetings. It is the responsibility of the Administrator to ensure the smoking policy is consistently enforced 24 hours per day.	

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

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F 323	Continued From page 172 smoking area with a smoking apron on. R36 was observed to have papers in his hand. At 9:50 a.m. R36 was overheard by the surveyor to inform another resident the facility had given him [R36] a copy of the smoking policy. At 9:54 a.m. R36 was observed to remove the smoking apron, threw it to the ground while stating "F###!" loudly. R36 immediately lit a cigarette. At 10:04 a.m. R36 picked up the smoking apron and wheeled back into the building. In a loud voice R36 stated, "Here! I'm going to give that to you [and threw the smoking apron on the reception desk]." R36 then stated, "I cannot safely roll with that on." On 3/13/14, at 3:35 p.m. R36 was observed to be in the front designated smoking area without the smoking apron on and was unsupervised. The smoking apron was lying next to R36. R36 had a lit cigarette with an inch long ash. R36 was sleeping in the w/c. The DON was summoned by the surveyor and notified of the observation. The DON immediately started a conversation with R36, picked up the smoking apron and folded it. R36 finished smoking at that time. R36's record was reviewed. The Admission Record dated 5/26/12, indicated R36's diagnoses included respiratory abnormalities, altered mental status and muscle weakness. A Camden Care Center Smoking Contract dated 5/31/12, was signed by R36's guarantor and included: - "I have received a copy of the Camden Care Center Smoking Policy/Procedure and agree to comply with all the rules set by this policy." - "I understand that smoking is NEVER allowed in resident rooms or anywhere inside the building." - "I understand that smoking is ONLY allowed in	F 323	**EZ Stand** As of 3/13/14 there were four residents, Which include resident AB, on the resident EZ Stand list. All four residents were reassessed on 3/14/14 by an RN and Occupational Therapist. Two residents assessments changed to a Hoyer Lift and two residents, AB is one of them, remained with the need for the EZ Stand. Care plans were updated by the RN on the four residents and RN communicated the change to the nurse overseeing the resident's direct care. Staff training on the EZ Stand was complete on 3/15/14 by physical and occupational therapists. Resident assessment auditing will be completed monthly x 12 and random staff competence of EZ Stand use will be completed by the DON weekly x 12. It is the responsibility of the DON to ensure that the EZ Stand use by staff is safe for residents. All notes on the EZ Stand random checks by the DON will be reviewed during quarterly QA meetings.	

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F 323	Continued From page 173 designated smoking areas." - "I understand that failure to comply with the Camden Care Center Smoking Policy/procedure may result in a 30 day discharge notice from the facility." The care plan lacked evidence the smoking interventions were ever put into place. R36's Smoking Evaluation dated 5/28/13, was completed by social services. Although the evaluation indicated R36 had a history of unsafe smoking practices, the evaluation lacked explanation as to what those unsafe practices were. The evaluation indicated R36 was cognitively intact, and had no behaviors. Although the evaluation had identified unsafe smoking practices in the past, the evaluation indicated R36 understood the safe storage of smoking materials, understood where smoking was allowed, and was deemed an independent smoker. R36's three consecutive Smoking Evaluations dated 8/29/13, 11/17/13, and for 2/18/14, all noted no changes from the Smoking Evaluation on 5/28/13. The unsafe smoking history still remained undetermined and all four assessments indicated R36 was deemed an safe smoker. The Nursing Assessment Packet Review for the reference period of 2/12/ (no year) through 2/18/ (no year) lacked any documentation of the safety risks regarding R36's smoking. The care plan dated 2/16/14, indicated on 5/27/13, R36's guardian requested a WanderGuard (departure from facility alert system) be applied to R36 "to prevent him from leaving the facility" and alerting staff R36 went out of the building, to smoke. The care plan indicated	F 323		

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F 323	Continued From page 174 R36 had a WanderGuard applied on 11/28/12, then on 6/2/13, the care plan indicated R36 refused the WanderGuard and it had been "cut off " by R36. The care plan still indicated the WanderGuard as an intervention and further indicated the WanderGuard was "not effective at this time." A behavior contract had been signed by R36 on 6/6/13, which indicated R36 would not drink alcohol while residing in the facility and would follow all policies in the facility. The contract specified the smoking policy and identified R36 would "only smoke on the back patio of the facility." The care plan was not revised for the smoking contract as R36 smoked in the front of the building unsupervised. Record review indicated that on 6/18/13, a letter had been presented by the facility to R36 to notify R36 he would be discharged in 30 days effective 6/18/13, for non-compliance with the facility's smoking policy, for non-compliance with the facility's (alcohol) drinking policy and non-compliance with other facility policies. However, the medical record lacked any evidence of why the facility had not discharged R36. Nursing notes documented on the Camden Care Center Quarterly Care Conference summary for R36 dated 9/17/13, indicated R36 had been assessed by the licensed nurse and deemed to be an independent smoker, risks versus benefits had been explained, and R36 had refused a smoking cessation program. The care conference summary written by the social worker designee on 11/26/13, indicated, "[R36] requires supervision with smoking; however he does not follow it. [R36] has had difficulty following facility	F 323		

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F 323	Continued From page 175 policy for smoking in designated area of back patio of facility, but over the last quarter he has improved greatly." During the survey, R36 was never observed to be smoking in the supervised smoking area on the back patio. R36 was always observed to smoke in the designated "unsupervised" smoking area in the front and to the side of the building. It could not be determined if R36 was deemed a safe smoker as the summary from nursing conflicted with the summary from the social worker. R36's most current quarterly Minimum Data Set (MDS) dated 2/18/14, indicated R36 had no behaviors and had a Brief Interview for Mental Status (BIMS) score of 13 which noted R36 was cognitively intact. The MDS also indicated R36 received one person assist with transfers, dressing, hygiene, and R36 used a wheelchair for mobility. R36's smoking care plan dated 2/18/14, identified R36 as an independent smoker, and indicated R36 would remain safe while smoking and would follow all guidelines regarding smoking. The care plan also indicated R36 was directed to smoke only in the designated areas and would not smoke around those with oxygen. The care plan conflicted with the social worker designee's most current summary dated 2/18/14, which indicated R36 was an unsafe smoker and needed supervision. The Physician's Order sheet signed by the geriatric nurse practitioner dated 3/5/14, indicated R36 received the following medications: -Methadone 10 milligrams (mg) twice a day (BID) for vascular pain. The package insert from Lake	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 176 Erie Medical DBA Quality Care Products dated 10/2013, noted, "Patients receiving other opioid analgesics, general anesthetics, phenothiazines, other tranquilizers, sedatives, hypnotics or other CNS [central nervous system] depressants (including alcohol) concomitantly with methadone may experience respiratory depression, hypotension, profound sedation, or coma." -Zolpidem (Ambien) 10 mg daily at bedtime insomnia. The package insert from "ECR Pharmaceuticals" last revised 5/7/13 noted, "Zolpimist [Zolpidem], like other sedative-hypnotic drugs, has central nervous system (CNS) depressant effects. Co-administration with other CNS depressants (e.g., benzodiazepines, opioids, tricyclic antidepressants, alcohol) increases the risk of CNS depression." -Oxycodone 10 mg three times a day (TID) for pain. The package insert from St. Mary's Medical Park Pharmacy last revised 1/10/13 noted, "CNS Depressants: Patients receiving narcotic analgesics, general anesthetics, phenothiazines, other tranquilizers, sedative-hypnotics or other CNS depressants (including alcohol) concomitantly with oxycodone hydrochloride tablets may exhibit an additive CNS depression. Interactive effects resulting in respiratory depression, hypotension, profound sedation, or coma may result if these drugs are taken in combination with the usual dosage of oxycodone hydrochloride tablets." R36's medical record lacked evidence of an assessment in regards to R36's medications as a safety risk for R36's unsafe smoking, as R36 was observed to be sleeping (dozing) while smoking on 3/12/14, at 1:58 p.m. On 3/12/14, at 2:35 p.m. the laundry supervisor	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 177 was interviewed and stated she had "noticed a couple [burn holes] and tried to get rid of them [clothing that had burn holes] last year." The laundry supervisor stated they let facility staff know about the burn holes, but "they are already aware of it." When the surveyor clarified who "They" were, the laundry supervisor stated "the nursing department and the aides." On 3/12/14, at 3:01 p.m. the DON and administrator were interviewed. The DON verified she was aware of the burn holes in R36's coat. The DON stated she was told in the interdisciplinary team (IDT) "all that stuff is old that's he's got." The administrator stated, "He has new gloves in his closet, glove burn happened one month ago." The administrator also verified she had been informed "the aides know about it." The administrator stated R36 just liked the old coat and stated the new coat was "just put on." The administrator stated R36 was given a discharge notice in June of last year. The administrator verified assessments were not accurate or up to date and stated the facility had started to redo all of the assessments. The administrator indicated the social worker designee (SSD) was not trained on how to do the assessments and no plan had been identified to ensure R36's safety. On 3/13/14, at 10:12 a.m. the DON stated R36 was one of the "IJs" and R36 had been given a 30 day notice due to his refusal to comply with smoking restrictions. The DON also stated R36 should wear a smoking apron, required supervised smoking, and R36 did not want to comply. On 3/13/14, at 2:17 p.m. during an environmental	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 178 tour the administrator verified the facility had two resident smoking areas. The first was the designated as an unsupervised smoking area located in the front of the building, to the left of the entrance to the facility. The second area was designated as a supervised resident smoking area located adjacent to the dining room. On 3/14/14, at 10:56 a.m. a nursing assistant (NA)-B indicated R36 was independent with dressing and staff only assisted him with his incontinent products. NA-B indicated they had never noticed burn holes in R36's clothing and stated they would let the nurse know right away about any burn holes. On 3/14/14, at 11:21 a.m. the physical therapist (O)-J stated she had noticed burn holes in R36's clothes and had noticed "more [burn holes]" recently. O-J did not recall if she had reported the burn holes to nursing. During an interview on 3/14/14 at 12:14 p.m., the guardian for R36 verified they were not aware of burn holes from unsafe smoking in R36's clothing and stated R36 had money to purchase new clothing. The guardian stated "burn holes in his [R36's] clothing would be a health and safety issue." R1 was observed to smoke unsafely on 3/12/14, 3/13/14, and on 3/14/14; the clinical record lacked development of a smoking care plan and Smoking Contract to potentially ensure safe smoking. In addition, R1 received multiple medications and unknown extra doses of Methadone (a synthetic opioid used to treat moderate to severe pain. Also used together with medical supervision and counseling to treat narcotic drug addiction, with a potential side	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 179	F 323		

effect of sedation), which potentially contributed to excessive sedation and observations of unsafe smoking. In addition, R1 was observed to provide smoking materials to other residents in the unsupervised smoking area.

R1's smoking observations were as follows:
On 3/12/14, at 12:52 p.m. R1 was observed sitting on a motorized wheelchair (w/c) and smoking in the designated unsupervised smoking area outside the front of the facility. R1 was observed to be falling asleep while smoking as she held a lit cigarette with her right hand.
- At 12:53 p.m. R1 was observed to doze off with her eyes closed, and her head jerking up and down. R1 then spontaneously woke up, looked at the lit cigarette, then shortly after appeared to fall asleep and spontaneously wake up. At the time of the observation, the surveyor alerted a licensed practical nurse (LPN)-D of the safety concern. LPN-D went outside spoke briefly with R1, and retrieved R1 back into the building.
- At 1:03 p.m. surveyor observed R1 sitting on her bed. R1 stated she was tired "all the time" and had told the facility staff of feeling tired. R1 stated she thought the tired feeling was related to her "Hepatitis-C." R1 stated she was waiting for a particular medicine to address the Hepatitis-C. R1 verified she had burn holes on her clothing and stating the burn holes were from her cigarette, "The ashes flicking off." R1 further stated she had never had a burn from the smoking. R1 acknowledged she had neuropathy and stated being tired was just not working with her smoking at times. R1 declined the surveyor's request to observed the clothing stored in the closet for burn holes.
- At 2:29 p.m. R1 was observed on the motorized w/c outside in the designated smoking area. R1

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 180	F 323		

removed a cigarette pack from her pocket, removed the wrapper, her eyes closed, her head drooped and she stopped all movements. R1's head jerked and then she continued to take out a lighter, her head was observed to droop and her eyes closed for several seconds. R1's head then suddenly jerked up, R1 lit her cigarette and proceeded to smoke as her eyes remained closed, holding the cigarette in her right hand.
- At 2:34 p.m. a male resident walked to R1 with a cigarette in his mouth, R1 retrieved a lighter, handed it to him. The male resident lit his cigarette and both residents remained next to each other talking. R1's eyes were observed to droop while she spoke with the male resident, her head jerked up as if she was suddenly being awaken. R1 was observed to have approximately half (1/2) inch long ash on the held lit cigarette. At the time of the observation, the lit cigarette and ash were held over a faux fur leopard print blanket folded over her lap (a potentially flammable cloth).
- At 2:35 p.m. R1 rested the right hand holding the cigarette on her lap, leaned forward and spoke to the male resident.
- At 2:36 p.m. R1's head slowly drooped, and R1 was observed to be leaning far forward in the w/c. R1's chin drooped onto her chest, her head bobbed and jerking as R1 tried to keep her eyes open and appeared to struggle to remain awake.
- At 2:38 p.m. R1 rested both hands in her lap (lit cigarette remained in her hand), her chin drooped against her chest, then lifted the cigarette and held it at face level; R1's head drooped, her eyes closed. The ash length had increased to approximately an inch long.
- At 2:39 p.m. the male resident got up and walked away. R1 spontaneously turned the motorized wheelchair around in circle, faced the

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 323	Continued From page 181 windows of the facility, switched the cigarette to her left hand and flicked the ash. R1 then spontaneously turned the motorized wheelchair around in circle again and faced the windows. - At 2:40 p.m. R1 handed an orange lighter to another male resident in a derby type hat, the male resident lit his cigarette. R1's head and chin drooped to her chest, her head jerked up then drooped immediately down. R1's eyes were closed, the ash was approximately a half an inch long again. - At 2:42 p.m. the cigarette was observed to be burned to the filter. R1 disposed of the burnt filter in the ashtray. On 3/13/14, at 8:20 a.m. R1 was observed smoking alone outside at the designated unsupervised smoking area. R1 was observed to be dozing off; dropping her chin down and up. R1 was sitting on her wheelchair at the corner of the brick wall almost bumping self on the wall, but would catch herself dozing. - At 8:33 a.m. R1 was observed continually dozing with the cigarette ash approximately a half (1/2) inch long and burning near the filter. R1 spontaneously woke up flicked the ash and continued dozing. - At 8:35 a.m. R1 continued holding the cigarette in her right hand, her head was hung over while dozing. R1 spontaneously woke up flipped the cigarette into the ashtray, then stayed in the smoking area. - At 8:36 a.m. another resident came to the smoking area, R1 then returned to the facility building. - 8:55 a.m. R1 was observed to return outside to the designated unsupervised smoking area. R1 lit a cigarette, was not wearing a smoking apron. R1's lap was covered with a folded pink, red,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 323	Continued From page 182 fluffy blanket (a potentially flammable fabric). - At 8:58 a.m. R1's eyes were observed to be shut and R1 appeared to be dozing; jerking her head up and down. R1 was holding the lit cigarette in her right hand with an approximately half (1/2) inch ash on the end of the lit cigarette. - At 8:59 a.m. R1 spontaneously woke up and was observed to talk to another resident in the smoking area. R1 flicked the ash on the ground. - At 9:03 a.m. R1 continued dozing, head jerking up and down, holding the lit cigarette on her right hand. - At 9:04 a.m. R1 spontaneously woke up and then left the unsupervised smoking area and returned to the building. On 3/14/14, at 11:00 a.m. R1 was observed in her motorized wheelchair outside the designated unsupervised smoking area with her eyes shut, dozing off, jerking her head up and down and holding a lit cigarette. R1 was observed to almost drop the lit cigarette on her lap, but spontaneously opened her eyes and caught it. On 3/12/14, at 3:01 p.m. the administrator and DON stated they were not aware of holes in R1's clothing but DON indicated laundry notified staff "nurses and aides." DON stated, "I talked with the laundry supervisor about another resident this morning and she said nothing." When asked about R1's medications, DON stated, "She seems to be on a significant amount of medications." When asked if a medication review had been completed DON stated she was not aware of any. Both the administrator and DON indicated they were not aware R1 was sleeping outside while smoking. The administrator stated R1 was very alert, "I have never seen her fall asleep in public." When asked who takes R1 to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 183	F 323		

the Methadone Clinic and if there was potential R1 was accessing more drugs, DON stated R1 was getting medical transportation and added, "I don't believe so, they are fast trips to the Methadone Clinic."

On 3/13/14, at 9:23 a.m. a registered nurse (RN)-C stated she was the only one doing all the MDS assessments for all the residents in the building and she had not developed a nursing care plan for R1 to address smoking. RN-C verified the temporary care plan had not been developed and stated, "The temporary care plan is supposed to be completed a few days after admission and the comprehensive care plan one by twenty one days after a resident is admitted to the facility."

On 3/18/14, at 8:25 a.m. DON stated the facility had just learned R1 was going to another Pain Clinic (located in Eagan, Minnesota) and was receiving additional Methadone. DON verified R1 went to this clinic twice a week. DON stated the Methadone doses (unclear on the dose)received from the Pain Clinic was in addition to receiving 100 milligrams (mg) of Methadone six times per week from a different Methadone Clinic (located in Minneapolis, Minnesota).

On 3/18/14, at 8:28 a.m. R1 approached and requested to speak to the surveyors. When asked about the Pain Clinic, R1 stated she was going to another clinic because it provided other services such as therapy, acupuncture and massage. R1 was hesitate to answer when asked if she was receiving any pain medications at the clinic and immediately changed the subject. R1 stated, "I relapsed three years ago and I now go to the Methadone Clinic (in Minneapolis) to receive my

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 184 medication there daily." On 3/18/14, at 8:40 a.m. an other staff (O)-E stated during a telephone conversation, the transportation driver had reported in addition to the six times the driver was bringing R1 to the Methadone Clinic, the driver was also transporting R1 to another Pain Clinic two times a week on "Tuesday and Thursday afternoon." O-E stated they contacted the physician at the Pain Clinic in Eagan via telephone. O-E stated the physician was not aware R1 was going to the Methadone Clinic in Minneapolis daily. O-E stated the physician would not have known R1 was receiving "Liquid Methadone," and liquid methadone was not listed on the Narcotic Registry. R1's admission MDS dated 12/6/13, indicated R1 had diagnoses to include insomnia, chronic pain, and traumatic brain injury. The MDS indicated R1 had no behaviors and had a BIMS score of 15 which noted R1 was cognitively intact. The MDS indicated R1 required supervision with dressing, eating, toilet use and personal hygiene. Additionally the MDS indicated R1 was independent with locomotion on and off the unit, she used a wheelchair for mobility. R1 did not have a temporary nor a comprehensive care plan developed since being admitted at the facility on 11/30/13. R1's medical record lacked evidence of a Camden Care Center Smoking Contract, when a copy of a contract was requested on 3/12/14, at 3:12 p.m. from the social worker designee (SSD), a copy of the contract was not provided.	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 185 A Smoking Evaluation dated 12/2/13, indicated R1 had no history of unsafe smoking practice, was able to utilize a lighter/matches safely, was able to safely handle lit smoking material; R1 was identified as cognitively intact, had no behaviors, understood the safe storage of smoking materials. The evaluation indicated R1 understood where smoking was allowed and was deemed an independent smoker. The next Smoking Evaluation dated 3/4/14, noted there were no changes from the 12/2/13, and R1 was deemed a safe smoker. Physician's Orders dated 2/26/14, indicated R1 received the following medications: -Methadone 100 mg daily for pain; -Trazadone (an antidepressant used to treat insomnia with potential side effects of dizziness and drowsiness) 300 mg at bedtime for insomnia; -MS (morphine sulfate, a narcotic used for pain with potential side effect of drowsiness) Contin 15 mg at bedtime for muscle spasms; -Venlafaxine (Effexor, an serotonin-norepinephrine reuptake inhibitor [SNRI] antidepressant with potential side effects of dizziness and drowsiness) 150 mg daily for depression; -Gabapentin (Neurontin, an antiseizure drug also used to treat pain with potential side effects of dizziness, drowsiness or sleepiness) 800 mg three times daily (TID) for neuropathy related to diabetes mellitus; -Zolpidem (Ambien, a sedative drug used to treat insomnia and known to cause sleepiness) 5 mg at bedtime as needed (PRN) for insomnia; -Oxycodone (a narcotic used to treat pain and known to have potential side effects of dizziness and drowsiness) 30 mg three times daily as needed for pain;	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 186	F 323		

-Diphenhydramine (Benadryl, an antihistimine drug used for treatment of allergic symptoms such as itching with potential side effects of dizziness and drowsiness) 125 mg 2 caps by mouth every 4-6 hours as needed for itching;
- Hydroxyzine (Atarax, an antihistimine drug used to treat allergic type symptoms such as itching with potential side effects of dizziness and drowsiness) 25 mg two caps by mouth every six hours prn (as needed) for itching.

A Medication Review Communication dated and signed on 3/17/14 (after concerns of potential medications causing the observed sedation while smoking were brought to the facility's attention), by the consultant pharmacist indicated R1's medications such as Trazadone, Gabapentin, Ambien, Atarax and Venlafaxine would decrease alertness, increase confusion, cause sedation, and dizziness.

A Physician Progress Notes dated 12/10/13, revealed R1 was on resumed as needed Zolpidem (Ambien) 5 mg related to complaints with difficulty sleeping despite a substantial dose of Trazadone. The Physician Progress Notes further indicated R1 had been cautioned to watch for excessive sedation and falls.

R22 was unsupervised and lacked a smoking apron during observations of R22 smoking on 3/11/14, 3/12/14, 3/13/14, and 3/14/14; R22 was observed to have possession of smoking materials throughout all observations and was observed to have multiple burn holes in his clothing.

R22's smoking observations were as follows:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 323	Continued From page 187 On 3/11/14, at 11:34 a.m. R22 was observed leaving the building in his motorized scooter wearing a light weight blue jacket. - At 11:37 a.m. R22 was observed parking his motorized scooter outside in the front designated unsupervised smoking area. R22 then took a cigarette and lighter out of a black glove and R22 lit the cigarette. R22 was not wearing a smoking apron and was unsupervised. - At 11:42 a.m. R22 was observed return to the building and to his room. On 3/12/14, at 1:15 p.m. R22 was observed to be smoking in front designated unsupervised smoking area. R22 was observed steering his motorized scooter while holding a lit cigarette in his mouth. R22 nearly hit a pool in front, the cigarette ash was noted to be approximately half (1/2) inch long. No smoking apron was observed on R22 or available in the unsupervised smoking area. On 3/13/14, from 8:15 a.m. to 8:46 a.m. R22 was observed in the dining room (DR) sitting on a regular straight back chair eating breakfast. R22 was wearing a gray half sweater and blue sweat pants. Both were observed to have burn holes at the front. - At 9:10 a.m. R22 was observed to leave the DR and go back to his room. R22 was observed watching television while lying in his bed. R22's legs were observed to dangle on the edge of bed. Several burn holes were observed in his sweater and pants. The black glove holding the cigarettes and lighter was observed to be lying on the seat of the motorized scooter. - At 11:10 a.m. R22 was observed to drive the motorized scooter out of his room and exit the building. R22 was observed to sit in his scooter in	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 188	F 323		

the front designated unsupervised smoking area. R22 retrieved his cigarette and lighter from a black glove, lit his cigarette and started smoking. R22 did not wear an apron and was unsupervised as he smoked.
- At 1:30 p.m. R22 was observed outside in the front designated unsupervised smoking area smoking a cigarette. R22 did not wear a smoking apron. R22 was observed to hit a bench while maneuvering his motorized scooter as he was smoking the cigarette. The heavy blue jacket R22 was wearing was observed to have several burn holes to both sides of the jacket zip line.
- At 2:15 p.m. R22 was observed outside in the designated unsupervised smoking area smoking sitting on his scooter and smoking a cigarette.

On 3/14/14, at 12:12 p.m. was observed outside at the front designated unsupervised smoking area. R22 retrieved his cigarettes and lighter from the black glove then a staff applied a smoking apron and remained in the area supervising R22.
- At 12:23 a.m. R22 returned to the building. The black glove with the cigarette and light in side was observed to be on R22's lap. R22 drove his motorized scooter down the hallway passing several facility staff and eventually entered his room.

On 3/14/14, at 3:39 p.m. the SSD verified R22's Smoking Evaluation was not in the clinical record, but stated since R22 had been at the facility since 2011, it would be downstairs in his social service thinned chart and needed to go get it.

On 3/14/14, at 3:43 p.m. SSD returned with the Smoking Evaluation dated 4/17/12. SSD stated she had not looked at it prior to completing the Smoking Assessment dated 1/9/14, but had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 189	F 323		

thought if there were changes another assessment would have been completed by the previous social service person. SSD verified according to the assessment dated 4/17/12, R22 was supposed to be a supervised smoker and smoking materials were to be secured by staff. SSD verified the assessment indicated R22 had a history of smoking in inappropriate places, such as his room and dining room. SSD verified R22 was currently considered an independent smoker and kept his own smoking materials with him. Although the assessment dated 4/17/12, contradicted, SSD verified the care plan dated 11/1/12, identified R22 as an independent smoker. SSD verified there was no other comprehensive assessment of R22's smoking ability.

On 3/17/14, at 8:19 a.m. the DON stated she believed there was a more recent smoking assessment. DON stated the assessment should not have been thinned in the from the clinical record and SSD should have looked back to see what the previous assessment directed, prior to completing the smoking assessment on 1/9/14.

On 3/17/14, at 9:11 a.m. RN-C was questioned regarding updating R22's care plan. RN-C stated she had updated R22's smoking care plan on 3/16/14, to reflect R22 required supervision with smoking and verified the prior care plan identified R22 was an independent smoker.

Review of R22's medical record indicated the following:
R22's Smoking Evaluation dated 4/17/12, revealed R22 had a known history of smoking in inappropriate places such as dining room and his room; would forget to verbalize that smoking was

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 190	F 323		

not allowed in the room; did not always pay attention to smoking materials; had smoked in a non-smoking areas and had lit his lighter in his room. Based upon the evaluation, the recommendation was made R22 required supervision with smoking and smoking materials were to be secured by staff.

The Smoking Assessment signed and dated on 1/9/14, and 10/17/13, indicated there were "no" changes noted to R22's Smoking Evaluation. The Assessment noted a statement, "I have read and reviewed the most recent Smoking Assessment and find it current and up to date."

The Quarterly Care Conference nursing note dated 10/17/13, identified R22 was a smoker; he and his son had received copy of the Camden Care Center Smoking policy and a smoking contract had been signed. The note indicated Risks and benefits of smoking had been reviewed with both R22 and his son. The note indicated R22 had been offered a smoking cessation program, but had declined. In addition, a social services note for the same date indicated R22 was an independent smoker.

R22's quarterly MDS dated 1/9/14, identified R22's diagnoses included peripheral vascular disease (PVD) and chronic obstructive pulmonary disease (COPD). The MDS indicated R22 had no behaviors and had a BIMS score of 10 indicating moderately impaired cognition. In addition, the MDS indicated R22 received one person assist with transfers, dressing, hygiene, and R22 used a wheelchair and walker for mobility.

R22's care plan dated 11/1/12, indicated R22 was a smoker with the goal, "[R22] Will follow all

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 191 guidelines regarding smoking at Camden Care Center, will remain safe while smoking." The care plan also indicated R22 was independent with smoking and had been offered smoking cessation program, but did not wish to quit smoking at the time. The undated and untitled list of Independent & Supervised Smokers list revealed R36, R1 and R22 were all identified as independent smokers. On 3/14/14, at 8:15 a.m. when asked about how residents were generally assessed to consider them either an independent or supervised smoker, SSD stated, "We would review the residents' diagnoses, health and cognitive status, and ask questions if the resident had a history of unsafe smoking. With the assessment each resident is supposed to verbalize they understand how to use smoking materials and how to safely store them." In addition, SSD stated all residents were offered assistance to quit smoking; SSD stated all residents understood they "are not supposed to share smoking materials or offer to store smoking materials for other residents." "If a nursing staff noticed any resident was not able to hold a cigarette right or had a burn holes on their clothing, facility staff would let nursing staff know so they can be supervised or use a smoking apron; we explain the policy and safety reasons to all the residents. If the resident refused to follow the smoking policy, they are given a thirty day notice indicating non-compliance and would be discharged from the facility." On 3/14/14, at 8:24 a.m. when SSD was asked if she was aware of burn holes in R36's, R1's and R22's clothing SSD stated she was not aware. SSD stated since the unsafe smoking concern	F 323		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 192	F 323		

had been brought to the attention of the facility, "every hour" there was a staff person in the designated smoking areas supervising residents. SSD stated "nobody checked the clothing for burn holes." SSD further stated all the independent smoking residents would be observed for burn holes when they were assisted with cares and laundry would report burn holes to her. When asked what the facility would do when a resident was "deemed" to be a unsafe smoker, the SSD stated nursing staff would review smoking assessments and make the necessary adjustments to care plan. SSD stated staff would be informed of the change immediately. SSD also stated, "Aprons are for those residents on supervised smoking and smoking was only to be at the front designated smoking area."

The facility Accidents/Incidents Management policy dated January 2013, directed, "It is the goal of the facility to provide safe, protected and monitored environments for all who enter the facility property. The reporting of incidents is a method to track and trend unsafe situations that may result in harm. Accidents do not have to result in injury to require reporting."

The facility Smoking Policy dated as revised on 1/2014, directed, "2. All smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by OBRA [Omnibus Budget Reconciliation Act] assessment timeframe's."; "7. Residents who smoke shall wear a smoking apron if they are found not to be safe (i.e. drop lit cigarette or do not handle the ashes properly. a. If clothing is found to have cigarette burn holes the smoker must wear an apron to protect themselves from burns. 8. All smoking materials will be stored in a

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 323	Continued From page 193	F 323		

secure area to ensure they are kept safe. Based on the individual resident smoking safety assessment facility staff shall determine the most appropriate method to secure storage."; "10. All smoking sessions will be supervised by facility staff members only."
R64 was observed to be transferred in an unsafe manner with an EZ-Stand mechanical lift on 3/13/14, at 11:05 a.m. The surveyor had to intervene during the transfer to prevent a potential fall and/or injury when R64 began to slide through the lift harness.

R64's record was reviewed. The Face Sheet dated 1/14/14, indicated R64 was admitted to the facility on 1/5/10, with diagnoses including senile dementia, essential hypertension, and lack of coordination.

R64's annual MDS dated 1/30/14, identified R64's cognitive skills for daily decision making were severely impaired and R64 was rarely/never understood. R64's transfer ability was scored as total dependence with a two person assist. Additionally, the MDS identified R64 as not steady, only able to stabilize with staff assistance when moving from seated to standing positions, and surface to surface transfer (transfer between bed and chair or wheelchair). R64's Care Area Assessment (CAA) for falls, dated 1/30/14, identified risk of falls related to difficulty maintaining sitting balance and impaired balance during transitions.

R64's ADL Self-care Performance Care Plan, dated 11/14/11, revealed R64 required assistance of two staff and an EZ-stand (a type of standing lift) for transfers and a hoyer (full body lift) if the resident was weak or too combative to be moved.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 194	F 323		

The undated facility nursing assistant worksheet for the south hallway indicated R64 required a check and change every two hours and as needed. Additionally, the worksheet indicated R64 required transfer assistance with an EZ-stand and two staff. The worksheet also directed to use a hoyer lift if R64 was resistive. The worksheet identified R64 used a wheelchair and was non-ambulatory.

On 3/13/14, at 8:19 a.m. NA-D and NA-B assisted R64 with a transfer in an EZ Way stand lift (a type of standing lift that uses a harness underneath the arms that attaches via loops to a mechanical lift, and is also secured around the resident's waist with a safety belt to raise the resident from a sitting to standing position). R64 was unable to hold onto the EZ Way stand lift handles. NA-D repeatedly tried to reapply R64's hands to the lift. The safety belt was noted to be loosely secured around R64's waist, with visible slack in the belt.
- At 11:05 a.m. NA-C and NA-B were observed to prepare to lift R64 out of his wheelchair for repositioning. During the transfer, R64 pulled their hands away from the EZ-stand handles, with the left hand becoming wedged between the handle of the EZ-stand and the frame of the lift. NA-C and NA-B lowered R64 back down into the wheelchair to free his hand. NA-B stated the resident "does this [won't hold onto the lift] a lot." NA-B and NA-C tried to manually place R64's hands on the handles and R64 was unable. NA-B and NA-C said R64 was unsafe in anything else but the EZ-stand.
- At 11:10 a.m. NA-B and NA-C obtained a licensed practical nurse (LPN)-B to assist. LPN-B came to the room and placed R64's hands on the handles, covering R64's left hand with his hand to maintain placement. NA-B and NA-C began to lift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 195	F 323		

the machine to stand R64; R64 immediately began to slide out of the EZ-stand harness. The surveyor immediately intervened to stop the transfer, immediately asked NA-B and NA-C to place the wheelchair underneath R64 to prevent them falling onto the floor. The belt of the EZ Way stand sling was noted to be very loose around R64's waist.
- At 11:17 a.m. NA-B and NA-C were removing the EZ-stand equipment from R64's room and said they were going to put R64 in the day room as he was still uncooperative. NA-B stated she had worked at the facility for about six months and had received training on the lift when she started. NA-C said she had worked in the facility for five months and had "never" been trained on use of the lift. NA-C verified she had been using the lift to transfer residents since hire. Neither NA-B nor NA-C were able to state if the belt should have been tightened as R64 was moved to a standing position. NA-B and NA-C stated they used the resident group lists for special information about residents, however neither NA staff member had the group list on their person at the time of the transfer observation. NA-B and NA-C were unable to state if R64 could use a hoyer lift if he was resistive.

On 3/13/14, at 11:38 a.m. NA-A revealed she had worked in the facility about three months, and stated she was trained by another aide "on the floor [while on the job]" on the proper use of the EZ Way stand lift. NA-A added she would ensure the resident was holding the handles of the lift securely and that the belt was tightened so it was not loose with transfers.

NA-C's training log revealed she received EZ Way stand training on 10/31/13. There was no

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 196 return demonstration of safe operation of the lift identified on the training form. On 3/13/14, at 1:19 p.m. NA-E stated she was trained on the use of the EZ Way stand lift prior to working on the floor. NA-E stated she would not lift someone who could not consistently hang on. NA-E stated if a resident could not bear weight and could not stand, she would get a third person to transfer them, and did not identify the use of a Hoyer or full body lift as a potential option. On 3/13/14, at 1:25 p.m. NA-D and NA-A were transferring R64 from the wheelchair into bed. NA-D began to lift the resident with the EZ Way stand. At the time of the observation, the surveyor immediately intervened to tell NA-D and NA-A that R64 was not hooked to the lift underneath the right arm. R64 was observed to have only one side of the sling hooked to the lift machine. Although the safety strap around R64's waist was secured, R64 was not holding onto the lift. R64 then began to hang onto the lift frame and not the handles. R64 was placed in bed with the standing lift after correction. NA-B's and NA-D's training logs were reviewed and revealed they had EZ Way stand training checked off on their files, no return demonstration was documented. On 3/13/14, at 2:10 p.m. the DON said she would check on that information (regarding a return demonstration), no further information was provided. DON showed surveyor staff the EZ Way stand operator's instructions that were part of the general orientation information manual. The EZ Way stand Operator's Instructions dated	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 323	Continued From page 197 3/11/09, revealed the safety strap should have been securely fastened around the patient's (resident's) torso prior to the patient being lifted. The harness should be secured by the same color loop to the lift on both sides of the harness. Additionally, the user's manual revealed patients should be able to bear some weight, have upper body strength (i.e. be able to sit on the side of the bed unattended), and be able to follow simple commands. If a patient does not meet each of these three criteria, the EZ Lift total body lift must be used. A warning box on page two of the operator ' s manual indicated - Warning: For safe operation of the EZ Way stand, the stand must be used by trained personnel in accordance with the operator's manual, video and training checklist to avoid injury to the patient. An EZ Way stand Competency Checklist was included in the manual on page 12. Evidence of the checklist being completed was not present in NA-B, NA-C or NA-D's training files. Incident reports were reviewed for the last year for R64 and did not reveal any falls from the EZ stand lift. On 3/13/14, at 2:23 p.m. occupational therapist (OTR)-C stated they screened every resident for therapy with each quarterly MDS. OTR-C stated this new process was started about a month and a half ago. OTR-C stated any documentation regarding transfer/lift assessments would be under the therapy section of the chart, much of their resident information prior to September 2013 was lost due to changes in software programs. OTR-C reviewed R64's chart and showed surveyor the last assessment from therapy done on 6/28/13. OTR-C stated the evaluation was done per family request due to	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 198 transferring difficulty. The evaluation recommended at that time to use the EZ stand for transfers as R64 was unsafe with one or two person transfers. OTR-C indicated to use the EZ stand, a resident should be able to bear at least partial weight and consistently be able to follow instructions enough to hang onto the handles. OTR-C stated "it would be a concern" if the resident was unable to follow these instructions. On 3/14/14, at 7:28 a.m. LPN-A was assisting NA-D to get R64 up in the EZ Way stand. R64 was physically assisted to a sitting position by LPN-A and NA-D. R64 was hooked up to the EZ-stand with the loops secured on the first black loop to the lift underneath each arm, as well as the safety strap secured about the waist. R64 was unable to hold onto the EZ- stand handles despite cueing from LPN-A and manual placement of R64's hands on the lift. LPN-A indicated at this time she was "not comfortable with this, he cannot hold onto the handles." LPN-A stopped the transfer at that point and had NA-D get a full body lift, stating to NA-D "we can always upgrade, but we cannot downgrade" referring to transfer lift equipment. LPN-A physically supported R64 while waiting for NA-D to return with the full body lift machine, as R64 was not capable of sitting on the side of the bed alone without falling. LPN-A additionally told NA-D he needed to get his transfer belt on "that is part of your uniform." NA-D did not have the transfer belt on his person. R64 was then assisted into the wheelchair with a full body lift, and exhibited no behaviors or resistance with the transfer. LPN-A said she was going to contact therapy regarding the resident's transfers, and stated "he really hasn't had a decline" and remarked he had "always been like this, unable to follow	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 199	F 323		

instructions." She further commented she did not know why they (therapy) had him using the EZ Way stand when he could not cooperate and was going to get an order for a therapy evaluation for R64.

Nursing progress notes by LPN-A dated 3/14/14, at 8:06 a.m. revealed R64 was unable to safely complete an EZ-Stand transfer, "Writer stopped the transfer and completed a hoyer transfer." Nursing progress notes by LPN-D dated 3/14/14, at 8:47 a.m. revealed an order was received for physical therapy evaluation and treatment for proper transfers.

The IJ that began on 3/12/14, at 5:00 p.m. was removed on 3/16/14, at 12:17 p.m. when the facility had implemented an IJ removal plan that included: The initiation of thorough investigations of ongoing incidents that involved R36, R1, R22 and R64; Re-assessments had been completed for smoking safety for residents who smoke; Staff were educated to the facility's smoker and safety monitoring systems; Staff had received education and conducted return demonstration for proper lift use; The staff were able to describe the job duties of the of smoke monitor and safety monitor, and were aware a smoking blanket and fire extinguisher were present whenever residents were outside smoking. Direct care staff and licensed nursing staff were interviewed and were able to explain their responsibilities for identification of incidents of potential accidents regarding improper safety during smoking and improper use of the mechanival lift/stand as defined in the removal plan. Although the IJ was removed on 3/16/14, non-compliance remained at the lower scope and severity (s/s) of an E.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 328 F 328 SS=D	Continued From page 200 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the continuous positive airway pressure (CPAP-breathing machine that provides a continuous supply of air which is positively pressurized) and mask were cleaned and stored properly. In addition, the facility failed to address the use of the CPAP and monitoring of respiratory status in the comprehensive care plan for 1 of 1 resident (R111) reviewed for respiratory concerns. Findings Include: On 3/11/14, at 6:34 p.m. R111 indicated to surveyor the staff did not clean the machine "CPAP." On 3/13/14, at 11:30 a.m. the CPAP mask and tubing were observed lying on the floor next to R111's bed with creamy white build up in the inside of the mask and around the seams.	F 328 F 328	F 328 For sampled resident R111 and for all residents assessed to receive treatment or care for special needs, the facility shall ensure proper treatment is received. These special care needs include but are not limited to the use of CPAP. The facility has a policy titled, "Care Standards" that was effective 05/2012 and was reviewed 05/2013. This policy has been reviewed and revised to specifically reflect direction to special treatment and care services. Also, an authoritative resource has been added related to respiratory care. This policy is now available to the facility on the remote desktop. Additionally the facility has a policy titled, "CARE Team Meeting" that was effective 05/2012 and reviewed 05/2013. Both of these policies will be made operational at the facility. Special treatment or care needs may be reviewed in a CARE Team Meeting at the discretion of the IDT. These meetings are now initiated again at the facility and once every month A log will be kept from each CARE meeting related to special treatment or care needs. This log will be presented to the QA committee for review and further recommendation as indicated. This will be an ongoing audit and QA review process.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 328	Continued From page 201 On 3/14/14, at 11:28 a.m. the CPAP mask and tubing were both again observed lying on the floor slightly under the bed but visible. The mask observed to have a thick creamy build up on the inside and the seams. R111's Admission Record dated 1/10/14, identified diagnoses to include head injury and depressive disorder. The admission Minimum Data Set (MDS) dated 12/23/13, indicated R111 was cognitively intact and had a diagnoses of asthma. The Care Area Assessments (CAAs) did not identify the use of a CPAP machine. When interviewed on 3/14/14, at 11:37 a.m. licensed practical nurse (LPN)-C stated the nursing assistants (NA's) are supposed to set the mask and tubing on the side table. LPN-C demonstrated how it should be stored and disconnected the mask from the tubing after applying gloves stated she was going to wash it and described the substance in the mask as "Gunk and dirt." LPN-C expressed that she had not worked in that side of the facility and verified there were no cleaning instructions in the Treatment Administration Record (TAR) and neither in the care plan. LPN-C further explained the procedure for cleaning the mask using warm water with soap then air dry the mask at R111's bedside. Physician's orders dated as printed on 3/17/14, indicated R111 used a CPAP. The clinical record lacked a comprehensive care plan to address the use of the CPAP, including monitoring of respiratory status, cleaning. A copy of the care plan was requested, but not provided	F 328	For sampled resident R111, a thorough and complete assessment shall be completed related to respiratory needs and treatments. Based on this assessments, the IDT shall develop a comprehensive care plan related to respiratory special care needs. The comprehensive care plan shall also address the care and maintenance of special treatment/needs equipment related to respiratory care. Additional assessments for sampled resident R111 will be done at least quarterly based on MDS schedule or more frequently at the discretion of the clinical staff based on clinical judgment and/or change in medical condition. The Resident Care Manager(s) or DON will do a monthly audit x6 of residents with special care needs/treatment to ensure the assessments are present and accurate and that the care plan is current and being followed. The results of this audit will be reviewed by the facility administrator and then presented to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DON, RCM, Social Service if appropriate, IDT Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 328	Continued From page 202 by the facility. In addition the clinical record lacked evidence of monitoring R111's respiratory status, such as but not limited to: oxygen saturations, lung sounds. The CPAP/BiPAP (Bilevel Positive Airway Pressure - a machine that helps users breathe more easily) Support policy dated as revised 10/2010, directed how to apply the CPAP and identified pertinent information on application of the device. The policy directed to document application of the CPAP, oxygen saturation during therapy and how the resident tolerated the procedure. The policy lacked direction for maintenance of the CPAP, such as delegated responsibility for cleaning the machine and tubing changes.	F 328		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and	F 329	F 329 For sampled residents R9, 89, 91, and 1 and for all residents at the facility, the facility shall ensure that residents are free from unnecessary drug use specifically by ensuring that; • gradual dose reductions (GDR) are attempted and documented • that target behaviors/moods/sleep patterns for which pharmacologics are prescribed are monitored The facility has a policy titled, "Behavior Management" that was effective 11/2011 and was reviewed on 05/2013. Additionally, the facility has a policy titled, "Psychoactive Medication Management" that was effective 05/2012 and reviewed 05/2013. These policies will be reviewed and revised if indicated. The facility shall ensure these policies are fully operational.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 329	Continued From page 203 behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 5 residents (R9, R89, R1, R91) were free from unnecessary medications; failed to ensure R9 had a gradual dose reduction (GDR) of Haldol (an antipsychotic) and Trazodone (used for sleep) or a documented clinical contraindication of a GDR and failed to ensure adequate monitoring of Haldol and Trazodone; failed to ensure R89 had target behavior monitoring for the use of Zyprexa (an antipsychotic); failed to ensure R1 was monitored for potential side effects, sleep patterns and mood monitoring related to use of Trazodone and Venlafaxine (anti-depressants) and Ambien (Zolpidem-sedative used for short term treatment of insomnia); and the facility failed to identify and monitor target behaviors for anxiety medications for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Findings include: R9 was observed in her room on 3/13/14, at 10:58 a.m. in her bed. R9 responded to questions appropriately when spoken to and was noted to have constant, involuntary movements of her head and hands.	F 329	Staff will be educated about the need monitor target behaviors/mood/sleep patterns for residents receiving medication for these issues. That education will include where the target behaviors/mood/sleep patterns are to be recorded and the frequency of that monitoring. For resident R9, an appointment with a psychiatrist or psychologist shall be arranged. The primary physician will be consulted to secure an order for a GDR for Haldol and Trazadone. Target behaviors will be identified and tracked. Side effects of all medications shall be monitored. The facility shall complete ongoing comprehensive assessments of sampled resident R9 based on OBRA/MDS guidelines and the IDT shall review these assessments are review/revise the care plan accordingly. The facility shall ensure the medication regimen for R9 is reviewed by a consulting pharmacist and the recommendations of the pharmacist are provided to the treating physician for review and comment.	

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F 329	Continued From page 204 The Admission Record dated 2/25/14, indicated R9 was admitted 10/4/11, with diagnoses including schizophrenia, orofacial dyskinesia, unspecified sleep disturbance, unspecified psychosis and bipolar disorder. Both the annual Minimum Data Set (MDS) dated 10/8/13, and the quarterly MDS dated 1/16/14, indicated R9 had no trouble falling or staying asleep, sleeping too much, had no delusions or hallucinations and had no behaviors. The MDS indicated R9 had a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The Psychotropic Drug Use Care Area Assessment (CAA) dated 10/17/13, triggered related to receiving antipsychotic medications and did not include a summary. The Psychosocial Well-Being CAA dated 10/17/13, triggered related to little interest or pleasure in doing things and noted was receiving antipsychotic and antidepressant medications. The uses antidepressant medication related to insomnia care plan dated 10/20/11; directed hours of sleep will be monitored. The uses psychoactive medications care plan dated 10/20/11, directed monitor/record and report to physician prn side effects and adverse reactions, monitor/record occurrence of target behavior symptoms (paranoid thoughts, hallucinations) and document per facility protocol and consult with pharmacy/physician to consider dose reduction when clinically appropriate. A Note To Attending Physician/Prescriber dated 9/26/13, noted a GDR should be attempted yearly	F 329	For sampled resident R89 target behaviors related to hallucinations will be initiated. The specifics of the hallucinations shall be documented such as are the hallucinations visual, auditory, olfactory, etc. Additional target behaviors will be tracked related to agitation, impulsivity and delusions. Side effects of pharmacologics used to treat these target behaviors and of all medications shall be monitored. The facility shall complete ongoing comprehensive assessments of sampled resident R89 based on OBRA/MDS guidelines and the IDT shall review these assessments are review/revise the care plan accordingly. The facility shall ensure the medication regimen for R89 is reviewed by a consulting pharmacist and the recommendations of the pharmacist are provided to the treating physician for review and comment. For sampled resident R1 a sleep monitor shall be initiated. Additionally, the resident shall be assessed for the potential of over medication and side effects of all medication.	

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F 329	Continued From page 205 unless clinically contraindicated and noted the last dose reduction of Haldol was completed 6/2012. The physician response dated 10/22, stated "Pt. [patient] being followed by psychiatry please forward to psychiatry." No additional follow-up was noted in the medical record. A target behavior tracking dated 1/14, included a target behavior of anxious health complaints which were marked to have not occurred. A target behavior tracking dated 9/13, included target behaviors of delusions and hallucinations which were noted to have not occurred. No other target behavior tracking was found. The Medication Administration Record (MAR) dated 3/1/14 through 3/31/14, indicated R9 received Haldol 8.5 milligrams (mg) every bedtime, Haldol 150 mg every month, and Trazodone 250 mg every bedtime. The medical record was reviewed and no psychiatry note was found. Psychiatry notes were requested and were not provided. There was no documentation of orthostatic blood pressures found in the medical record for R9 to monitor for adverse reactions. When interviewed on 3/13/14, at 2:47 p.m. licensed practical nurse (LPN)-A reported she was unable to find documentation of orthostatic blood pressures for R9. LPN-A stated since the facility switched over to a new pharmacy last year, there was nowhere to track target behaviors and the target behaviors for R9 were missing including sleep logs. Upon interview on 3/14/14, at 7:25 a.m. medical records stated R9 had not had a psychiatry visit in	F 329	The facility shall complete ongoing comprehensive assessments of sampled resident R1 based on OBRA/MDS guidelines and the IDT shall review these assessments are review/revise the care plan accordingly. The facility shall ensure the medication regimen for R1 is reviewed by a consulting pharmacist and the recommendations of the pharmacist are provided to the treating physician for review and comment. For sampled R91 targeted behaviors related to the use of anxiolytics shall be monitored. Side effects of all medications shall be monitored. The facility shall complete ongoing comprehensive assessments of sampled resident R91 based on OBRA/MDS guidelines and the IDT shall review these assessments are review/revise the care plan accordingly. The facility shall ensure the medication regimen for R1 is reviewed by a consulting pharmacist and the recommendations of the pharmacist are provided to the treating physician for review and comment.	

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F 329	Continued From page 206 the last six months. When interviewed on 3/14/14, at 7:45 a.m. LPN-A stated she was not aware of any GDRs for R9 and was not aware of any follow-up on the GDR request written by the pharmacy consultant on 9/26/13. LPN-A stated she expected the request to be sent back to the primary physician as psychiatry was not involved in the care of R9. The director of nursing (DON) was interviewed on 3/14/14, at 7:53 a.m. and stated pharmacy recommendations should be followed up on as soon as possible and not more than a month. The DON stated she expected pharmacy recommendations would be referred back to the physician or the medical director if needed for follow-up. R89 was not monitored for target behaviors to determine efficacy of Zyprexa (an antipsychotic medication). R89's admission MDS dated 12/28/13, indicated R89 was never or rarely understood, had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behaviors concerns towards others. The CAA for ADL (activities of daily living) function/Rehabilitation Potential dated 1/3/14, identified R89's diagnoses to include altered mental status, cognitive impairment and weakness. The CAA identified R89 required staff assistance for ADLs, had no pain concerns, had a history of falls (but no falls in the facility) and was incontinent of bowel and bladder. The CAA for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to	F 329	The clinical records of sampled residents R9, 89, 1, and 91 will be audited monthly X6 for target behaviors/mood/sleep monitor, the need for GDR, and medication side effect monitoring. The results of these audits will be reviewed by the DON and signed. Additionally, these audits will be reported to the QA Committee for review and further comment. A random sample of clinical records for residents using psychoactive, anti-depressant, anxiolytic, or sleep medication will be conducted for target behaviors/mood/sleep monitor, presence of GDR, and medication side effects monitoring. The results of these audits will be reviewed by the QA Committee for review and further comment. This is an ongoing process. Responsible: Administrator, DON, RCM, Social Services, clinical staff Compliance date: 4/28/2014	

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F 329	Continued From page 207 assess her. SS [social services] will care plan this matter accordingly." The CAA for falls, also dated 1/3/14, recapitulated the same information as the ADL CAA. The CAA for psychotropic drug use identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were, what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A physician's Progress Note dated 2/12/14, identified R89 was seen for her first visit. The note indicated while in the hospital R89 had been on a high dose of Seroquel and switched to a low	F 329		

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F 329	Continued From page 208 dose of Zyprexa. The note indicated R89's Zyprexa would be considered to be increased to 7.5 mg. The Physician's Order Sheet dated 3/5/14, indicated R89 had olanzapine (Zyprexa) 5 mg ordered by mouth daily for diagnosis of atypical psychosis. A Geriatric Services of Minnesota Progress Note dated 3/7/14, indicated R89 was seen by a nurse practitioner. The note identified R89 "appears to be distressed" and was noted to "sit/stand multiple times from wheelchair." The note indicated R89 received 5 mg of Zyprexa daily, "Staff have no reports of behavior changes, but note impulsivity" and identified R89 fell twice in February. The "Psych:" section indicated R89 was "Agitated w/ [with] worried look on face. Mumbling. Slight diaphoresis [sweating]." Continuation of the note indicated Zyprexa would be increased to 7.5 mg "due to continued agitation/impulsivity." A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia. Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no behavioral concerns were documented, such as hallucinations, agitations symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.	F 329		

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F 329	Continued From page 209 On 3/13/14, at 2:24 p.m. the LPN-D verified there was no target behavior monitoring for Zyprexa and stated there "should be." LPN-D was unclear on what target behaviors to monitor for R89. On 3/14/14, at 8:57 a.m. the DON verified the facility did not have psychiatric services and stated they "signed the contract yesterday." ACP (associate clinic of psychology) was unclear when they would be starting. DON verified target behaviors should be monitored for the use of Zyprexa. On 3/14/14, at 9:27 a.m. LPN-A stated she was unclear why the Zyprexa was increased and unclear on the indications for the use of the medication. LPN-A verified the facility lacked a system to ensure target behavior monitoring was in place for antipsychotic medications. On 3/14/14, at approximately 9:40 a.m. the geriatric nurse practitioner (GNP) verified R89's Zyprexa was increased due to increased delusions and agitation. GNP stated R89's agitation was evidenced by diaphoretic symptom, R89 unable to relax, and increased falling. GNP stated she would expect the facility to monitor for efficacy of the medication and be looking for things like increased somnolence, decreased delusions. GNP stated R89 had been on Seroquel before and was hospitalized (before admission) for too much Seroquel and "that was how she was started on Zyprexa." GNP stated she has observed R89's behavior improve since the increase. When asked if she directed the facility to monitor for behaviors or gave suggestions of target behaviors, GNP stated she did not direct monitoring for target behaviors	F 329		

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F 329	Continued From page 210 because "they were usually identified on behavior sheets." On 3/14/14, at 10:51 a.m. when asked regarding determining behavior monitoring for resident, DON stated nursing staff along with the social worker would create a behavior plan for the resident. DON verified there was no behavior plan in place for R89. The Psychoactive Medication Management policy dated as reviewed 5/2013, directed the IDT to identify residents whose behaviors may require the use of psychotropic medications, and identify the diagnosis and/or behavior that are "antecedent" for the psychoactive medication. The policy indicated the goal of the IDT was to assess/monitor the psychoactive drug use and "ensure residents are assessed/evaluated for dose reduction opportunities on an ongoing basis." Although the policy identified potential examples of behaviors which may require monitoring, the policy incorrectly identified diagnoses of "Agitation" and vague terms such as "Aggression" and "Socially inappropriate actions" as "behaviors." The policy lacked clear direction to determine resident specific target behaviors, and lacked clear direction on where to document target behaviors in the facilities clinical record. The policy lacked identification of the frequency of target behavior monitoring and frequency of the evaluation of the data. R1 was not being monitored for potential side effects, sleep patterns and mood monitoring related to use of Trazodone and Venlafaxine (anti-depressants) and Ambien (Zolpidem-sedative used for short term treatment of insomnia).	F 329		

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F 329	Continued From page 211 R1 was observed on 3/12/14 and 3/13/14, outside in the front designated smoking area sitting on a motorized wheelchair (w/c) smoking and dozing off with her head and chin drooping and jerking up and down. During observations R1 appeared to be struggling to keep her eyes open. On 3/12/14, at 1:03 p.m. R1 was observed sitting on her bed stated she was tired "All the time" and had told the facility staff but thought it was related to her "Hepatitis-C" which she was waiting for a particular medicine. R1 verified she had burn holes on her clothing stating from her cigarette "The ashes flicking off." R1 further stated she had never had a burn from the smoking but acknowledged she had neuropathy and being tired was just not working with her smoking at times. R1's diagnoses included insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 12/6/13. The Mood section of the MDS identified R1 as having symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 all the symptoms were nearly every day. The CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1	F 329		

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F 329	Continued From page 212 was at risk for adverse side effects. No temporary and comprehensive care plans developed on medications since R1 had been admitted to facility on 11/30/13. Physician's Orders dated 2/26/14, indicated R1 received the following medication: -Trazodone 300 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for depression -Zolpidem (Ambien) 5 mg by mouth at HS as needed (PRN) for insomnia Review of the Monthly Pharmacist Review Medication Regimen last reviewed 3/7/14, indicated "NO New Suggestions." Medication Review Communication dated and signed on 3/17/14, by the pharmacist indicated these medications Trazodone, Gabapentin, Ambien, Atarax and Venlafaxine would decrease alertness, increase confusion, cause sedation, and dizziness. The review was completed after the concern of R1 being sedated had been brought to the facility attention after numerous observations. When interviewed on 3/13/14, at 9:44 a.m. the LPN-D stated if a resident was on sleep aides and an antidepressant behavior or mood monitoring was supposed to be documented in the "Red book." LPN-D went over the "Red book" and the medical record verified documentation was lacking. On 3/13/14, at 10:02 a.m. LPN-D approached surveyor stated she had looked in R1's record over again but had not found any information on	F 329		

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F 329	Continued From page 213 monitoring of side effects, behavior/mood, sleep patterns for the antidepressants, and hypnotics. LPN-D further stated she was going to start the documentation/monitoring. When interviewed on 3/13/14, at 10:23 a.m. social services designee (SSD) stated she was responsible to check with resident's regarding the mood and how they were feeling but at the same time since nursing was providing the resident's direct care the staff needed to monitor the side effects and behaviors or mood for all medications R1 was taking including the antidepressants and sleep aides. She further stated " I would check with R1 occasionally as she is alert and able to verbalize how she felt." When interviewed on 3/14/14, at 4:00 p.m. the facility medical director (MD) stated R1's side effects, mood and sleep patterns should have been monitored since R1's antidepressant and sleep aides had been increased. In addition MD stated R1 needed to go back to see the prescribing physician to re-evaluate the effectiveness of dosage increase. When interviewed on 3/17/14, at 8:17 a.m. the DON stated sleep monitoring and target behavior/mood monitoring should have been documented. She expected the consultant pharmacist (CP) to have alerted the facility that these pieces were lacking during monthly review. When interviewed on 3/17/13, at 1:11 p.m. about best practice; monitoring of sleep patterns and side effects the consultant pharmacist (CP) stated "I feel cornered by the surveyors asking me questions about residents which I don't have direct access to their information and I don't feel	F 329		

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F 329	Continued From page 214 comfortable." On 3/17/14, at 12:13 p.m. facility policy for side effects and behavior/mood monitoring was requested but was not provided. The facility did comprehensively assess behaviors and develop non pharmacological interventions related to depression and anxiety for R91, prescribed both anti-depressant and anti-anxiety medications. R91's care area assessments dated 10/22/13, for Mood, Cognitive Loss/Dementia, Behavior, and Psychosocial Well Being included the same summary statement under the Care Plan Considerations section: "Resident has some behavior r/t [related] medical Dx [diagnosis]. Staff will monitor her behavior and ensure pt [patient] needs are met and she is safe." The assessment did not include a thorough analysis including: specific behaviors exhibited by R91 were to be monitored, causative factors and health diagnoses related to display of behaviors and what interventions have been most effective. R91's current care plan, last reviewed 1/30/14, did not include non-pharmacological interventions related to R91's behaviors related to mood or anxiety. The care plan did identify "Psychotropic drug use: resident uses anti-depression (Prozac) and antianxiety (Buspar) R/t [related to] Dx [diagnosis] of depressant and anxiety" with an intervention to "Observe change in behavior and memory." Review of Medication Administration Record For March 2014 revealed R91 was being administered Buspirone HCL [an anti-anxiety	F 329		

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F 329	Continued From page 215 agent] 17.5 MG twice daily for "anxiety", Mirtazapine [an anti-depressant] 30 MG at night time for "depression", Prozac [an anti-depressant] 30 MG every day for "depression", and Ativan [a benzodiazepines anti-anxiety agent] 1 MG twice daily as needed for "agitation". R91 had used the as needed Ativan twelve times from 3/1/14 to 3/17/14. A review behavior intervention monthly flow record for January, February and March 2014, revealed behavior monitoring for sad facial expression and hours of sleep. A review of progress notes for January, February and March 2014 revealed no notes regarding behavior monitoring related to anxiety or depression. On 3/14/14, at 2:14 p.m. the SSD reported the care area assessments for R91 were completed prior to her employment at the facility. SSD reported the care area assessments were not comprehensive, did not identify what behaviors were occurring. SSD confirmed R91's care plan did not address her mood or anxiety issues. On 3/17/14 at 11:37 a.m. LPN-D reported the facility had not been monitoring for behaviors related to the use of buspirone. She said she would check how the facility was monitoring behaviors related to the use of as needed Ativan. No further information was provided. The Videll Healthcare, LLC policy on Psychoactive Medication Management, last reviewed on 5/2013, directed staff "1. Psychoactive medication management begins during the pre-admission process. Key data points to gather include but are not necessarily limited to: a. Admission information. b. Diagnosis	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 329	Continued From page 216 history c. Persistent psychiatric and/or mood problems d. Medications and route of delivery e. Pain history including past pain management programs f. Abuse or addition [sic] issues g. Rehabilitation status h. Neurological status i. Cognitive status j. Functional status" "2. A resident is assessed by a licensed nurse and/or social service director for psychoactive medication use during the admission/re-admission process. a Subsequent assessments are completed at least quarterly based on OBRA [federal] guidelines." "Based on the IDT [interdisciplinary team] analysis of psychoactive medication use and/or behavior issues and individualized care plan is developed to accommodate and/or manage the resident's behavior and psychoactive mediation use. a. The individualized care plan may address: i. Cognition ii. Mood iii. Behavior tracking logs iv. Residents' mobility v. Use of medication." "10. The DNS [Director of Nursing Services] or designee is responsible to ensure a behavior log is used to document antecedents and to monitor medication effectiveness." The Videll Healthcare, LLC policy on Behavior Management dated as reviewed 1/2013, identified a component of behavior management included, "Ongoing assessment, monitoring, and evaluation of the effectiveness of the behavior management program including the effectiveness of psychoactive drugs."	F 329		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental,	F 353		

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F 353	Continued From page 217 and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility did not provide sufficient staff to ensure residents received care per the care plans. This had the potential to affect all 49 of 84 residents who are consistently dependent for cares, and 2 of 2 residents (R11, R41) who occasionally need assistance for cares in the facility. Findings include: During the survey conducted on the following dates and times: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.;	F 353	F 353 For sampled residents R11 and 41 and for all residents in the facility, the facility shall ensure adequate staffing of licensed and certified care staff to meet the assessed needs of the residents. The facility has a DON that is on duty a minimum of Monday through Friday. The RN DON has 24/7/265 responsibility for the facility in concert with the facility Administrator. Additionally, the day shift is now staffed with 2 licensed nurses in the role of Resident Care Manager. An RN is hired working in the role of Clinical Nurse Liaison. The evening shift has an RN Resident Care Manager now. As ancillary responsibilities, one RCM will be responsible for tracking infection control, one RCM will be responsible for clinical orientation, and one RCM will be responsible for clinical inservice education. All of these ancillary responsibilities are under the direct supervision of the DON in concert with the facility administrator. The night shift has both an RN and an LPN permanent assigned to that shift.	

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F 353	Continued From page 218 - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m.; - On 3/15/14, from 10:00 a.m. to 12 noon, - On 3/16/14, from 12 noon to 2:15 p.m., - On 3/17/14, from 7:30 a.m. to 3:30 p.m., - On 3/18/14, from 7:30 a.m. to 8:45 p.m. Staff was observed to not be able to consistently provide services for the residents as directed by their plans of care based on a comprehensive assessment of their needs. The facility failed to ensure self-administered medications were safely administered for 1 of 1 resident (R36) observed to self-administer medications (SAM). Refer to F176. The facility failed to ensure 1 of 1 resident (R89) was assessed for the restraint of having both wheelchair brakes locked and having the wheelchair placed flush against a table or desk; in addition, the facility failed to ensure the restraint was the least restrictive and clinical indications for the use of the restraint. Refer to F221. The facility failed to promote and enforce a resident environment that was free from physical, verbal, and emotional abuse of residents for 1 of 4 residents (R56) as R56 was not protected from another resident (R63) in the sample. Refer to F223. The facility failed to immediately notify the administrator and the State agency (SA) of allegations of abuse, neglect and mistreatment for 6 of 7 residents (R21, R62, R71, R17, R56, R63) in the sample reviewed for abuse prohibition. These practices had the potential to affect all 84 residents residing in the facility. Refer to F225.	F 353	Bedside care staffing is evaluated daily by the DON or nurse manager on duty during the off shifts. Additional staffing is brought in with the consultation of the DON. The facility does not routinely staff to cover 1:1 situations but will do so on a case by case basis to ensure resident assessed needs are met and the safety of all residents in the facility is ensured. A gross miscommunication related to using PTO occurred. A facility staff member inappropriately directed this activity. When the President/CEO and COO were made aware of this gross miscommunication it was corrected. The facility has a policy titled, "Vacation Policy" that was initiated in June 2012 and reviewed in 2013. This policy clearing states that PTO is requested 60 days in advance so that shift coverage is ensured. Additionally, the department heads are responsible for approving PTO in advance and the PTO requests will be denied if staff coverage is compromised. Additionally, the facility has a policy titled, "Attendance and Punctuality" that was effective 05/2012 and reviewed 01/2013. It addresses the standards of attendance and unexcused absences. Both of these policies will be made fully operational in the facility.	

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F 353	Continued From page 219 The facility failed to provide care and services in a dignified manner for 1 of 2 residents (R38) whose living environment was permeated by an overwhelming urine odor from clothing soiled by urine and that was stored in the closet. Refer to F241. The facility failed to provide six days' worth of physician ordered and care planned pain medications for 1 of 3 residents (R41) in the sample reviewed for pain. Refer to F309. The facility failed to provide assistance with nail care for 1 of 3 residents (R64) in the sample who was dependent on staff for grooming. Refer to F312. The facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Refer to F314. The facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F319. The facility failed to provide adequate supervision and interventions to ensure safe smoking	F 353	A master schedule for CNAs is posted for a 90 day period of time. A master schedule for licensed nurse is posted for a 90 day period of time. The Resident Care Managers on the AM and PM shift will review the daily staffing upon arrival for their shift. They will consult with the DON and/or Administrator if there are unmet staffing needs. Daily staffing sheets will be kept and presented to the QA committee for review and further comment as indicated. This review process will be ongoing. Responsible: Administrator, DON, RCM, Social Service if appropriate, IDT Compliance date: 4/28/2014	

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F 353	Continued From page 220 practices for 3 of 28 residents (R36, R1, R22) who currently smoked unsupervised in the facility. In addition, the facility did not ensure safe use of a mechanical stand lift (a mechanical device used for transfers) for 1 of 2 residents (R64) in the sample. Refer to F323. The facility failed to ensure the continuous positive airway pressure (CPAP-breathing machine that provides a continuous supply of air which is positively pressurized) and mask were cleaned and stored properly. In addition, the facility failed to address the use of the CPAP and monitoring of respiratory status in the comprehensive care plan for 1 of 1 resident (R111) reviewed for respiratory concerns. Refer to F328. Resident care: The facility did not develop a care plan to address R11's refusals of cares, psychosocial needs, vulnerability, social service needs, discharge planning, pertinent diagnoses, contracture of the left side including hand and wrist, dental status and ADL requirements. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 was cognitively intact, had a mood problem of feeling tired, and had no behavior problems. The MDS indicated R11 was independent with bed mobility, transferring, locomotion on the unit and eating; required supervision with locomotion off the unit, dressing and toilet use; R11 was identified as requiring extensive physical assistance from staff for personal hygiene. The CAA for nutrition dated 1/7/14, identified	F 353		

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F 353	Continued From page 221 diagnoses of spastic hemiplegia on left side, history of alcohol abuse and congestive heart failure. The CAA identified R11 had "no upper teeth and few lower teeth" and, "He does not wish to receive a mechanically altered diet." - The CAA for ADL Functional/Rehabilitation Potential dated 1/13/14, identified the CAA was triggered due to R11's need for supervision with ADLs. The CAA identified R11 had left sided hemiplegia due to a history of cerebrovascular accident (CVA, stroke). The CAA identified R11's other pertinent diagnoses to include altered mental status, and homelessness. The CAA identified R11 "was eval [evaluated] for therapy" and refused. The CAA identified R11 was continent of bowel and bladder, had no skin issues or falls. - The CAA for falls and pressure ulcers (both dated 1/13/14), recapitulated the same data as ADL CAA. R11's care plan only had a focus for activities dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's concerns with roommate, refusals of care nor behaviors of calling staff derogatory names. The clinical record lacked evidence R11 had care plans developed (including goals and interventions) to address his clinically related social service needs, such as, but not limited to: R11's identified behaviors of refusals/rejection of cares, R11's identified behavior of calling staff derogatory names, and identification of R11's increased vulnerability due to physical limitations and individual psychosocial needs (such as a history of homelessness). In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture	F 353		

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F 353	Continued From page 222 due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming and skin assessments/evaluations and refusals of doctor visits. R41's Brief Interview for Mental Status (BIMS) from the Minimum Data Set (MDS), dated 2/10/14, indicated he was cognitively intact. R41 did not have behaviors related to rejection of care or which interfered with delivery of care. R41 was assessed as totally dependent on two or more staff for toileting. On 3/14/14, at 8: 15 a.m. R41 reported it frequently took 15-45 minutes to answer call light requests for toileting. R41 explained he needed two staff to assist him to change a soiled incontinence brief with the mechanical standing lift. He reported he often waited in soiled incontinence brief for staff to assist him. R41 reported this made him feel "less than human", "terrible", "angry" and "disgusted" R41 reported he decreased the amount of times he requested help toileting as it was a bothersome process. During observation on 3/14/14 at 9:01 a.m. R41 to put his call light on. At 9:09 a.m. a trained medication aide, (TMA)-A responded to the call light and turned it off. TMA-A informed R41 nursing assistants (NA) would be in shortly. At 9:21 a.m. (20 minutes later) NA-G and NA-H entered the room with the mechanical lift and assisted R41 in changing his soiled brief. A strong odor of urine was noted. R41's activities of daily living care plan, dated 2/17/14, directed staff "[R41] is dependent on 2	F 353		

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F 353	Continued From page 223 staff for toileting." R41's care plan, dated 2/17/14, did not address refusal of cares. On 3/14/14 at 12:09 p.m. NA-G and NA-H explained they have had to care for more residents than usual for about a month as staff were required to take vacation during a short period of time. At times resident rooms were far apart from each other. NA-G and NA-H reported some residents reported frustration with waiting longer periods of time for assistance in activities of daily living such as transferring to bed. NA-G and NA-H reported it took awhile to assist R41 with toileting this morning due to assisting other residents. NA-G and NA-H reported R41 would at times refuse toileting cares and his brief would be heavily soiled. Additional interviews: On 3/13/14, at 9:00 a.m. trained medication aide (TMA)-A stated that there are enough staff for days and PM's and when staff call in sick they are replaced. On 313/14, at 9:10 a.m. registered nurse (RN)-B stated that if all the staff show up it's okay, otherwise they have to split up groups and improvise. On 3/13/14, at 10:00 a.m. other (O)-E stated the nursing assistants were short staffed today, so people had to pitch in and help serve breakfast, if not the residents will just take charge and do it themselves. On 3/14/14, at 12:09 p.m. licensed practical nurse (LPN)-A stated that the two floor nurses are the charge nurse, they has never been a "charge nurse assignment" on the evening or night shift. LPN-A was not aware a designed charge nurse was a regulation. LPN-A further stated that the facility had worked short, even during the survey,	F 353		

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

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F 353	Continued From page 224 everyone was on vacation time because corporate would not give any vacation time last year, so everyone had to use vacation before the end of March, that was announced to all and everyone demanded their vacation. LPN-A further stated that because the census was down, she had been directed to reduce one aide from the schedule. On 3/14/14, at 2:00 p.m. the facility owner/governing board stated there had been four administrators in the facility since the last survey and listed them in order. The facility owner verified "complaints of insufficient staffing have gotten to me, we were aware and doing everything that we can. The fact that there is any issue is disappointing." The facility owner further stated "can't compromise care over shifting gears" during change and transition, was happy to have the director of nursing (DON) here, and stated the administrator was new to the position. The facility owner stated his chief operating officer (COO) will be here more often, she will make sure that anything put into place was implemented. "We ourselves are having corporate restructuring, to make sure at least one of us is here every week. Corporate is family, my wife is a social worker (SW), and the corporate SW consultant (CSW), she had been here doing corporate team building. We have been in health care, hands on with tuff populations for 21 years. we are a small company with four facilities. We like homes that we can work with that are community based care, we have been out here more and we are going to continue to be here more and have a plan for renovations and to put capital into the building." When asked if he was aware of who had control of the medical records and why the environmental director would have a	F 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 225 key, but the DON and medical records (HIM) person wouldn't have keys, the facility owner stated, "I am becoming aware of things, to be fully honest, why don't I pull in" (the COO was conferenced (by phone) into the conversation). The facility owner stated to the COO "We were talking about staffing and I let [the surveyor] know that we are remedying it with immediacy, and then talking about control of medical records and why the environmental director has the key rather than the DON and HIM person. The COO stated "It is my understanding that we do have a MR person. That's the first I heard of that [unlicensed personal with key to medical records], he [environmental director] is on a scheduled and pre-approved vacation, we can ask when he gets back." When informed of the conversation with the medical director (MD) and the MD-B's understanding that they would not be seeing patients in the facility. The COO stated "that is not what I have with any other facilities, it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. the facility has also to find another medical director or a back up medical director to get the work done." The facility owner stated "My understanding was as late as last week that she was going to in the interim cover us." On 3/18/1,4 at 2:00 p.m. the DON stated she had been given staffing when she arrived to improve the consistency of staffing process, and had started the process of block scheduling, and then immediately handed it off, because of larger concerns. The DON verified the facility had worked short staffed, because of the vacation deadline of March 31st, that was imposed by corporate. The facility had been directed to plug	F 353		

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F 353	Continued From page 226 in vacation days and had done the best job possible to try to spread them out, but a lot of people had not had vacation in the prior year. A review of the facility staffing schedule from 2/23/13 through 3/8/13, revealed 96 paid time off (PTO) shifts were granted in that 14 day period, which averaged six people per day on PTO, but actually ranged as high as eight people off on 2/24/14, and multiple days of having six and seven people on a PTO in a single day.	F 353		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	F 356 For all residents in the facility, the facility shall ensure the daily staffing of both licensed and certified staff is posted and readily available for review. Additionally the facility shall ensure that 18 months of historic daily staffing that was posted is readily available for review if requested. The facility has a policy titled, "Nursing Staff Posting Requirements" that was effective 05/2012 and reviewed 05/2013. This policy shall be made fully operational by the facility. The administrator shall designate an individual responsible for ensuring the facility daily staffing is posted every day. Additionally, the facility administrator shall ensure that all historic daily staffing sheets are kept readily available for a period of 18 months.	

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F 356	Continued From page 227 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Daily Staffing Hours (nurse staff posting) was posted in a prominent place accessible to be read by residents (including residents in wheelchairs), families and visitors from the public. In addition, the nurse staff posting was not consistently posted daily at the beginning of each shift. This had the potential to affect all 84 residents residing in the facility. Findings include: On 3/10/14, at approximately 11:30 a.m. upon entrance to the facility, the nurse staff posting was observed to be stored in a glass sealed frame at the front desk at the entrance to the facility. The posting was observed to be leaning against a yellow and white binder labeled State Survey Results, behind a basket, and behind a vase containing a bouquet of flowers. A maroon wing back chair was observed to potentially block access to the posting. During random observations on 3/11/4, at approximately 1:00 p.m.; 3/12/14, at approximately 9:00 p.m.; on 3/13/14, at approximately on 3:30 p.m.; on 3/14/14, at approximately 10:00 a.m. the nurse staff posting was observed to be posted at the front receptionist desk. Although the staff posting had	F 356	The QA committee will review the daily staffing sheets on a monthly basis to ensure they are posted and kept as required by federal regulation. This review will occur for 6 consecutive months. The QA committee will then review the need to continue or discontinue the monthly review or to make further recommendations as appropriate. Responsible: Administrator, QA committee Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 356	Continued From page 228 the required information, the nurse staff posting was not accessible to residents in the wheelchair or the public without asking facility staff for assistance. On 3/15/14, during a monitoring visit beginning at 10:00 a.m. the nurse staff posting was observed to not be posted. The reception desk and surrounding area, the nursing desk and other sections of the walls were observed, the nurse staff posting was not in place. At 11:58 a.m. the nurse staffing was not posted. On 3/17/14, at 1:13 p.m. the director of nursing (DON) verified the nurse staff posting and survey results were behind a maroon wing back chair, a basket with mail and a bouquet of silk flowers. The DON verified they were not accessible to residents in wheelchairs and could not be accessed without asking staff. DON stated the nurse staff posting was posted by the night shift. DON stated the posting should have been posted daily and updated at the beginning of every shift. DON stated the facility lacked a policy for the nurse staff posting.	F 356		
F 385 SS=E	483.40(a) RESIDENTS' CARE SUPERVISED BY A PHYSICIAN A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. The facility must ensure that the medical care of each resident is supervised by a physician; and another physician supervises the medical care of residents when their attending physician is unavailable.	F 385	F 385 For sampled residents R33, 103, 115, 71 and for all residents at the facility, the facility shall ensure the resident has a treating physician.	

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F 385	Continued From page 229 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician services were provided for 4 of 5 residents (R103, R115, R33, R71) out of a list of 16 residents reviewed after they were admitted for which no physician was designated for care. Findings include: A list of residents was posted by the telephone in the nursing station, with the wording "If you need any orders for MD-B (the current facility medical director) residents, you must bring the request to the licensed practical nurse (LPN)-A first. Do not call anyone or scan to anyone. If licensed practice nurse (LPN)-A is NOT available please call (##-###-#####) or if it can wait until Monday, please wait. If it is an emergency, EMERGENCIES ONLY Please call on -call Dr. MD-OC at (###-###-####). R103 was admitted to the facility 7/29/13, with diagnoses related to injuries from a motor vehicle accident (MVA) per the Admission Record. R103 was discharged to the hospital on 1/2/14, and re-admitted on 1/3/14. The quarterly Minimum Data Set (MDS) dated 1/16/14, revealed a Brief Interview of Mental Status (BIMS) score of 15/15 indicated R103 was cognitively intact. A Patient Depression Questionnaire (PHQ9) score of 7, indicating mild depression, R103 required supervision and physical assist of one for bed mobility and transfers, dressing and toilet use; required	F 385	The clinical record of R33, 103, 115, and 71 will be reviewed. The primary physician will be identified and appropriate arrangements will be made for physician visit to have the medical/treatment plan thoroughly reviewed and all orders signed. If the sampled resident does not have a physician identified Social Services will make arrangements for a treating physician. Until these arrangements can be made the Medical Director will provide medical supervision for the resident. At the time a referral is received and evaluated for admission, the Clinical Nurse Liaison will ensure that a physician has agreed to follow the resident at the facility prior to admission. All clinical records will be audited to ensure each resident has a primary physician. Social Services will secure a primary physician for the resident if one is not currently on record. The Medical Director will provide medical supervision on a short term interim basis until a primary physician is secured. The results of this audit will be reported to the QA Committee for review and further recommendation.	

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F 385	Continued From page 230 supervision and set up for locomotion on the unit and off the unit; was independent in personal hygiene, ambulating in room and in hallway and eating. Care Area Assessment (CAA's) dated 8/9/13 triggered for activities of daily living (ADLs), urinary incontinence, psychosocial well-being, activities, dental care and pain. The resident had three face sheets in the chart, the first identified a short-term family medicine provider in Brooklyn Park, the second has the prior medical director hand written in as primary (MD-A), and the third identified the current medical director (MD-B) An admission progress note from the physician dated 8/2/13, the chart was reviewed. The last facility physician progress note was dated 8/11/13, by MD-A. The medical record lacked a comprehensive physician review since 8/11/13. R103 physician went as follows: - had follow-up urology visits outside the facility on 8/8/13, 8/9/13, and 9/23/13. - had follow-up orthopedic visits outside the facility on 8/8/13, 9/19/13, 10/15/13, 12/5/13, and 1/15/14. The current Physician Orders were requested before exit and facility faxed the Physician Orders on 3/26/14. The Physician's Orders were undated and unsigned. Even though the hospital discharged R103 to the facility with discharge orders from hospital physician and R103 was seen by a consult physician for the first 90 days, the medical record lacked evidence R103 had a physician that supervised the total medical care since	F 385	Quarterly, a random number of clinical records will be audited X4 to ensure there is a primary physician for each audited residents. The results of this audit are reported to the QA Committee for further review and recommendation as indicated. Responsible: Administrator, DON, RCM, Social Services, ward secretary Compliance date: 4/28/2014	

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F 385	Continued From page 231 admission. R115 was admitted to the facility on 1/3/14, with diagnoses of injuries and fractures related to a MVA and underlying schizophrenia per the Admission Record. The face sheet identified a primary care physician who was actually a hospitalist at Hennepin County Medical Center (HCMC). The admission MDS was dated 1/15/14, and indicated a BIMS score of 15/15 indicating R115 was cognitively intact. A PHQ9 score of 3 indicating minimal depression. R115 received two person physical assist for transfers and toileting; physical assist of one person for bed mobility, dressing, and personal hygiene. The CAA's triggered for activities of daily living, urinary incontinence, falls, nutritional status, pressure ulcer, psychotropic medications, and pain. The Camden Care Center admission orders were unsigned and undated. The Physician's order Sheet printed 1/20/14, was not signed or dated by a facility physician. The Physician's orders were reviewed from 1/3/14, forward and did not indicated the physician reviewed the admission orders as the medical record lacked a telephone order or hand written orders upon admission. R115 had follow-up orthopedic visits outside the facility on 2/5/14 and 3/7/14. On 1/3/14 the medical record noted a hand written Physician Order for Zyprexa (an antipsychotic medication), Thiamine, and Folic Acid (supplements). The medical record lacked total supervision of care after R115 was admitted.	F 385		

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F 385	Continued From page 232	F 385		

R33 was admitted to the facility on 8/22/13, with diagnoses of Diabetes, hypertension, chronic kidney disease, chronic pulmonary embolism, vitamin B12 deficiency, Bipolar disorder, and depression per the Admission Record.

The MDS dated 9/11/13, revealed a BIMS score of 15/15 indicated R33 was cognitively intact. A PHQ9 score of 6, indicating mild depression. R33 received assistance of two person for transfers and toileting; extensive physical assist of one person for bed mobility, dressing, and personal hygiene. The CAA's triggered for activities of daily living, urinary incontinence, falls, dental status nutritional status, pressure ulcer, psychotropic medications, and pain.

Two face sheets were in the chart, the first identified MD-A, the second MD-B as primary care physician.

An admission progress note dated 9/19/13 indicated the medical record was reviewed. The last facility physician progress note was dated 9/19/13, by MD-A. The medical record lacked a comprehensive physician review since 9/19/13.

R33 outside physician visits went as follows:
- had follow-up orthopedic visits outside the facility on 12/13/13, and 1/17/14 for a "tear of left quadriceps tendon" due chronic rupture of left quadriceps tendon. Surgery was to be scheduled.

The current Physician Orders were requested before exit and facility faxed the Physician Orders on 3/26/14. The Physician's Orders were undated and unsigned.

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F 385	Continued From page 233	F 385		

Even though the hospital discharged R33 to the facility with discharge orders from hospital physician, the medical record lacked evidence R33 had a physician that supervised the total medical care since admission.

R71 was admitted to the facility 5/17/10, with diagnoses of hemiplegia related to stroke, hypertension, (high blood pressure), diabetes, depression, and chronic pain syndrome per the Admission Record.

The quarterly MDS dated 2/10/14, revealed a BIMS score of 15/15 indicated R71 was cognitively intact. A PHQ9 score of 8, indicating mild depression. R71 received two person physical assist for bed mobility and transfers; extensive physical assist of one person for and toileting, dressing, and personal hygiene. CAA's were not available.

An admission progress note dated 11/8/13, indicated the medical record was reviewed by MD-A. The medical record lacked a comprehensive physician review since 11/8/13.

R71's medical record lacked any referrals to the outside for consult or for a primary physician visit.

The current Physician Orders were requested before exit and facility faxed the Physician Orders on 3/26/14. The Physician's Orders were undated and unsigned.

Even though the hospital discharged R71 to the facility with discharge orders from hospital physician, the medical record lacked evidence R71 had a physician that supervised the total

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F 385	Continued From page 234 medical care since admission. On 3/13/14, at 12:20 p.m. the medical record coordinator (HIM) stated "MD-A, gave notice in November [2013], and left in January [2014], and several patients were reassigned to MD-C who will only take residents 65 and older. For those residents under 65. I attempted to re-assign them to doctors, and send them out to doctors, but they won't leave the building for appointments. (Before MD-A left, I was told we were getting a new doctor, but the prior director of nursing (DON) told me it was a new medical director who was going to take the case load. One week before MD-A left, the prior director of nursing (DON) told me the new medical director was not going to see patients. When residents come to the building without a doctor, they default to the medical directors list (to be seen). Finally, we were able to get the medical director to see some people." On 3/13/14, at 3:45 p.m. the DON was aware that physician visits were behind, and they had been trying to catch up, but MD-B was on vacation. On 3/14/14, at 2:00 p.m. during an interview with facility owner, the facility owner/governing board stated, "I am becoming aware of things, to be fully honest, why don't I pull in the chief operating officer" (the COO was conferenced (by phone) into the conversation). When informed of the conversation with the medical director (MD) and the MD-B's understanding that they would not be seeing patients in the facility." The COO stated "that is not what I have with any other facilities; it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. The facility has also to find another medical director or	F 385		

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F 385	Continued From page 235 a backup medical director to get the work done." The facility owner stated "My understanding was as late as last week that she was going to, in the interim cover us." On 3/14/14, at 2:45 p.m. the medical director was interviewed. The medical director was not aware she was expected to be the physician of record for the undoctored residents, on top of her other full time job. She was now seeing residents in the facility, until they could get some help, but had just returned from vacation. The signed but undated medical director contract identified Background: B. The facility requires the services of a medical director (the "Medical Director") to assist the facility in meeting the applicable standards established under state and federal law. D. The facility wishes to engage MD-B, to provide physical-related consulting services (the Consulting Services"), and to obtain the personal services Phrygian to fill the position of medical Director in the facility. The signed but undated medical director contract listed the medical director duties as: a. Help promote appropriate attitudes. Objective: To foster attitudes among physicians and other staff at the facility and care processes that will help the facility meet its essential care objectives.	F 385		
F 386 SS=E	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c)	F 386		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 386	Continued From page 236 of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents care was fully reviewed for 4 of 5 residents out of 16 residents (R103, R33, R71, R82) who had both medical directors (MD)-A and MD-B for their physician. Findings include: R103 was admitted to the facility 7/29/13, discharged to the hospital on 1/2/14, and re-admitted on 1/3/14, with diagnoses related to injuries from a motor vehicle accident (MVA), lung contusion (a bruise of the lung tissue from impact), open fractures of left femur (hip bone) (a fractured bone that protrudes through the skin), right femur, left tibia (leg bone), right tibia, right forearm. The quarterly Minimum Data Set (MDS) dated 1/16/14, revealed a Brief Interview of Mental Status (BIMS) score of 15/15 indicated R103 was cognitively intact. A Patient Depression Questionnaire (PHQ9) score of 7, indicating mild depression, R103 required supervision and physical assist of one for bed mobility and transfers, dressing and toilet use; required supervision and set up for locomotion on the unit and off the unit; was independent in personal hygiene, ambulating in room and in hallway and	F 386	F 386 For sampled residents R33, 82, 71, 103 and for all residents at the facility, the facility shall ensure physicians will review the medical and treatment plan/orders with each visit. Medical visits shall occur once every 30 days for the first 90 days after admission and then every 60 days thereafter. The clinical record of R33, 82, 71, and 103 will be reviewed. The primary physician will be identified and appropriate arrangements will be made for physician visit to have the medical/treatment plan thoroughly reviewed and all orders signed. A tracking system for physician/physician extender visits will be developed and maintained by the DON/RCM in concert with the ward secretary. Physicians will be contacted if they are not keeping to the federal requirement. The medical director will be advised of all overdue physician visits for peer to peer contact.	

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F 386	Continued From page 237 eating. Care Area Assessment (CAA's) dated 8/9/13, triggered for activities of daily living (ADLs), urinary incontinence, psychosocial wellbeing, activities, dental care and pain. The resident had three face sheets in the chart, the first identified a short-term family medicine provider in Brooklyn Park, the second has the prior medical director hand written in as primary (MD-A), and the third identified the current medical director (MD-B). R103 currently had a physician identified on the medical record as MD-B who took over on 1/1/14. The medical record contained a physician progress note dated 8/11/13, by MD-A. R103 had follow-up urology visits outside the facility on 8/8/13, 8/9/13, and 9/23/13. R103 had follow-up orthopedic visits outside the facility on 8/8/13, 9/19/13, 10/15/13, 12/5/13, and 1/15/14. The medical record lacked evidence of MD-B ever reviewing R103's total program of care, including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R103. The chart lacked evidence of a comprehensive physician review since 8/11/13. R33 was admitted to the facility on 8/22/13, with diagnoses of diabetes, hypertension, chronic kidney disease, chronic pulmonary embolism, vitamin B12 deficiency, Bipolar disorder, and depression.	F 386	This tracking system will also ensure that documentation of physician visit/evaluation is received by the facility and maintained in the clinical record. This includes securing copies of progress notes/visit notes from out of facility appointments. The DON/RCM in concert with ward secretary will ensure this documentation is secured. Finally, this tracking system will ensure that medical/treatment orders/regimen is reviewed and signed by the physician along with other physician orders. On a case by case basis the medical director will evaluate a resident who does not have a primary physician while the facility arranges for a primary physician. Social Services will be actively involved in securing a treating physician. If a resident refuses medical appointment the medical director will be consulted to talk with the resident regarding the risks of refusing medical treatment. Such intervention will be thoroughly documented in the clinical record. The tracking system and the record of physician visits will be reported to the QA Committee for review and further recommendation. This is an ongoing process.	

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F 386	Continued From page 238 The MDS dated 9/11/13, revealed a BIMS score of 15/15 indicated R33 was cognitively intact. A PHQ9 score of 6, indicating mild depression. R33 received extensive assistance of two person physical assist for transfers and toileting; extensive physical assist of one person for bed mobility, dressing, and personal hygiene. The CAA's triggered for activities of daily living, urinary incontinence, falls, dental status nutritional status, pressure ulcer, psychotropic medications, and pain. Two face sheets were in the chart, the first one identified MD-A, the second one MD-B as primary care physician. A last physician's progress note was dated 9/19/13. R33 currently had a physician identified on the medical record as MD-B who took over on 1/1/14. The medical record lacked evidence of MD-B ever reviewing R33's total program of care, including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R33. The chart lacked evidence of a comprehensive physician review since 9/19/13. R71 was admitted to the facility 5/17/10, with diagnoses of hemiplegia related to stroke, hypertension, (high blood pressure), diabetes, depression, and chronic pain syndrome per the Admission Face Sheet.	F 386	The Business Office Manager shall audit each active clinical record to ensure the face sheet is current and accurate regarding the payer source and that the primary physician entered on the face sheet is correct. This audit will be reported to the QA Committee for review and further recommendation. The DON/RCM will be accountable to notify the BOM of any change in physician so the face sheet can be updated and a current one placed in the clinical record. The DON/RCM/Social Service will randomly audit the face sheets of clinical records to ensure they accurately reflect the current primary physician and the payer source. This audit will be done for 6 months. This audit will be reported to the QA committee for review and further recommendation as indicated. Responsible: Administrator, DON, RCM, Social Services, ward secretary Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 386	Continued From page 239 The quarterly MDS dated 2/10/14, revealed a BIMS score of 15/15 indicated R71 was cognitively intact. A PHQ9 score of 8, indicating mild depression. R71 received extensive assistance of two person physical assist for bed mobility and transfers; extensive physical assist of one person for and toileting, dressing, and personal hygiene. CAA's were requested on 3/14/14, at 10:00 a.m. and not provided. Two face sheets were in the chart, the first one identified MD-A, the second one MD-B as primary care physician. A last physician's progress note was dated 11/8/13. R71 currently had a physician identified on the medical record as MD-B who took over on 1/1/14. The medical record lacked evidence of MD-B ever reviewing R71's total program of care, including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R71. The chart lacked evidence of a comprehensive physician review since 11/8/13. R82 was admitted to the facility on 11/8/13, with admission diagnoses of cardiovascular disease with native graft (heart bypass), chest pain, high blood pressure, abnormality of gait, and asthma per the Admission Face Sheet. The MDS dated 11/20/13, revealed a BIMS score of 15/15 indicated R82 was cognitively intact. A PHQ9 score of 3, indicating minimal depression.	F 386		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 386	Continued From page 240 R82 required limited assistance of one person physical assist for transfers and toileting, bed mobility, dressing, and personal hygiene. The CAA's triggered for vision, communication, activities of daily living, urinary incontinence, falls, dental status, nutritional status, and pressure ulcer. The medical record lacked evidence of MD-B ever reviewing R82's total program of care, including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R82. The chart lacked evidence of a comprehensive physician review since 11/26/13. On 3/13/14, at 12:20 p.m. the medical record coordinator (HIM) stated MD-A, gave notice in November, and left in January, and several patients were reassigned to MD-C who will only take residents 65 and older. "For those residents under 65 I attempted to re-assign them to doctors, and send them out to doctors, but they won't leave the building for appointments. (before MD-A left, I was told we were getting a new doctor, but the prior director of nursing (DON) told me it was a new medical director who was going to take the case load. One week before MD-A left, the prior director of nursing (DON) told me the new medical director was not going to see patients. When residents come to the building without a doctor, they default to the medical directors list (to be seen). Finally, we were able to get the medical director to see some people."	F 386		

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F 386	Continued From page 241 On 3/13/14, at 3:45 p.m. The DON was aware that physician visits were behind, and they had been trying to catch up, but MD-B was on vacation. On 3/14/14, at 2:00 p.m. during an interview with facility owner, the facility owner/governing board stated, "I am becoming aware of things, to be fully honest, why don't I pull in the chief operating officer" (the COO was conferenced (by phone) into the conversation). When informed of the conversation with the medical director (MD) and the MD-B's understanding that they would not be seeing patients in the facility. The COO stated "that is not what I have with any other facilities, it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. the facility has also to find another medical director or a back up medical director to get the work done." The facility owner stated "My understanding was as late as last week that she was going to, in the interim cover us." On 3/14/14, at 2:45 p.m. the MD-B was interviewed. The medical director was not aware she was expected to be the physician of record for the undoctored residents, on top of her other full time job. She was now seeing residents in the facility, until they could get some help, but had just returned from vacation. The signed but undated medical director contract identified Background: B. The facility requires the services of a medical director (the "Medical Director") to assist the facility in meeting the applicable standards established under state and federal law.	F 386		

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F 386	Continued From page 242 D. The facility wishes to engage MD-B, to provide physical-related consulting services (the Consulting Services"), and to obtain the personal services Phrygian to fill the position of medical Director in the facility. The signed but undated medical director contract listed the medical director duties as: a. Help promote appropriate attitudes. Objective: To foster attitudes among physicians and other staff at the facility and care processes that will help the facility meet its essential care objectives.	F 386		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure physician visits were provided as required for 3 of 6 out of 16 residents (R11, R33, R82) in the sample reviewed for physician's visits. Findings include: R11 was not provided physician's visits as required, including a visit from the medical director, after R11 was identified to refuse	F 387	F 387 Sampled resident R11 is no longer in the building. For sampled residents R33, 82 and for all residents at the facility, the facility shall ensure physician visits occur once every 30 days for the first 90 days after admission and then every 60 days thereafter. The clinical record of R33, and 82 will be reviewed. The primary physician will be identified and appropriate arrangements will be made for physician visit.	

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F 387	Continued From page 243 physician visits. The Admission Record indicated R11 was admitted to the facility on 12/31/13. R11's Medicine Admission History and Physical dated 12/31/13, indicated when R11 was seen by a physician. The clinical record lacked evidence R11 was evaluated/assessed by a nurse practitioner or physician within the required time frames since admission to the facility on 12/31/13. Review of the IDT Progress Notes from 12/31/13, through 3/17/13, indicated on 2/25/14, at 3:17 p.m. a note from medical records indicated, "[R11] has refused all medical appt [appointments] since admit to include cardiology on 1-19-14. He has refused all offers of appts at the Indian Health Board for Primary care follow up. D.O.N. (director of nursing), clinical care manager and Admin [administrator] updated. Plan is for pt [patient] to be seen by the Medical Director." On 3/13/14, at 2:37 p.m. a facility staff member (O)-E verified there were no physician ' s visits for R11 in the clinical record. O-E stated R11 refused referrals to "Indian services," cardiology and the medical director. The clinical record lacked evidence the medical director attempted to evaluate or assess R11. The clinical record lacked evidence DON, administrator or medical director were notified R11 had not been seen a physician or nurse practitioner after admission. On 3/14/14, at 10:41 a.m. social service	F 387	A tracking system for physician/physician extender visits will be developed and maintained by the DON/RCM in concert with the ward secretary. Physicians will be contacted if they are not keeping to the federal requirement. The medical director will be advised of all overdue physician visits for peer to peer contact. This tracking system will also ensure that documentation of physician visit/evaluation is received by the facility and maintained in the clinical record. This includes securing copies of progress notes/visit notes from out of facility appointments. The DON/RCM in concert with ward secretary will ensure this documentation is secured. On a case by case basis the medical director will evaluate a resident who does not have a primary physician while the facility arranges for a primary physician. If a resident refuses medical appointment the medical director will be consulted to talk with the resident regarding the risks of refusing medical treatment. Such intervention will be thoroughly documented in the clinical record. The tracking system and the record of physician visits will be reported to the QA Committee for	

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F 387	Continued From page 244 designee, (SSD) stated she was unaware of R11's refusals, including refusals to see a physician. On 3/14/14, at 2:45 p.m. the medical director was interviewed. The medical director was not aware she was expected to be the physician of record for the undoctored residents, on top of her other full time job. She was now seeing residents in the facility, until they could get some help, but had just returned from vacation. On 3/18/14, at approximately 2:05 p.m. the director of nursing (DON) verified the clinical record lacked evidence R11 had seen a physician. DON verified the medical director should have attempted a physician's visit with R11. R33 was admitted to the facility on 8/22/13, with diagnoses of diabetes, hypertension, chronic kidney disease, chronic pulmonary embolism, vitamin B12 deficiency, Bipolar disorder, and depression. The MDS dated 9/11/13, revealed a BIMS score of 15/15 indicated R33 was cognitively intact. A PHQ9 score of 6, indicating mild depression. R33 received extensive assistance of two person physical assist for transfers and toileting; extensive physical assist of one person for bed mobility, dressing, and personal hygiene. The CAA's triggered for activities of daily living, urinary incontinence, falls, dental status nutritional status, pressure ulcer, psychotropic medications, and pain. Two face sheets were in the chart, the first one	F 387	review and further recommendation. This is an ongoing process. Responsible: Administrator, DON, RCM, ward secretary Compliance date: 4/28/2014	

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F 387	Continued From page 245 identified MD-A, the second one MD-B as primary care physician. A last physician's progress note was dated 9/19/13. R33 currently had a physician identified on the medical record as MD-B who took over on 1/1/14. The medical record lacked evidence of MD-B ever reviewing R33's total program of care, including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R33. The chart lacked evidence of a comprehensive physician every 30 days for the first 90 days after admission 9/19/13. R82 was admitted to the facility on 11/8/13, with admission diagnoses of cardiovascular disease with native graft (heart bypass), chest pain, high blood pressure, abnormality of gait, and asthma per the Admission Face Sheet. The MDS dated 11/20/13, revealed a BIMS score of 15/15 indicated R82 was cognitively intact. A PHQ9 score of 3, indicating minimal depression. R82 required limited assistance of one person physical assist for transfers and toileting, bed mobility, dressing, and personal hygiene. The CAA's triggered for vision, communication, activities of daily living, urinary incontinence, falls, dental status, nutritional status, and pressure ulcer. The medical record lacked evidence of MD-B ever reviewing R82's total program of care,	F 387		

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F 387	Continued From page 246	F 387		

including medications and treatments which would have evaluated the resident's condition and a review of and decision about the continued appropriateness of the resident's current medical regime. The medical record also lacked any evidence a written, signed, and dated progress note which indicated MD-B ever saw R82. The chart lacked evidence of a comprehensive physician every 30 days for the first 90 days after admission 11/26/13.

On 3/13/14, at 12:20 p.m. the medical record coordinator (HIM) stated MD-A, gave notice in November, and left in January, and several patients were reassigned to MD-C who will only take residents 65 and older. "For those residents under 65 I attempted to re-assign them to doctors, and send them out to doctors, but they won't leave the building for appointments. (before MD-A left, I was told we were getting a new doctor, but the prior DON told me it was a new medical director who was going to take the case load. One week before MD-A left, the prior DON told me the new medical director was not going to see patients. When residents come to the building without a doctor, they default to the medical directors list (to be seen). Finally, we were able to get the medical director to see some people."

On 3/13/14, at 3:45 p.m. The DON was aware that physician visits were behind, and they had been trying to catch up, but MD-B was on vacation.

On 3/14/14, at 2:00 p.m. during an interview with facility owner, the facility owner/governing board stated, "I am becoming aware of things, to be fully honest, why don't I pull in the chief operating

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F 387	Continued From page 247 officer" (the COO was conferenced (by phone) into the conversation). When informed of the conversation with the medical director (MD) and the MD-B's understanding that they would not be seeing patients in the facility. The COO stated "that is not what I have with any other facilities, it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. the facility has also to find another medical director or a back up medical director to get the work done." The facility owner stated "My understanding was as late as last week that she was going to, in the interim cover us." On 3/14/14, at 2:45 p.m. the MD-B was interviewed. The medical director was not aware she was expected to be the physician of record for the undoctored residents, on top of her other full time job. She was now seeing residents in the facility, until they could get some help, but had just returned from vacation. The signed but undated medical director contract identified Background: B. The facility requires the services of a medical director (the "Medical Director") to assist the facility in meeting the applicable standards established under state and federal law. D. The facility wishes to engage MD-B, to provide physical-related consulting services (the Consulting Services"), and to obtain the personal services Phrygian to fill the position of medical Director in the facility. The signed but undated medical director contract listed the medical director duties as: a. Help promote appropriate attitudes. Objective: To foster attitudes among	F 387		

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F 387	Continued From page 248 physicians and other staff at the facility and care processes that will help the facility meet its essential care objectives.	F 387		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R36) received assistance to obtain his dentures or coordinate dental care services to get new dentures when his dentures were missing in the sample reviewed for dental status. Findings include: R36 was observed during the survey conducted on the following dates and times, not wearing dentures: - On 3/10/14, from 11:30 a.m. until approximately 8:30 p.m., - On 3/11/14, from 8:00 a.m. until 5:00 p.m.; - On 3/12/14, from 6:45 a.m. until 5:30 p.m.; - On 3/13/14, from 6:45 a.m. until 4:00 p.m.; - On 3/14/14, from 7:00 a.m. to 5:15 p.m.	F 412	F 412 For sampled resident R36 and for all residents at the facility, the facility shall ensure the resident has access to dental services either in the facility or from the community. Additionally, the facility shall ensure the residents have access to other services such as podiatry, optometry, audiology, etc. The facility has a policy titled, "Medical Services" that was effective 05/2012 and reviewed 05/2013. This policy is found in both the clinical manual and the social services manual. This policy will be made fully operational. The facility is contracted with a dentist who comes to the facility to provide for the dental needs of the resident. These visits are on a monthly basis. For sampled resident R36, social service and nursing will coordinate getting him fitted for dentures. Additionally, social services and nursing will coordinate getting his hearing checked and getting a hearing aide if indicated.	

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F 412	Continued From page 249 When asked on 3/11/14, at 11:11 a.m. if he had tooth problems, gum problems, mouth sores, or denture problems R36 stated, "I have missing teeth, they are in storage and the guardian won't get them." The Oral Health Plan & Consent Form dated 5/31/12, indicated both R36 and his guarantor had signed the form authorizing Apple Tree to provide routine care including comprehensive and periodic oral evaluations. The Minimum Data Set (MDS) 3.0 Oral/Dental Assessment Form dated 6/11/12, indicated R36 had no natural teeth or tooth fragment(s) (edentulous); maintained oral care independently and R36 had reported he had dentures at home not at the facility. Dental Progress notes dated 10/9/12, noted R36 had refused to be seen as he did not have his dentures with him and wanted to be rescheduled for next time when he had his dentures with him. Dental Progress notes dated 10/23/12, indicated R36 did not want to be seen as he did not have his dentures with him and did not want the dentist to look at his gums. The dental care plan dated 6/14/13, identified R36 had oral/dental health problems (edentulous) related to natural teeth missing. The care plan directed "Conduct oral assessment/evaluation per facility protocol; Coordinate arrangements for dental care, transportation as needed/as ordered and provide mouth care ..." The Camden Care Center Quarterly Care	F 412	These activities will be clearly documented in the clinical record including any and all communications with the guardian. Resident Care Managers will audit the clinical record of R36 monthly X6 months to ensure dental issues are addressed timely. This audit will also ensure the clinical record is accurately documented related to efforts and interventions related to dental services and audiology. These audits will be reviewed by the facility administrator. Additionally the audits will be reported to the QA committee for review and further recommendation as indicated. Resident Care Managers and social services shall randomly audit resident clinical records monthly X6 related to dental services and audiology services. These audits will ensure the clinical record is accurately documented related to efforts and interventions related to dental and audiology services. These audits will be reported to the QA committee for review and further recommendation as indicated. Responsible: Administrator, RCM, Social Services Compliance date: 4/28/2014	

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F 412	Continued From page 250 Conference summary dated 9/17/13, written by nutrition & culinary indicated R36 had upper and lower dentures but stated that they were at home and had reported he was able to chew adequately without dentures and did not want a mechanically textured diet. R36's quarterly MDS dated 2/18/14, indicated R36's Brief Interview for Mental Status (BIMS) score of 13 out of 15 which noted R36 was cognitively intact. The MDS also indicated R36 received limited assistance of one person with hygiene which included brushing teeth. In addition the MDS was void of any oral concerns. The Care Conference Summary dietary assessment dated 3/4/14, noted had no teeth or dentures and is able to chew adequately without his teeth and noted weight as stable. Review of the Progress notes lacked evidence the facility had made attempts to see if the guardian would be able to bring R36's old dentures that he was referring to or schedule an appointment to have R36 fitted new dentures as requested. When interviewed on 3/14/14, at 10:56 a.m. regarding oral hygiene for R36 nursing assistant (NA)-B stated R36 was independent with oral care. When interviewed on 3/14/14, at 11:02 a.m. medical records (HIM) stated she was not aware of R36 needing his dentures and only filed the dental forms. When interviewed on 3/14/14, at 11:05 a.m. in relation to the dentures licensed practical nurse	F 412		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 412	Continued From page 251 (LPN)-A who also was the manager stated she was not aware of dental notes from previous visits on R36 refusing dental visits because he did not have his dentures at the facility and verified nobody had attempted to get R36's dentures for him. When interviewed on 3/14/14, at 11:13 a.m. registered nurse (RN)-C who also completed the MDS assessments stated she was not aware of missing dentures and verified the MDS dated 2/18/14, as void of any dental concerns and the annual MDS dated 5/29/13, in addition had indicated R36 had "No natural teeth of tooth fragments(s)..." On 3/14/14 11:17 a.m. R36 reported he had asked for both his dentures and hearing aids a while ago and would like new ones if his old ones could not be found. On 3/14/14, at 12:14 a.m. during a phone interview R36's guarantor indicated R36 did not have dentures and the facility had not asked him to inquire if he was able to locate his old dentures or get fitted new ones. The most recent Care Area Assessment (CAA) was requested but was not provided on 3/18/14, at 10:15 a.m. and the policy for dental was requested but was never provided.	F 412		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit	F 425	F 425 For sampled resident R41 and for all residents at the facility, the facility shall ensure medication ordered by the physician is available in the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 425	Continued From page 252 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. 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. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 1 of 3 residents (R41) reviewed for availability of pain medications had scheduled pain medications available to be administered. Findings include: R41's supply of scheduled pain medication was available at the facility. The current Physician Orders, dated 2/4/14, directed staff to administer "Morphine Sulfate ER Tablet Extended Release 30MG [milligrams] Give 30MG orally at bedtime for pain give at HS only" The narcotic administration record for February and March 2014 indicated no morphine administered on 3/5, 3/6, 3/7, 3/8, 3/9, and 3/10.	F 425	The medication regimen for R41 will be reviewed to ensure all ordered medications are available on the medication cart. Staff will be educated about the process for re-ordering medications and the timeliness and frequency of that ordering and the special timing that is required when reordering narcotics. The medication regimens of all residents will be reviewed related to the medications ordered and their availability for administration. Medications will be reordered as necessary. Medication administration records will be audited monthly to ensure medications are delivered as prescribed and are available in the facility as ordered X6. The results of this audit will be presented to the DON for review and immediate action if necessary. Additionally, the results of this audit will be reported to the QA committee for further review and recommendation as indicated. Responsible: Administrator, DON, RCM, licensed staff, clinical staff Compliance date: 4/28/2014	

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F 425	Continued From page 253 The March 2014 medication administration notes indicated medications were not available on 3/5, 3/6, 3/8, 3/9, and 3/10. On 3/14/14, at 8:15 a.m. R41 would have preferred to receive his scheduled morphine every night. R41 reported "It took them more than a few days to get the meds. It took a few days for them to take action on it. I got the lady at the desk to order some new ones. They had to have the house doctor prescribe a new order for morphine." On 3/13/14, at 8:50 a.m. R41 reported he had not received his scheduled morphine for about a week recently. R41 reported his pain increased from not receiving his scheduled dose of morphine. On 3/14/14, at 10:00 a.m. the medical records staff (MR) reported R41 reported he was out of morphine so she wrote out the form for the medical director to sign. MR reported the process was for TMAs or nurses to order refills from pharmacy. The pharmacy sends back a form for the prescriber to fill out and renew the refill order for controlled substances. When MR received the fax she gave it to the nurse. MR reported "the process does not work" and further added "this is inexcusable" yet "happens all the time". MR reported the facility should be reordering medications earlier. On 3/13/14, at noon, the narcotic administration record and medication administration record with trained medication aide (TMA)-A. TMA-A confirmed the narcotic administration record for February and March 2014 indicated no morphine administered on 3/5, 3/6, 3/7, 3/8, 3/9, and 3/10.	F 425		

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F 425	Continued From page 254 On 3/14/14, at 11:42 a.m. the licensed practical nurse, (LPN)-D, confirmed R41 did not have morphine available from 3/5/14 through 3/10/14. On 3/14/14, at 11:42 a.m. the director of nursing (DON) reported R41's scheduled medications should have been available to him as prescribed. R41 not having medications from 3/5/14 through 3/10/14, did not meet her expectations. The Videll Healthcare LLC Pain Management Policy, last reviewed 1/2013, directed staff: "The goal of any pain management process is to maintain function and improve quality of life. The goal of the interdisciplinary team is to promptly identify pain and develop an effective management program." "8. A comprehensive care plan is developed by the interdisciplinary team that addresses pain and an individualized pain management program based on individualized assessed need. a. The pain management program may address the following: i. Scheduled use of pain medication"	F 425		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428	F 428 For sampled residents R9, 89, 91, and 1 and for all residents at the facility, the facility shall ensure that pharmacy recommendations are reviewed by the primary physician. The primary physician will choose what action, if any, is taken related to the consulting pharmacist's recommendation.	

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F 428	Continued From page 255 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R9, R89, R91, R1) pharmacy recommendations were acted upon. Findings include: R9: The Medication Administration Record (MAR) dated 3/1/14 through 3/31/14, indicated R9 received Haldol (an anti-psychotropic medication) 8.5 milligrams (mg) every bedtime, Haldol 150mg every month, and Trazodone (an anti-depressant) 250 mg every bedtime. The Admission Record dated 2/25/14, indicated R9 was admitted 10/4/11, with diagnoses including schizophrenia, orofacial dyskinesia, unspecified sleep disturbance, unspecified psychosis and bipolar disorder. A Note To Attending Physician/Prescriber dated 9/26/13, noted a gradual dose reduction (GDR) should be attempted yearly unless clinically contraindicated and noted the last dose reduction of Haldol was completed 6/2012. The physician response dated 10/22, stated "Pt. [patient] being followed by psychiatry please forward to psychiatry." No additional follow-up was noted in the medical record. The medical record was reviewed and no psychiatry note was found. Psychiatry notes were requested and were not provided. Upon interview on 3/14/14, at 7:25 a.m. medical	F 428	For sampled residents R9, 89, 91, and 1 the facility will ensure that pharmacy recommendations have been reviewed by the primary physician or the most appropriate specialty. The facility Administrator and/or DON shall ensure that at the conclusion of each consulting pharmacy visit, the consulting pharmacist holds an exit conference with the facility. Copies of the consulting pharmacist recommendations are secured during this exit conference. The DON will review the consulting pharmacists recommendations ensure the RCMs receive the recommendations from the consulting pharmacist for their individual resident case load. The RCMs review the consulting pharmacist's recommendations to ensure known or suspected variances, issues, discrepancies are addressed by the pharmacist. The RCMs will ensure the consulting pharmacy recommendations are reviewed by the physician. The RCM will follow up on any action taken by the primary physician.	

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F 428	Continued From page 256 records stated R9 had not had a psychiatry visit in the last six months. When interviewed on 3/14/14, at 7:45 a.m. licensed practical nurse (LPN)-A stated she was not aware of any GDRs for R9 and was not aware of any follow-up on the GDR request written by the pharmacy consultant on 9/26/13. LPN-A stated she expected the request to be sent back to the primary physician as psychiatry was not involved in the care of R9. On 3/14/14, at 7:53 a.m. the director of nursing (DON) was interviewed and stated pharmacy recommendations should be followed up on as soon as possible and not more than a month. The DON stated she expected pharmacy recommendations would be referred back to the physician or the medical director if needed for follow-up. R89 lacked target behavior monitoring for the use Zyprexa (an anti-psychotropic medication) and the pharmacist did not identify the irregularity. R89's admission Minimum Data Set (MDS) dated 12/28/13, indicated R89 was never or rarely understood had short and long-term memory problems and R89 had moderately impaired decision making ability. The MDS identified R89 had hallucinations, delusions, and other behaviors concerns towards others. The Care Area Assessment (CAA) for behaviors dated 1/3/14, indicated, "Resident exhibits behavioral symptoms and is cognitively not alert and orient [sic] when writer attempted to assess her. SS [social services] will care plan this matter accordingly." The CAA for psychotropic drug use	F 428	Consulting pharmacist's reviews and summary report of the consulting visits will be reviewed by the QA committee on a monthly basis. This is an ongoing process. Responsible: Administrator, DON, RCM, Social Services Compliance date: 4/28/2014	

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F 428	Continued From page 257 identified R89 used an antipsychotic and R89 had "hallucinations." Although the CAA identified the class of medication used and hallucinations, the CAA lacked identification of what the hallucinations were what antipsychotic was used, and what target behaviors would be monitored. The CAA indicated, "Nurses will continue to assess for effectiveness of meds [medications] and side effects." R89's care plan for psychotropic medications dated as revised on 1/5/14, identified R89 used Zyprexa related to "potential injury to self or others, dementia and agitation, pick [sic] disease." The care plan directed to administer the medication as ordered, monitor/document for side effects and effectiveness. The care plan directed to "discuss with MD [physician], family re [regarding] ongoing need for use of medication," directed to educate on risks and benefits of using Zyprexa, "Monitor/record occurrence of for target behavior such as agitation, inappropriate response to verbal communication, and document per facility protocol." The care plan lacked appropriate identification of a target behavior which warranted the use of an antipsychotic, such as hallucinations. Although the care plan directed to monitor for a target behavior, the care plan lacked indications for the ongoing use of Zyprexa. A Physician's Order dated 3/7/14, indicated Zyprexa was increased to 7.5 mg by mouth daily and directed to add the diagnosis of schizophrenia. Review of the clinical record, including interdisciplinary team (IDT) Progress Notes from admission to the time of survey indicated no	F 428		

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F 428	Continued From page 258	F 428		

behavioral concerns were documented, such as hallucinations, agitation symptoms or impulsivity. R89 had no IDT progress notes documented after 2/14/14. Although appropriate side effect monitoring was noted in the clinical record, such as labs and Abnormal Involuntary Movement Scale (AIMS) on 3/12/14, the clinical record lacked evidence of target behavior monitoring for the efficacy of Zyprexa.

On 3/13/14, at 2:24 p.m. the LPN-D verified there was no target behavior monitoring for Zyprexa and stated there "should be." LPN-D was unclear on what target behaviors to monitor for R89.

On 3/14/14, at 8:57 a.m. the DON verified the facility did not have psychiatric services and stated they "signed the contract yesterday." ACP (associate clinic of psychology) was unclear when they would be starting. DON verified target behaviors should be monitored for the use of Zyprexa.

On 3/14/14, at 9:27 a.m. LPN-A stated she was unclear why the Zyprexa was increased and unclear on the indications for the use of the medication. LPN-A verified the facility lacked a system to ensure target behavior monitoring was in place for antipsychotic medications.

On 3/14/14, at approximately 9:40 a.m. the geriatric nurse practitioner (GNP) stated she would expect the facility to monitor for efficacy of the medication and be looking for things like increased somnolence, decreased delusions. When asked if she directed the facility to monitor for behaviors or gave suggestions of target behaviors, GNP stated she did not direct monitoring for target behaviors because "they

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

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F 428	Continued From page 259 were usually identified on behavior sheets." On 3/14/14, at 10:51 a.m. when asked regarding determining behavior monitoring for resident, DON stated nursing staff along with the social worker would create a behavior plan for the resident. DON verified there was no behavior plan in place for R89. The Medication Regimen Review indicated the consultant pharmacist (CP) reviewed R89's medication regimen monthly. Reviews on 1/18/14, 2/5/14 and on 3/7/14 identified the use of Zyprexa, directed to complete an AIMS (Abnormal Involuntary Movement Scale, an assessment to determine side effects for antipsychotic medications). The recommendations did not identify the lack of target behavior monitoring. On 3/14/14, at 12:15 p.m. CP was contacted via telephone and stated she "did not have her files in front of her." CP stated if she asked for the AIMS, she "would have stopped digging," and further stated "because she would want that addressed [first]." CP stated she did not look for target behavior monitoring when she did her reviews and stated she would only look in the chart and ask the staff. On 3/14/14, at 12:31 p.m. DON verified CP should have evaluated target behavior monitoring and verified the facility should have developed target behavior monitoring. R91: The facility failed to provide consultant pharmacy services that identified lack of monitoring for target behaviors for R91 for anxiety medications.	F 428		

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F 428	Continued From page 260 The facility failed to identify consultant pharmacy services that identified a lack of a comprehensive assessment of behaviors and non pharmacological interventions related to depression and anxiety for R91, prescribed both anti-depressant and anti-anxiety medications. R91's care area assessments, dated 10/22/13, for Mood, Cognitive Loss/Dementia, Behavior, and Psychosocial Well Being included the same summary statement under the Care Plan Considerations section: "Resident has some behavior r/t [related] medical Dx [diagnosis]. Staff will monitor her behavior and ensure pt [patient] needs are met and she is safe." The assessment did not include a thorough analysis including: specific behaviors exhibited by R91 were to be monitored, causative factors and health diagnoses related to display of behaviors and what interventions have been most effective. R91's current care plan, last reviewed 1/30/14, did not include non-pharmacological interventions related to R91's behaviors related to mood or anxiety. The care plan did identify "Psychotropic drug use: resident uses anti-depression (Prozac) and antianxiety (Buspar) R/t [related to] Dx [diagnosis] of depressant and anxiety" with an intervention to "Observe change in behavior and memory." Review of Medication Administration Record For March 2014 revealed R91 was being administered Buspirone HCL (an anti-anxiety agent) 17.5 MG twice daily for "anxiety", Mirtazapine (an anti-depressant) 30 MG at night time for "depression" , Prozac (an anti-depressant) 30 MG every day for "depression", and Ativan (a benzodiazepines	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 261 anti-anxiety agent) 1 MG twice daily as needed for "agitation." R91 had used the as needed Ativan twelve times from 3/1/14 to 3/17/14. A review behavior intervention monthly flow record for February and March, February and January 2014 revealed behavior monitoring for sad facial expression and hours of sleep. A review of progress notes for January, February and March 2014 revealed no notes regarding behavior monitoring related to anxiety or depression. On 3/14/14 at 2:14 p.m. the social service designee (SSD) reported the care area assessments for R91 were completed prior to her employment at the facility. SSD reported the care area assessments were not comprehensive, did not identify what behaviors were occurring. SSD confirmed R91's care plan did not address her mood or anxiety issues. On 3/17/14 at 11:37 a.m. LPN-D reported the facility had not been monitoring for behaviors related to the use of buspirone. She said she would check how the facility was monitoring behaviors related to the use of as needed Ativan. No further information was provided. The pharmacy Medication Regimen Review for October, November, December, January, February and March 2014 were reviewed. No suggestion including behavior monitoring, assessment or non-pharmacological interventions were included. On 3/17/14 at 1:11 p.m. the consultant pharmacist [CP] reported she would expect indications for use to be monitored for all	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 262 medications. CP reported she felt uncomfortable commenting on R91's medication regimen as she did not have access to her medical record during interview. CP was offered, but declined an opportunity to contact surveyor later with more information or provide further documentation. R1's potential side effects, sleep pattern and mood monitoring irregularities had not been identified by the consultant pharmacist. R1 was observed on 3/12/14, and 3/13/14, outside in the front designated smoking area sitting on a motorized wheelchair (w/c) smoking and dozing off with her head and chin drooping jerking up and down. During observation R1 appeared to be struggling to keep her eyes open. On 3/12/14, at 1:03 p.m. surveyor observed R1 sitting on her bed stated she was tired "All the time" and had told the facility staff but thought it was related to her "Hepatitis-C" which she was waiting for a particular medicine. R1 verified she had burn holes on her clothing stating from her cigarette "The ashes flicking off." R1 further stated she had never had a burn from the smoking but acknowledged she had neuropathy and being tired was just not working with her smoking at times. R1's diagnoses included Insomnia, chronic pain, arthritis, osteoporosis, depression and diabetes mellitus obtained from the MDS dated 12/6/13. Physician's Orders dated 2/26/14, indicated R1 received the following medications: -Trazodone 300 mg by mouth at bedtime (HS) for insomnia -Venlafaxine (Effexor) 150 mg by mouth daily for	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 263 depression -Zolpidem (Ambien) 5 mg by mouth at HS as needed (PRN) for insomnia Review of the Monthly Regimen Review dated 12/11/13, through 3/7/14 indicated "NO New Suggestions" and lacked evidence that the consultant pharmacist had identified the irregularities. When interviewed on 3/13/14, at 9:44 a.m. the LPN-D stated if a resident was on sleep aides and an antidepressant behavior or mood monitoring was supposed to be documented in the "Red book." LPN-D went over the "Red book" and the medical record verified documentation was lacking. When interviewed on 3/13/14, at 10:23 a.m. SSD stated she was responsible to check with resident's regarding the mood and how they were felt but at the same time since nursing was providing the resident's direct care the staff needed to monitor the side effects and behaviors/ mood for all medications R1 was taking including the antidepressants and sleep aides. She further stated "I would check with R1 occasionally as she is alert and able to verbalize how she felt." When interviewed on 3/14/14, at 4:00 p.m. the facility medical director stated R1's side effects, mood and sleep patterns should have been monitored and since R1's antidepressant and sleep aides had been increased R1 needed to go back to see the prescribing physician to re-evaluate the effectiveness of dosage increase. When interviewed on 3/17/14, at 8:17 a.m. the DON stated she expected the CP to have alerted	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 428	Continued From page 264 the facility that these pieces were lacking during monthly review. When interviewed on 3/17/13, at 1:11 p.m. about best practice; monitoring of sleep patterns and side effects the CP stated "I feel cornered by the surveyors asking me questions about residents which I don't have direct access to their information and I don't feel comfortable." The Mood MDS dated 12/6/13, identified R1 had this symptoms "Feeling down, depressed, or hopeless, trouble falling or staying asleep, or sleeping too much, feeling tired or having little energy, poor appetite or overeating, feeling bad about yourself-or that you are a failure or have let yourself or your family down and thoughts that you would better off dead, or of hurting yourself in some way." The assessment indicated R1 all the symptoms were nearly every day. CAA dated 12/10/13, indicated R1 used antidepressants, and sleep aides, and indicated staff would continue to monitor for effectiveness of the antidepressants and sleep aides as well as for side effects. In addition the CAA indicated R1 was at risk for adverse side effects. No temporary and comprehensive care plans developed on medications since R1 had been admitted to facility on 11/30/13. On 3/17/14, at 12:13 p.m. facility policy for side effects and behavior/mood monitoring was requested but was not provided. The Videll Healthcare, LLC policy on Psychoactive Medication Management, last reviewed on 5/2013, directed staff "1. Psychoactive medication management begins during the pre-admission process. Key data	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 428	Continued From page 265 points to gather include but are not necessarily limited to: a. Admission information. b. Diagnosis history c. Persistent psychiatric and/or mood problems d. Medications and route of delivery e. Pain history including past pain management programs f. Abuse or addition [sic] issues g. Rehabilitation status h. Neurological status i. Cognitive status j. Functional status" "2. A resident is assessed by a licensed nurse and/or social service director for psychoactive medication use during the admission/re-admission process. a Subsequent assessments are completed at least quarterly based on OBRA [federal] guidelines." "Based on the IDT [interdisciplinary team] analysis of psychoactive medication use and/or behavior issues and individualized care plan is developed to accommodate and/or manage the resident's behavior and psychoactive mediation use. a. The individualized care plan may address: i. Cognition ii. Mood iii. Behavior tracking logs iv. Residents' mobility v. Use of medication." "10. The DNS [Director of Nursing Services] or designee is responsible to ensure a behavior log is used to document antecedents and to monitor medication effectiveness." The policy did not address consultant pharmacist responsibilities.	F 428		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 266 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 4 of 6 TMA (trained medication aide) medication carts and nurse treatment carts (North/West treatment cart, North TMA cart, West TMA cart, South TMA cart) were kept clean, that nasal medications were stored separately from eye medications; the facility failed to establish a system of records to accurately reconcile narcotics (controlled drugs) to prevent potential diversion in 6 of 6 carts. In addition, the facility did not have a system to	F 431	F 431 For all of the medication and treatment carts in the facility, the facility shall ensure they are kept in a clean and sanitary condition. For all of the medication carts in the facility, the facility shall ensure medications are properly stored with special attention to keeping nasal preparations separate for eye preparations. For all medication carts in the facility, the facility shall ensure a system is established for a shift narcotic count. The facility shall ensure a system as outlined by the PharMerica policy manual is followed related to incoming and outgoing medications. The facility shall consult with and take direction from PharMerica and the policy manual related to the proper handling and destruction of medications. The facility shall ensure the medication refrigerator is kept clean and defrosted. Each TMA or licensed staff assigned to a medication/treatment cart each shift will ensure the cart is clean before beginning a medication pass or delivering treatments. TMA and/or licensed staff will be educated in the clean and sanitary maintenance of the medication/treatment cart.	

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F 431	Continued From page 267 ensure incoming (newly delivered medications) and outgoing (medications to be sent back to pharmacy or destroyed) medications were handled and disposed of properly. The facility lacked a system to ensure the medication storage refrigerator was cleaned and defrosted. These practices had the potential to affect all 84 residents. Findings include: NORTH/WEST HALL TREATMENT CART On 3/18/14, at 9:28 a.m. a licensed practical nurse (LPN)-G stated the Treatment "insulin" cart for the North hallway had insulin's, glucometers machines, treatment supplies, and "medications for residents who do not want the TMA to administer their medications." The Narcotic book was observed to be a large black bound book. When asked to explain the system for narcotic reconciliation, LPN-G removed a loose sheet of paper labeled Shift/Shift Narcotic Count Record Month of: March 2014, which was loosely placed in the front of the narcotic book. LPN-G stated two nurses from each shift were expected to count the narcotics together and compare them to the register (bound book). The Shift/Shift Narcotic Count Record was noted to have 23 blank spaces. LPN-G stated when the nurses do the narcotic count, they needed to document they were completed and needed two nurse signatures (leaving shift counting with the oncoming shift). LPN-G verified the blank spaces indicated a count may not have been completed. LPN-G verified there was a lack of signatures across all different shifts. LPN-G stated they could not speak for those days (signatures were missing), but verified if it was not signed it could not be verified as completed. LPN-G verified their	F 431	The DON/RCM will do random checks of the medication/treatment carts weekly X6 for cleanliness and sanitation. These random checks will be reported to the QA committee for review and further action as indicated. Each TMA and/or licensed nurse is responsible to ensure that medications are properly stored in the medication cart. Special attention is given to ensuring nasal preparations are stored separately from eye preparations. The DON/RCM will do random audits of the medication carts to ensure medications are properly stored. The random audits are reported to the QA committee. This is an ongoing process. The facility will also request the pharmacy check the carts on a random basis for medication storage and medication/treatment care maintenance. The reports from these pharmacy checks will be reported to the QA Committee for review and further action as indicated.	

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F 431	Continued From page 268 own signature and confirmed with the surveyor the narcotic count currently matched the amounts in the Narcotic Book. When LPN-G was asked what they did or should do when blank spaces were noted and the narcotic count was not completed, LPN-G stated they were "responsible to report" the lack of a narcotic count and verified they had not reported other unsigned days of the narcotic counts. LPN-G verified the loose sheet could be removed, copied or "lost" and verified the sheet of paper was started to be used on 3/5/14 (arrows indicated the form was initially started on the evening shift). The internal compartments and drawers of the Treatment cart were observed to have a heavy build-up of a white powder in the bottom and back aspects of the second drawer. LPN-G, present during the observation, stated the treatment carts were cleaned "weekly" and by the night shift. LPN-G was unclear what the white powdered substance was from and was unclear if the cart cleaning was documented. NORTH HALL TMA CART On 3/18/14, at 10:03 a.m. the TMA cart was observed with TMA-B present during the observation. The third drawer was observed to have many red colored, sticky, but dried spills in the bottom of the drawer; approximately two loose pills were also observed on the bottom of the drawers (second and third drawers). A white colored powder, debris of paper and foil pieces was observed to built-up in the corners of the drawer. TMA-B verified R51's opened artificial tears eye drops and opened tube of LubriFresh eye ointment, R111's Deep Sea nasal spray (Nasal Moisturizer), R15's Oxymetazoline HCl (used to treat nasal congestion), R70's Fortical	F 431	The medication refrigerator is checked for appropriate temperature every shift. On a weekly basis the medication refrigerator is checked for cleanliness and sanitation. The refrigerator will be thoroughly cleaned on a monthly basis at a minimum and more frequently as needed to keep clean and sanitary. The medication refrigerator will be defrosted on a monthly basis. The DON/RCM will do random checks of the medication refrigerator to ensure cleanliness and sanitation. These checks will also ensure the refrigerator is defrosted appropriately. The temperature log and weekly refrigerator check will be reported to the QA committee for review and further recommendation as indicated. Responsible: DON, RCM, licensed nursing staff Compliance date: 4/28/2014	

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F 431	Continued From page 269 nasal spray (used to treat osteoporosis) and fluticasone propionate nasal spray (used for the treatment of seasonal or perennial nasal allergy) symptoms, and R81's fluticasone propionate nasal spray were all stored together loosely in the top drawer of the cart. All the nasal and eye bottles were opened. TMA-B stated the cart was only cleaned when staff "volunteered" to clean it. TMA-B verified the presence of a large yellow pill in the second drawer back right corner, a pinkish colored pill third drawer back right corner, and verified the build-up of debris and spills. TMA-B stated there was no schedule to clean the medication carts. The Shift/Shift Narcotic Count Record was observed to be a loose sheet of paper placed next to the bound Narcotic Book. TMA-B verified 12 empty spaces and times the narcotic count was not reconciled. TMA-B verified the form was started on the evening shift of 3/5/14. WEST TMA CART On 3/18/14, at 10:27 a.m. TMA-A stated she was unclear on the frequency of the medication cart cleaning. The top working space of the cart had multiple areas of light pinkish colored staining on the surface. The third and fourth drawers were observed to each have three areas of sticky, dried, red spills built-up on the bottom of the drawers. TMA-A stated she did not know when the cart was last cleaned; TMA-A stated she believed the debris, spill build-up was from longer than a week. Further observation revealed all four drawers had a build-up of multiple loose pills, paper and foil debris, and a build-up of powder in all drawers. TMA-A, present during the observations, verified all findings.	F 431		

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F 431	Continued From page 270 TMA-A verified there were eight blank signature spaces on the Shift/Shift Narcotic Count Record (also a loose sheet of paper). TMA-A verified the signature space for the night shift/day shift count was blank and stated she should have "signed off for today" and did not. TMA-A was unclear why. TMA-A stated the form was started on 3/5/14, on the evening shift. SOUTH TMA CART On 3/18/14, at 10:36 a.m. TMA-D stated the cart was cleaned weekly, but she was "off last weekend." TMA-D remained present during the observation of the cart and verified a heavy build-up of white powder, paper and foil debris, approximately five different (pink, yellow, white) pills in all the drawers of the cart including a loose capsule in the bottom of the locked narcotic drawer. A pinkish colored staining was observed on the top surface of the cart. TMA-D wiped at the stain with a wet towelette. TMA-D showed the surveyor the towelette was stained pinkish color and the stain could be removed. TMA-D then removed the loose capsule from the narcotic drawer (even though TMA-D had verified the presence of multiple loose pills in the other drawers) and was observed to place the pill into the trash receptacle on the side of the cart. When the surveyor asked if that was where she normally disposed of medications, TMA-D stated, "Oh, I'll dig that out." Immediately dug into the trash and removed the capsule and placed it in a soufflé cup (paper medication cup). TMA-D stated she should report it to the nurse. Although the South Shift/Shift Narcotic Count Record had all signatures for all shifts and days of March 2014, the form was noted to start on	F 431		

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F 431	Continued From page 271 3/5/14, on the evening shift. In addition, the page was loosely stored on the top of the cart and could easily be lost, removed or altered. SOUTH/EAST TREATMENT CART On 3/18/14, at 10:48 a.m. LPN-A was observed to be already cleaning and organizing the South/East Treatment cart. LPN-A stated on 3/5/14, she implemented the "Narcotic Count Record sheet" for the narcotic counts. LPN-A stated prior to starting the sheet, each cart had a different small book which staff was "signing in and out of." LPN-A showed the small book for the South/West cart and stated, "It didn't make sense, you can't make sense of this." LPN-A and surveyor reviewed the small black bound book together at the time. The book was observed to have multiple pages of blank spaces, a vague system of lines, boxes and sporadic signatures with various dates. LPN-A stated there was "no system" for prevention of narcotic diversion. LPN-A verified all Shift/Shift Narcotic Count Record forms were loose sheets of paper and if staff observed blank spaces, it should be reported to the director of nursing (DON). - At the time of the observation and interview, TMA-D approached LPN-A and reported the capsule (from the narcotic drawer of the South TMA cart, previously disposed of in the trash by TMA-D needed to be destroyed. LPN-A directed TMA-D to dispose of the capsule in the hopper. TMA-D left the area alone, LPN-A did not accompany TMA-D to dispose of the medication. LPN-A stated to the surveyor the capsule should have been disposed of in the hopper after the TMA reported it to the nurse. When LPN-A was informed the cart the capsule came from had other loose pills in the bottoms of the drawers, and the capsule had potentially come from the	F 431		

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F 431	Continued From page 272 bottom of the locked narcotic drawer, LPN-A verified only one capsule was presented and the rest should have been reported (from all carts) and disposed of in the hopper. LPN-A was unclear if two nursing staff needed to dispose of wasted medications together, or if the medication required a pharmacist to be present. - LPN-A stated there was no policy for medication cart cleaning, the cleaning "should be done" at least weekly and "they know they [TMA/nursing staff] should clean it [the cart] after each use." The East TMA Cart and South/East Treatment Cart Shift/Shift Narcotic Count Record: Month of March 2014 were both noted to be loose sheets of paper and started on the evening shift of 3/5/14. The East TMA Cart was noted to have 24 empty spaces, including a complete day of no narcotic counts on 3/17/14. The East TMA cart had 22 empty signature spaces. MEDICATION ROOM On 3/18/14, at 10:59 a.m. LPN-D assisted the surveyor with access to the locked medication storage room directly behind the nursing station. Upon observation, the counter area was observed to be completely filled with multiple bottles and bags of various medications, and to contain two locked plastic (tackle type) boxes. A large grey bin was observed stored on top of a small white refrigerator. The bin was observed to be overflowing with boxes and bottles of medications. LPN-D, present during the observation, stated the medications on the counter were "just brought in," one of the locked boxes was the "emergency kit," was unclear what the other locked box was for, and the medications in the large bin were medications "waiting to be returned to the pharmacy for credit." LPN-D	F 431		

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F 431	Continued From page 273 pointed drawers in a cupboard directly across from the overflowing bin and stated the medications stored there were "over flow" medications for residents currently admitted to the facility. LPN-D verified the medication room was cluttered, verified there was no clear system for preventing mixing of new, old and current medications. LPN-D was unclear on the documentation for the medications to be returned to the pharmacy for credit. - The refrigerator was observed to have "over flow" insulin, vaccination and suppository medications appropriately stored. The freezer was observed to have a two-three inch thick build up frost. Two gel packs were observed to be encased in the frost. LPN-D was unclear when the refrigerator was last cleaned or defrosted. LPN-D was unclear on the schedule for cleaning and defrosting of the medication storage refrigerator. On 3/18/14, at 11:06 a.m. DON stated she expected the medication carts to be cleaned "regularly." Stated there maybe policies for medication storage, cart cleaning and narcotics, but then stated the nursing staff were not trained on the policies. DON explained staff should be documenting when they completed the narcotic counts and explained the sheets were started on 3/5/14. DON stated prior to 3/5/14, each cart had a different small book, binder or note book. The DON verified medications should be stored separately (by route). A letter dated 3/18/14, directed to the facility vice president, indicated the PharMerica Pharmacy Director was "following up on your inquiry regarding drug destruction." The letter indicated, "The pharmacy consultant is available, during	F 431		

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F 431	Continued From page 274	F 431		

their monthly visits to assist in Controlled Substance Drug Destruction if requested by the facility. I have also made myself available to facilities who need destruction, more frequently or out of cycle of the visit." The letter further indicated, "The non-controlled medications can and should be returned to the pharmacy, where we send them off pursuant to current pharmacy regulations for destruction." The letter indicated attached were policies for medication handling, such as destruction of medications/returning medications to the pharmacy.

The Returning Medications to the Pharmacy policy dated 9/10, identified which medications would be accepted for return credit. The policy directed, "2. Prior to acceptance of any returned medications/supplies, the pharmacy must receive form the nursing care center, documentation of all returned medications/supplies on the appropriate forms, including any state specific form as required by regulation." The policy further indicated, "5. All return medications/supplies must be transported back to the pharmacy in a sealed traceable container and prevent diversion or adulteration of the return medications/supplies." The policy identified the DON and consultant pharmacist as responsible to monitor for compliance and directed to use "approved containers" to separate and securely store different types of pharmaceutical waste. The policy further indicated medications (non-controlled) "shall be destroyed by the nursing care center in the presence of a pharmacist or nurse, and one other witness as per state regulation. Documentation of non-controlled medication may be completed on a medication administration record (MAR), a medication disposition log or form..." The policy

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F 431	Continued From page 275 identified to retain the record.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	F 441 For sampled residents R64 and 56 and for all residents at the facility, the facility shall ensure staff change gloves appropriate during cares. The facility shall ensure that sharps containers are changed out when they are 2/3 full and replaced with empty containers. The facility shall ensure that smoking areas are kept clean and sanitary for anyone who uses the designated smoking areas. The facility has polices related to hand hygiene and the disposal of used needles. The facility shall ensure these policies are operational. The facility defaults to the CDC standard for hand hygiene. Staff will be educated in the CDC guidelines for hand hygiene and use of universal precautions including gloves. Sharps containers will be inspected daily by the Director of Maintenance and containers that are 2/3 full or more will be immediately changed out. Smoking areas will be inspected daily for cleanliness and sanitary conditions by the Director of Maintenance. The areas will be cleaned at least 2x/shift on both the day and evening shift.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 276 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure appropriate glove changes during cares for 2 of 4 residents observed for cares (R64, R56); facility did not ensure 1 of 1 sharps container attached to the treatment cart was changed when full to prevent access to used syringes and needles this had the potential to affect all 84 residents. In addition the facility failed to keep 1 of 2 designated smoking areas adjacent to the dining room in a clean and sanitary manner which had the potential to affect all 28 residents residing at the facility who were smokers. Findings include: On 3/11/14, at 11:49 a.m. during an interview R1 expressed that the back smoking area adjacent to the dining room was really dirty and she needed the surveyor to go out there with her to see what she was talking about. -At 11:50 a.m. during tour of the smoking area with R1 the surveyor observed thick yellowish slimy mucus sputum with blood streaks along the walls at knee level, on the floor, around the cigarette butt concrete stand and on the right side of the wall behind the door. In addition several sheets of rolled of Kleenex, papers and plastic cups were observed lying on the ground cluttering the area. -At 11:53 a.m. R1 stated she had brought this to the attention of the facility on numerous occasions especially about the sputum with blood streaks as she thought "Other residents who use	F 441	The facility administrator shall do random checks of sharps containers to ensure they are changed out on a timely basis when the container is 2/3 full. Results of these random checks will be reported to the QA Committee monthly X6 for review and further recommendation as indicated. The facility administrator shall do random cleanliness/sanitation checks of the smoking areas for cleanliness and sanitation. The results of these random checks will be reported to the QA Committee monthly X6 for review and further recommendation as indicated. The DON/RCM and/or licensed nursing staff shall randomly observe residents cares weekly to ensure hand hygiene and glove changes are done appropriately. The results of these random observations will be reported to the QA Committee for review and further comment. The Director of Maintenance was counseled and educated about his job responsibilities. Responsible: Administrator, Director of Maintenance, DON, RCM, licensed staff Compliance date: 4/28/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 441	Continued From page 277 this area deserve to know if the resident that does this has some sort of communicable disease." R1 further stated "I have sometimes cleaned the place up and picked it up because no one does s**t around here." On 3/13/14, at 2:17 p.m. during a tour to the smoking area with the administrator, she verified and acknowledged the area was not clean and sanitary stated she was aware of the area being dirty and every time it had been brought to her attention she had the place cleaned. She further stated she was aware residents were smoking in this area and for the resident who was spitting she indicated she had gone outside numerous times asked him to stop spitting as this was "not good manners" and as far as she knew the resident did not have a communicable disease. -At 2:20 p.m. records of the cleaning and up keep of the smoking area were requested but were not provided. Sharps container On 3/13/14, at 8:00 a.m. the sharps container attached to the nurse's treatment cart station in the South West Hallway was observed to be filled all the way past the marked line on the container. -At 8:02 a.m. licensed practical nurse (LPN)-B was observed coming down the hallway carrying a used syringe with a pulled retractable seal approached the side of the cart with the sharps container and was observed forcefully pushing the used syringe to the container for approximately seven seconds to keep the syringe down. -At 8:11 a.m. surveyor approached the treatment cart pulled the sharps container cover and was able to retrieve two used insulin syringes without reaching out.	F 441		

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F 441	Continued From page 278	F 441		

When interviewed on 3/13/14, at 1:47 p.m. the licensed practical nurse (LPN)-A stated the sharps container should not been filled past the marked line. She further stated "The nurse knew better. Oh my God, he needs to see this to be educated." Surveyor stated to LPN-A that had been observed since that morning and LPN-B had continued to force the syringes into the container.

When interviewed on 3/13/14, at 1:58 p.m. LPN-B stated he had noticed it was full in the morning when he had gotten on the floor but did not know the key to open the sharps container was in the treatment cart keys he had been carrying. He further stated he was going to change the sharps container then "Thank you."
-At 2:01 p.m. LPN-B was overheard asking LPN-D where the filled sharps containers were stored and both LPN-B and LPN-D were observed leaving the hallway with the filled sharps container.

When interviewed on 3/13/14, at 2:03 p.m. the director of nursing (DON) stated her expectation was the sharps container was not supposed to go above the marked line. The DON shook her head during the conversation.

Hand washing and gloving practices to prevent the spread of infection was not observed during personal cares.

On 3/13/14, at 7:56 a.m. R64 was assisted by nursing assistant (NA)-D with morning cares. NA-D applied gloves, and then went to the

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F 441	Continued From page 279 bathroom sink and wet several clean washcloths with water. NA-D returned to the bedside with the washcloths and used the first clean washcloth to wipe R64's peri-area from back to front. NA-D then used a second wet washcloth to cleanse R64's buttocks. NA-D applied Remedy Calazime paste to R64's perineum and groin folds. The surveyor noted two open areas on the scrotum, NA-D stated he had told the nurse about those and then applied more Remedy Calazime paste to the areas with his gloved hands. NA-D applied a clean incontinent brief still wearing the visibly soiled gloves, then also touched R64's arm, their shoulder and their hospital gown. NA-D applied R64's clean pants still wearing the soiled gloves. NA-D left the room to obtain assistance from NA-B and applied new gloves without washing their hands. NA-D sat R64 up on the side of the bed to dress the upper body, applied deodorant to R64's underarms and dressed R64's upper body. After NA-D and NA-B got R64 into the wheelchair using a standing lift, NA-D wiped R64's head with a third washcloth, attempting to smooth the hair down rather than combing, then used a fourth washcloth to wipe R64's mouth. During interview on 3/13/14, at 8:31 a.m. NA-D said he would change gloves after done with incontinence care on residents. NA-D said he usually washes his hands when he comes in a room to complete cares and washes his hands when cares are finished. NA-D confirmed he did not change gloves or wash his hands after completing the peri-care on R64 and between touching his clean brief, clothing, shoulder and arm. On 3/13/14, at 8:33 a.m. NA-B was completing morning cares on R33. NA-B handed R33 a wet	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 280	F 441		

washcloth with her gloved hands. NA-B picked up the residents urinals which were three quarters full of urine. NA-B went to the bathroom and dumped the urine in the toilet, then filled a disposable plastic cup with water from the faucet. NA-B used the plastic cup to pour water into the urinals to rinse and dumped the urinals again into the toilet. While wearing the same gloves, NA-B wiped the entire top of the toilet seat with paper towels to remove urine and water that had splashed onto the rim. While still wearing the same set of gloves, NA-B then wiped down the edges of the bathroom sink including the faucet handles with another set of paper towels. NA-B changed R33's garbage bags and then removed the soiled gloves. NA-B went to the resident bathing area and obtained a clean gown, returned to R33's room and then washed her hands, wiping the bottom of the sink out with her ungloved hands afterwards.

During interview on 3/14/14, at 8:47 a.m., the DON said it would be a concern if staff did not wash their hands in between performing peri-cares and then touching clean linen and the resident. She also added it would be a concern if staff wiped the lid of the toilet seat off and then did not change gloves or wash hands before wiping down the resident's sink.

The facility Handwashing/ Hand Hygiene policy revised April 2012, indicated all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. In addition the policy indicated handwashing would be completed after handling soiled or used linens, dressings, bedpans, catheters and urinals; after handling soiled equipment or utensils; after

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F 441	Continued From page 281 performing personal hygiene and the use of gloves did not replace handwashing/hand hygiene practice.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure resident toilet armrests, light fixtures, radiators, carpets, E-Z stand (a mechanical stand used for transfers and dining room ceiling were not kept in good repair, safe, clean and in a sanitary manner for 10 of 84 residents (R5, R44, R15, R62, R56, R22, R6, R72, R91, R33). Findings include: A tour of the facility was conducted on 3/17/14, at 10:00 a.m. through 12:03 p.m. with the director of facility operations the following concerns were identified: Toilet armrests: R5's toilet armrests were loose and unsafe. On 3/11/14, at 11:18 a.m. both the armrests over the toilet were observed to be loose and wobbly. R5's quarterly Minimum Data Set (MDS) dated 1/23/14, indicated R5 had moderate impaired cognition, was independent with mobility and	F 465	F 465 For sampled residents R5, 44, 15, 62, 56, 22, 6, 72, 91, 33 and for all residents at the facility, the facility shall ensure that toilet arm rests, light fixtures, radiators, carpets, EZStand mechanical lifts, and the dining room ceiling tiles are kept in good repair, safe, clean, and sanitary. The facility has a policy titled, "Housekeeping Services." The facility shall ensure this policy is fully operational. Additionally, the facility has a policy titled, "Homelike Environment." The facility administrator shall ensure both of these policies are operational. For the sampled residents" All toilet arm rests will be checked and repaired/replaced to ensure safe, clean, and sanitary condition. All light fixtures will be checked for dead insects and thoroughly cleaned. The radiators will be checked, cleaned, and/or painted.	

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F 465	Continued From page 282 transfers. However, R5 needed supervision for toileting which included toilet use, transfers on/off the toilet, adjusting and cleansing self after elimination. During the tour at 10:11 a.m. the director of facility operations verified the armrests were loose and wobbly, stated the mounting blots needed to be tightened. He further stated the rubber to one of the legs of the armrest was missing and daily the maintenance staff did one room check. It was the staff's job to look at the whole aspect of the room and report any concerns. "I mean each room is checked every 87 days." R44's toilet armrest was loose and unsafe. On 3/11/14, at 11:29 a.m. R44's left side toilet armrest was observed loose; bent inward at the supporting base and wobbled loosely greater than four to five inches span; the armrest loosely swung out to the left with ease. R44 at the time was observed to be ambulating independent with walker and stated she wanted to use the bathroom. -At 11:30 a.m. trained medication aide (TMA)-A was notified and verified the armrest was loose. TMA-A stated "I can't answer that question, I will have to find someone else who knows the answer" when asked if she was aware of the equipment being broken. Although surveyor repeatedly stated to TMA-A if "she" knew, TMA-A repeated she could not answer the question and would have to find a staff who knew. TMA-A was observed reporting to a male staff and led him by the hand to the bathroom. -At 11:32 a.m. TMA-A stated the maintenance would fix the equipment. Maintenance staff (M)-B	F 465	Common area carpets will be cleaned professionally. Resident rooms will be professionally cleaned on a rotating schedule. All EZStands will be inspected and will be cleaned and repaired as necessary. All dining room ceiling tiles will be inspected and cleaned as necessary. Housekeeping will be provided with a daily room check list to ensure all aspects of the resident room is attended to and cleaned. Additionally, all housekeepers will be educated on the responsibilities of their jobs. Director of Maintenance will do weekly and random daily audits of resident rooms after housekeeping services have been provided. These daily/weekly audits will be reported to the facility administrator and the administrator will sign the audits. Additionally, these audits will be reported to the QA Committee for review and further recommendation as indicated. The Director of Maintenance was counseled and educated about his job responsibilities. Responsible: Administrator, Director of Maintenance Compliance date: 4/28/2014	

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F 465	Continued From page 283 verified he was the maintenance staff and removed the armrest. M-B verified he had not been notified and he should have been. M-B further stated all requests were written in a green book at the desk, but repeated he was not notified and was observed to remove the armrest from the room. R44's quarterly MDS dated 1/2/14, indicated R44 had severe impaired cognition, required assist of one staff with cares, toileting and used both the walker and wheelchair for mobility. During the tour on 3/17/13, at 10:08 p.m. the director of facility operations stated before the armrest were applied to the toilet they were cleaned and inspected for safety. He further stated all the staff are supposed to be the eyes and ears and should have caught on the issue and logged it on the maintenance log for repair immediately. Insects: R15's light fixture was not clean. On 3/11/14, at 11:09 a.m. during interview both circular light fixtures on the ceiling in R15's room were observed to have many dead insects (greater than twenty) in both light lenses on either side of the R15's space. R15's annual MDS dated 1/16/14, indicated R15 had intact cognition, and required assist of one staff with activities of daily living (ADL's) and used the wheelchair for mobility. During the tour the director of facility operations verified the findings stated he had not been doing this and had never even thought of it but will start	F 465		

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F 465	Continued From page 284 to check all the lenses. Radiators: R62's room radiator was noted to be in ill repair. On 3/10/14, at 4:41 p.m. the air vent radiator was observed to have several rusty patches and paint was scratched off in the front aspect of the radiator. R62's quarterly MDS dated 11/27/13, indicated R62 had moderate impaired cognition, required assist of one staff with cares and required one staff assist during ambulation. When interviewed at 10:16 a.m. the director of facility operations verified the finding and stated "This is a problem in every single room, we do not have a plan for up keeping this and if we were to fix they will have to be sanded before painting them and we will have to have a set schedule to do all the rooms with concerns." R56's radiator was noted to be with ill repair and was not clean. On 3/15/14, at 11:10 a.m. the radiator was observed with several patches of chipped paint and with grey fluffy build up substance on the vents at the top of the radiator. R56's quarterly MDS dated 12/29/13, indicated R22 had intact cognition, and required assist of one staff with ADL's and used the wheelchair for mobility. At 10:49 a.m. the director of facility operations stated "That's dust. It has probably never been cleaned."	F 465		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 465	Continued From page 285	F 465		

R6's radiator was noted to be with ill repair.

On 3/11/14, at 8:58 a.m. the radiator was observed to have several rusty patches on the front aspect of the radiator and an accumulation of a thick fluffy grey build up substance on the vents.

R6's quarterly MDS dated 12/29/13, indicated R22 had intact cognition, and was independent with all functional status.

R22's radiator was noted to be in ill repair.

On 3/13/14, at 9:56 a.m. R22's radiator was observed with multiple rusty patches on the front and top aspects parallel to the window seal. In addition, multiple dark brown spots were observed on the entire carpet area between the dresser and the bed which extended to the radiator.
R22's quarterly MDS dated 1/9/14, indicated R22 had moderate impaired cognition, required assist of one staff with walking in the room and transfer needs, and R22 used both the walker, wheelchair for mobility in his room.

At 10:37 a.m. the director of facility operations verified the findings stated again the was a facility wide problem with the radiators and for the carpet he had been pushing for R22's flooring to be changed in the past because of the challenges of maintaining it clean but because of R22's risk for falls the vinyl flooring was not an option. He added to state the carpet was shampooed two times a month.
R33's light cover lens was uncovered and radiator was with ill repair.

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 465	Continued From page 286	F 465		

On 3/11/14, at 9:30 a.m. the light lens over light at end of R33's bed was observed missing which exposed the wires and the bulbs. R33's space had a strong smell of urine. The two urinals at R33's bedside dresser noted one to be half full of urine and the other one was full with urine. In addition, the radiator was observed with multiple rusty patches, and chipped paint.

R33's quarterly MDS dated 11/13/13, indicated R33 had intact cognition, required assist of one staff with toileting and transfer needs, and R33 used both the walker, wheelchair and limb prosthesis for mobility.

On 3/17/14, at 11:10 a.m. both the urinals were observed hanging on R33's bedside dresser empty, director of facility operations verified R33's space had a strong smell of urine. He stated the lens was missing because the facility had an unpaid bill of forty seven dollars with a particular electric lighting company and when that was paid off the facility would be able to replace the lens and the bulbs as there were no extra bulbs.

Carpet:
R91's carpet was not kept clean

On 3/11/14, at 8:33 a.m. during interview R91 stated, "The carpet is very nasty. My roommate once had an accident and was never cleaned." "I hate to walk on this carpet and this is dirty."
-At 8:47 a.m. observed several rusty patches and chipped paint in the front aspect of the radiator.

R91's admission MDS dated 10/15/13, indicated R91 had intact cognition, had functional limitation of the lower extremity on one side, was un-steady

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F 465	Continued From page 287 and needed assist of one with transfers and used both the walker and wheelchair for mobility. On 3/17/14, at 11:30 a.m. the director of facility operations verified the carpet was not clean "I see it is not clean." He further stated the radiators had never been maintained. R72's carpet was not kept clean On 3/11/14, at 2:30 p.m. the carpet was observed with multiple red stains in the room on the carpet. At 10:32 a.m. the director of facility operations verified the findings stated, "It's dirty am not sure if it is juice and seriously I can show you our carpet shampooer as it is not heavy duty." R72's annual MDS dated 2/18/14, indicated R72 had moderate impaired cognition, had functional limitation which needed assist of one staff and used wheelchair for mobility. Mechanical lift: E-Z stand was not clean On 3/13/14, at 7:15 a.m. the E-Z stand 2 stored on the alcove on the South Hall was observed with thick grey fluffy build up on the base, the left bar were observed with vinyl peeling off which exposed the foam underneath and the paint was chipping off on the handles making it not a cleanable surface. On 3/17/14, at 11:37 a.m. director of facility operations verified the build-up stated was "Dust/dirt" and the other concerns he stated he was responsible for maintaining all the mechanical lifts which included the cleaning and up keep maintenance.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 465	Continued From page 288	F 465		

Dining room:
Dining room ceiling was not clean

On 3/10/14, at 4:45 p.m. during a dining observation the ceilings at the main dining room was observed to have several brown stained tiles and slightly to the middle of the ceiling were observed multiple red spots/stains on several ceiling tiles.

On 3/17/14/14, at 11:49 p.m. the director of facility operations verified the ceiling tiles water damaged stains. The director of facility operations stated that was from the water pipe condensations caused by extreme temperature changes. He further stated there was no up keep plan for the concern but had brought the concern to cooperate nine months ago but had thought the renovation was going to happen sooner. He added that he was not aware of the red spots/stains on the ceiling.

The Maintenance Request Log policy and procedure revised April 2012, directed "Administrator or designee will complete monthly audits to identify preventative Maintenance needs and will document identified repairs in log."

The undated Carpet Cleaning policy directed "Resident rooms are to be shampooed every six months. "Excessive spills and accidents will require more frequent shampooing as needed."

The Home Like Environment policy dated August 2013, directed "Videll Healthcare, LLC facilities shall provide a safe, clean, comfortable, and homelike environment."

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 490	Continued From page 289	F 490	F 490	
F 490 SS=F	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently 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 administrator failed to provide adequate supervision to residents, which resulted in Immediate Jeopardy (IJ) issues at F223 related to the failure of the facility to prevent abuse, and F323 related to failure to supervise (unsafe smoking, and unsafe mechanical lift transfers); in addition, the administrator failed to adequately oversee care to ensure care and services were provided to prevent pressure ulcer development which resulted in a harm level deficiency at F314; the administrator also failed to ensure vendors were paid in a timely manner to ensure services were received in an uniterrupted manner. These administrative failures had the potential to affect all 84 residents in the facility. Findings include: Refer to F223: R56 had informed facility staff that she had suffered emotional, physical and verbal abuse from R63, and the facility did not take adequate precautions to protect R56 from the alleged physical, verbal and emotional abuse. Refer to F225 and F226: The facility failed to appropriately screen 6 of 6 newly hired	F 490	For sampled residents and for all residents at the facility, the governing body shall ensure there are resources available for establishing and maintaining policies and for management of the facility. The corporate governing body has appointed permanent and interim facility administrators that are licensed by the state of MN. Currently the corporate interim administrator is seated and the appropriate notification letter was sent to the state. Additionally, a permanent administrator has been hired. A letter will be sent to the state when he takes over the facility from the corporate interim administrator. The corporate governing body has secured an interim DON licensed in the state of MN as an RN. The appropriate notification letter was sent to the state. Additionally, a permanent DON is being recruited and the governing body has extended an offer of employment. A letter will be sent to the state when the newly hired DON takes over the facility from the interim DON.	

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F 490	Continued From page 290 employees (licensed practical nurse [LPN]-G, nursing assistant [NA]-A, LPN-F, NA-K, NA-D, NA-I) reviewed for screening of new employees. The facility failed to immediately notify the administrator and the State agency (SA), and failed to initiate investigations, for allegations of abuse, neglect and mistreatment for 4 of 5 residents (R21, R62, R71, R17) in the sample reviewed for abuse prohibition. Refer to F309 - The facility failed to provide medications for pain as prescribed by the physician and care planned for 1 of 3 residents (R41) in the sample reviewed for pain. Refer to F314: The facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner, and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Refer to F319 - The facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F323: The facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 3 of 28 residents (R36, R1, R22) who currently smoked in the facility. The facility's failure to provide supervision	F 490	The governing body does have policies and procedures available to the facility on the corporate remote desk top. The governing body regularly reviews and revises as necessary existing policies and procedures. The facility is notified when a policy is revised so they can read it and ensure the proper education about any changes is completed. The governing body has placed nationally accepted standard of care references at the nurses' station for the clinical staff. These standards are referred to in many of the corporate policies and procedures. The social worker that was present during the survey submitted resignation prior to the survey. The governing body in concert with the facility was recruiting for a licensed social worker at the time of the survey. The governing body has secured the services of interim social workers and the facility has 2-3 social workers in the building at least 5 days/week. The governing body continues to recruit for a qualified licensed social worker. The interim social workers will remain in place until an appropriate licensed social worker is hired and fully oriented.	

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F 490	Continued From page 291 and a safe environment to prevent potential burns from unsafe smoking practices constituted an immediate jeopardy for R36, R1, and R22. This practice resulted in an Immediate Jeopardy being called on 3/12/14, at 5:00 p.m. In addition, the facility did not ensure safe use of a mechanical stand lift for 1 of 2 residents (R64) in the sample. This practice resulted in an Immediate Jeopardy component being called on 3/13/14, at 1:50 p.m. The Immediate Jeopardy was removed on 3/16/14, but non-compliance remained at the scope and severity of a pattern, with no actual harm with the potential for more than minimal harm at a pattern. Refer to F353 - The facility did not provide sufficient staff to ensure residents received care per the care plans. This had the potential to affect all 49 of 84 residents who are consistently dependent for cares, and 2 of 2 residents (R11, R41) who occasionally need assistance for cares in the facility. On 3/14/14, at 2:00 p.m. the facility owner verified four administrators had been in the facility since the last survey 6/2013. When asked if he had been aware of the complaints received by the Office of Health Facility Complaints (OHFC) and from residents of: resident's not receiving showers or getting cares, insufficient staffing, and lack of bill paying (for the facility vendors), the facility owner/governing board stated "we were aware of staffing and doing everything that we can. The fact that there is any issue is disappointing." "Can't compromise care over shifting gears and change and transition. Happy to have the DON here and a new administrator." The facility owner further stated the chief operating officer (COO), will be here more often,	F 490	The governing body has directed the restructure of the clinical department. This restructure has included adding 2 resident care managers (one on the day shift and one on the evening shift), adding an RN for the admission process, transitioning the TMAs away from the med carts to the bedside for ADL care and adding licensed nurses to the med carts. The governing has directed the facility to add a full time human resource staff to ensure that employee background checks and credential verification is completed prior to working. Additionally, the HR staff will track and ensure performance evaluations are completed timely and that HR files are properly maintained for all employees. The governing body reviewed and adopted the Vulnerable Adult Act as part of the facilities abuse prohibition process. This VA Act is available to the staff both online and in the facility specific folder on the remote desktop. Please refer to the POC documented at F 223, F225, F226, F309, F314, F319, F323, F353, and F490 for additional information regarding the governing body's direction to the facility related to correction of the statement of deficiencies.	

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F 490	Continued From page 292 she will make sure that anything put into place was implemented. He further commented, "We ourselves are having corporate restrictions, to make sure at least one of us is here every week." The COO acknowledged corporate consisted of "my wife is a social worker (SW) and was the corporate SW consultant (CSW), and had been here doing corporate team building. We have been in health care, hands on, with tough populations for 21 years. We are a small company with four facilities. We like homes that we can work with that are community based care. We've been out here more and we're going to continue to be here more, and are planning renovations and capital funds into the building." The facility owner stated to the COO, "Were talking about staffing and I let (surveyor) know that we are remedying it with immediacy. When asked about the Medical Director (MD-B) contract, and MD-B's understanding that she would not be seeing patients. The COO stated, "That is not what I have with any other facilities, it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. The facility also had to find another medical director or a back up medical director to get the work done." The facility owner added, "My understanding is this is at late as last week that she was going to in the interim cover us." When were you notified of the IJ? The COO stated at 7:30 p.m. on Tuesday when I landed in Seattle, and I was on a plane at 5:30 yesterday morning to come here, I was there all day yesterday and most of today." On 3/17/14, at 10:40 a.m. the administrator and corporate interim administrator (CIA) were interviewed. The administrator stated the last quality meeting should have been held in	F 490	The governing body does direct the convening of a QA committee. Please refer to F520 for additional information regarding the governing body's direction related to the convening and functioning of the QA committee. The COO/Director of Clinical Services has been physically present at the building multiple times during the survey process and since the survey process. The COO/Director of Clinical Services has recruited and secured the new facility administrator and is actively involved in recruiting, interviewing, and hiring the new DON. The COO/Director of Clinical Services is actively involved in training the RN added for the admission process and the additional resident care manager positions. The governing body has established an accounts payable process. It is a function managed at the corporate office. Facilities scan invoices they receive at the facility to the corporate office so the invoices can be entered into the accounts payable system. Facilities are asked to contact service providers/vendors that send invoices to the facility to send directly to corporate. A special accounts payable email is established and is cleared multiple times during a business day at corporate to ensure all invoices are being entered into the accounts payable system.	

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F 490	Continued From page 293 December, the DON and MD-B as well as herself were all hired after that date. The administrator further stated since I've been here, no quality meetings were held, but I think we were in compliance here, the lack of food complaint was not substantiated by OHFC. On 3/17/14, at 10:40 a.m. an interview with the administrator and corporate interim administrator (CIA); the administrator stated she had started February 4th, 2014 and there had not been a quality meeting held since, but stated "I think we are in compliance, the lack of food was not substantiated by OHFC (Office of Health Facility Complaints). The CIA stated she would need to look at the 4th quarter to determine when a quality meeting should have been held, or when their 4th quarter ended. The administrator and CIA, were asked, Is there a plan to ensure at least minimum payment for vendors to continue services so your residents can receive cares? Did that plan include repaying employees for items purchased, which include milk, Wanderguards and side walk salt. Was there a plan to pay the unpaid pharmacy bills to ensure delivery of medications as the were complaints from the residents about not receiving medications because of unpaid bills. The CIA stated two to three weeks ago, corporate started a centralized accounts payable (AP) process, where bills would all go to corporate to be processed. The administrator stated, "The food director purchased milk, the nursing director bought Wanderguards, as far as I know they were reimbursed. Linens were taken out at one time due to nonpayment. To be fair with that the linen service was nasty about it, they came in the back door and just started loading linens, there was no	F 490	**Accounts Payable specifically mentioned in the 2567L:** Double Team Carpet Cleaning - We have not used April 2013 Turf Tigers Snow Plowing - $100.00 current Net 30 Extreme Pest Control - $96.55 current Net 30 G&K Services - No longer use them for laundry we have not used since July 2013 Plunkets - $0 We have not used them since July 2013 "NAC" – Corporate accounts payable is working on payment arrangements with this service provider and an agreement will be reached. Conway Fire and Summit - $0 current NES Electric - Have not used since Feb 2013 and have not had any contact from them Midwest Lighting - $0 current Iron Mountain - $52.98 current Net 30 Cummins Generator - $0 current	

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F 490	Continued From page 294 communication to me at all. The environmental director caught them and brought them to the administrato, who said 'let me call corporate and get this cleared up.' We did have proof of payment in our hands, but they had loaded up and left, and were just being nasty about it. Corporate had chosen vendors: Medline and US foods, Ameripride linens, PharmMerica for drugs." "For the medications, I think no-one has communicated to me that medication service has stopped, on Saturday they faxed over a letter (from attorney office regarding PharmMerica's unpaid bill), they hadn't even called me. You can't just stop medication service to a nursing home." On 3/17/14, at 11:40 a.m. The administrator and corporate interim administrator (CIA) were interviewed regarding the SSD as to what training/orientation was provided so that she could successfully carry out the job? The administrator stated, "When I started here with [SSD], I asked CIA if she was being supervised. CIA stated, 'I told you she was, because the corporate social workers (CSW) were going to mentor her.' "The administrator stated, "When corporate came into town on 2/11/14, (facility owner and CSW) were here, and I asked when are you going to counsel SSD? The CSW acted like she did not know what was happening and stated, 'I can't supervise her', the facility owner stopped the conversation and stated, 'you will supervise her' , it was very alarming to me, a new social worker (without a mentor)." CIA interjected, "When I got here in November she was already hired and here. " The administrator stated "social work is so essential to proper discharge planning, and I was downright angry that she was not supervised, and mentored. My regional administrator stated he had hired her with the	F 490	Metro Sales – A payment plan has been made with this service provider and we are within the agreed payment plan. B SAFE locks - $0 current PharMerica – we pay PharMerica weekly a negotiated amount. Medication deliveries are current and there has been no direction to interrupt service. The survey team was provided with this type of documentation during the survey and that is stated in the 2567L. Responsible: Governing body in concert with the Administrator Compliance date: 4/28/2014	

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F 490	Continued From page 295 understanding that CSW was going to be her supervisor." On 3/17/14, at 12:00 p.m. CIA stated the last quality meeting was held in 9/9/13, they had attempted to hold a quality meeting in December 2013, but OHFC came in and it was postponed. They then attempted a quality meeting after that but the medical director (MD-B) broke her leg and they had to cancel. On 3/18/14, at 3:15 p.m. chief operations officier (COO) stated she did not attend or conference into the quality meetings because they are a small company and she was the "boots on the ground at all facilities," but did ensure she got the meeting minutes quarterly. The COO stated she did not know what training was provided for the SSD, she was hired by prior administrator and DON. The CSW was available as consultant and had been onsite with all SSD in all buildings to meet the DSW personally, and was provided telephone support. A resignation letter was provided from the current administrator dated 3/13/14. The administrator indicated she had resigned her position with a 30 day notice given on 3/13/14. The reason given was "unable to care for residents without resources." The facility failed to pay vendors in a timely manner, accruing a potential balance of $232,865.38 owed to 16 vendors and the pharmacy. On 3/18/14, at 12:02 p.m. a professional facility staff (O)-P was asked regarding unpaid bills for the facility. At 3:45 p.m. a sheet of paper labeled	F 490		

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F 490	Continued From page 296 Outstanding Bills For Videll Healthcare Camden LLC was provided with attached copies of corresponding invoices and receipts. The sheet identified 16 vendors with outstanding bills. The list of vendors was as follows: - Double team carpet cleaning - Turf Tigers snow plowing - Xtreme Pest Control - G&K services - Plunketts - Guardian - "NAC" - Conway Fire & Summit Companies - N.E.S. electric - Midwest Lighting - Iron Mountain - "LVC" - Cummins generator service - Metro Sales - B-SAFE locks - Direct supply In addition, the list included a potential amount of money owed to facility staff that had purchased supplies for the facility out of their own pockets. O-P verified the staff waiting to be paid had accumulated the dollar amounts from purchases made last "November." The approximate total of the dollar amount owed to the 16 vendors and facility staff was $94, 918.44. O-P further stated Videll Corporation had directed facility staff to "try seeking different vendors" even though there were outstanding bills to vendors. O-P verified the listed vendors provided services to Camden care essential for maintaining quality of care and quality of life for all 84 residents admitted to the facility. On 3/18/14, at approximately 11:50 a.m. DON	F 490		

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F 490	Continued From page 297 provided a letter from Fultz Maddox Hovious & Dickens dated for 3/14/14, and verified the letter was from legal firm representing the pharmacy (PharMerica). The letter indicated the firm represented PharMerica "in connection with amounts owed by Camden for pharmaceutical goods and services provided to the facility..." The letter identified the facility was "currently in default" due to "its failure to pay invoices as they came due for goods and services provided by PharMerica." The letter identified the "principal amount owed" by the facility through 1/31/14, was "$137,946.49." The letter identified interest was accruing at "10% per year" and indicated "Camden" may also be responsible for attorneys' fees and costs. The letter indicated PharMerica would only provide goods and services for which Camden was responsible on a "prepayment basis" and outlined a potential payment schedule of $7,803.79 weekly before the "following week ' s shipment." On 3/18/14, at 12:10 p.m. the pharmacy (PharMerica) was contacted via telephone and the pharmacy director was contacted. The pharmacy director was unclear on billing questions and stated billing was managed corporately and stated he could not offer concrete evidence regarding outstanding bills. The pharmacy director stated his job was to fill prescriptions, ensure the medication was accurate and delivered. The pharmacy director stated he had not been directed by his supervisors to not fill prescriptions or send medications to the facility "as of this date." The pharmacy director referred the surveyor to speak with a corporate account executive. On 3/18/14, at 12:25 p.m. an account executive	F 490		

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F 490	Continued From page 298 for PharMerica verified he oversaw the payment account between PharMerica and Videll (specifically Camden Care Center). The account executive verified the facility owed the approximate amount of money identified in the letter, but was unclear on the exact amount. The account executive stated "at this point" the pharmacy was working with "Videll" and "it was positive." The account executive verified the pharmacy had not received the requested payment and the "two parties" were in talks "above my level." The account executive stated if the pharmacy services were stopped to the facility, the residents may be "in jeopardy." The account executive requested the surveyor email him with further requests for information on the outstanding bills. At 12:37 p.m. an email was sent to the account executive requesting information on outstanding bills, last payment, and any details of an agreed payment plan. On 3/20/14, at 5:08 p.m. a manager over facility collections for PharMerica contacted the surveyor via telephone. The manager stated the matter of the overdue bill was turned over to "their attorney." The manager stated the attorney was "handling negotiations of payment plan" with Videll/Camden. The manager verified the facility was "in collections" and there was "no current plan accepted [for payments to PharMerica]."	F 490		
F 493 SS=F	483.75(d)(1)-(2) GOVERNING BODY-FACILITY POLICIES/APPOINT ADMN The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility; and the	F 493		

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F 493	Continued From page 299 governing body appoints the administrator who is licensed by the State where licensing is required; and responsible for the management of the facility This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's governing body failed to ensure appropriate resources were available for establishing and maintaining policies and management to operate the facility. This had the potential to affect all 84 residents in the facility. Findings Include: Refer to F223: R56 had verbalized to facility staff willful emotional, physical and verbal abuse from R63, and the facility did not take adequate precautions to protect R56 from the alleged physical, verbal and emotional abuse. Refer to F225 and F226: The facility failed to appropriately screen 6 of 6 newly hired employees (licensed practical nurse [LPN]-G, nursing assistant [NA]-A, LPN-F, NA-K, NA-D, NA-I) reviewed for screening of new employees. The facility failed to immediately notify the administrator and the State agency (SA) and failed to investigate, allegations of abuse, neglect and/or mistreatment for 4 of 5 residents (R21, R62, R71, R17) in the sample reviewed for abuse prohibition. Refer to F309 - The facility failed to ensure 1 of 3 residents (R41) reviewed for pain, received physician ordered and care planned pain medications.	F 493	F 493 For sampled residents and for all residents at the facility, the governing body shall ensure there are resources available for establishing and maintaining policies and for management of the facility. The corporate governing body has appointed permanent and interim facility administrators that are licensed by the state of MN. Currently the corporate interim administrator is seated and the appropriate notification letter was sent to the state. Additionally, a permanent administrator has been hired. A letter will be sent to the state when he takes over the facility from the corporate interim administrator. The corporate governing body has secured an interim DON licensed in the state of MN as an RN. The appropriate notification letter was sent to the state. Additionally, a permanent DON is being recruited and the governing body has extended an offer of employment. A letter will be sent to the state when the newly hired DON takes over the facility from the interim DON.	

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F 493	Continued From page 300 Refer to F314: The facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner, and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Refer to F319 - the facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F323: The facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 3 of 28 residents (R36, R1, R22) who currently smoked in the facility. The facility's failure to provide supervision and a safe environment to prevent potential burns from unsafe smoking practices constituted an immediate jeopardy for R36, R1, and R22. This practice resulted in an Immediate Jeopardy being called on 3/12/14, at 5:00 p.m. In addition, the facility did not ensure safe use of a mechanical stand lift for 1 of 2 residents (R64) in the sample. This practice resulted in an Immediate Jeopardy component being called on 3/13/14, at 1:50 p.m. The Immediate Jeopardy was removed on 3/16/14, but non-compliance remained at the scope and severity of a pattern, with no actual harm with the potential for more than minimal harm at a pattern.	F 493	The governing body does have policies and procedures available to the facility on the corporate remote desk top. The governing body regularly reviews and revises as necessary existing policies and procedures. The facility is notified when a policy is revised so they can read it and ensure the proper education about any changes is completed. The governing body has placed nationally accepted standard of care references at the nurses' station for the clinical staff. These standards are referred to in many of the corporate policies and procedures. The social worker that was present during the survey submitted resignation prior to the survey. The governing body in concert with the facility was recruiting for a licensed social worker at the time of the survey. The governing body has secured the services of interim social workers and the facility has 2-3 social workers in the building at least 5 days/week. The governing body continues to recruit for a qualified licensed social worker. The interim social workers will remain in place until an appropriate licensed social worker is hired and fully oriented.	

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F 493	Continued From page 301 Refer to F353 - The facility did not provide sufficient staff to ensure residents received care per their individualized care plans. This had the potential to affect 49 of 84 residents who are consistently dependent for cares, and 2 of 2 residents (R11, R41) who occasionally need assistance for cares in the facility. Refer to 490 - The administrator failed to provide adequate supervision to residents, which resulted in Immediate Jeopardy (IJ) issues at F223 related to the failure of the facility to prevent abuse, and F323 related to failure to supervise (unsafe smoking, and unsafe mechanical lift transfers); in addition, the administrator failed to adequately oversee care to ensure care and services were provided to prevent pressure ulcer development which resulted in a harm level deficiency at F314; the administrator also failed to ensure vendors were paid in a timely manner to ensure services were received in an uniterrupted manner. These On 3/14/14, at 2:00 p.m. the facility owner verified four different administrators had been employed by the facility since the last survey 6/2013. When the owner was asked if he had been aware of the complaints received by the Office of Health Facility Complaints (OHFC) and from residents of resident's not receiving showers or getting cares, insufficient staffing, and lack of bill paying (for the facility vendors), the facility owner/governing board stated "we were aware of staffing and are doing everything that we can. The fact that there is any issue is disappointing. We can't compromise care over shifting gears and change and transition. We are happy to have the DON here and a new administrator." The facility owner further stated the chief operating officer (COO), will be here more often, she will make sure that	F 493	The governing body has directed the restructure of the clinical department. This restructure has included adding 2 resident care managers (one on the day shift and one on the evening shift), adding an RN for the admission process, transitioning the TMAs away from the med carts to the bedside for ADL care and adding licensed nurses to the med carts. The governing has directed the facility to add a full time human resource staff to ensure that employee background checks and credential verification is completed prior to working. Additionally, the HR staff will track and ensure performance evaluations are completed timely and that HR files are properly maintained for all employees. The governing body reviewed and adopted the Vulnerable Adult Act as part of the facilities abuse prohibition process. This VA Act is available to the staff both online and in the facility specific folder on the remote desktop. Please refer to the POC documented at F 223, F225, F226, F309, F314, F319, F323, F353, and F490 for additional information regarding the governing body's direction to the facility related to correction of the statement of deficiencies.	

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F 493	Continued From page 302 anything put into place is implemented. He further commented, "We ourselves are having corporate restrictions, to make sure at least one of us is here every week." The owner acknowledged corporate consisted of "my wife is a social worker (SW) and was the corporate SW consultant (CSW), and had been here doing corporate team building. "We have been in health care, hands on, with tough populations for 21 years. We are a small company with four facilities. We like homes that we can work with that are community based care. We've been out here more and we're going to continue to be here more, and are planning renovations and capital funds into the building." The facility owner then stated to the COO, who was present during the interview, "Were talking about staffing and I let (surveyor) know that we are remedying it with immediacy. When asked about the Medical Director (MD-B) contract, and MD-B's understanding that she would not be seeing patients. The COO stated, "That is not what I have with any other facilities, it is not the intent of the contract. I have been made aware of that and I have directed that we went to her and told her that she needs to do that. The facility also had to find another medical director or a back up medical director to get the work done." The facility owner added, "My understanding is this is at late as last week that she was going to in the interim cover us." The owner asked the COO, "When were you notified of the IJ?" The COO stated at 7:30 p.m. on Tuesday when I landed in Seattle, and I was on a plane at 5:30 yesterday morning to come here, I was there all day yesterday and most of today." On 3/17/14, at 10:40 a.m. the administrator and corporate interim administrator (CIA) were interviewed. The administrator stated the last	F 493	The governing body does direct the convening of a QA committee. Please refer to F520 for additional information regarding the governing body's direction related to the convening and functioning of the QA committee. The COO/Director of Clinical Services has been physically present at the building multiple times during the survey process and since the survey process. The COO/Director of Clinical Services has recruited and secured the new facility administrator and is actively involved in recruiting, interviewing, and hiring the new DON. The COO/Director of Clinical Services is actively involved in training the RN added for the admission process and the additional resident care manager positions. The governing body has established an accounts payable process. It is a function managed at the corporate office. Facilities scan invoices they receive at the facility to the corporate office so the invoices can be entered into the accounts payable system. Facilities are asked to contact service providers/vendors that send invoices to the facility to send directly to corporate. A special accounts payable email is established and is cleared multiple times during a business day at corporate to ensure all invoices are being entered into the accounts payable system.	

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F 493	Continued From page 303 quality meeting should have been held in December, the DON and MD-B as well as herself were all hired after that date. The administrator further stated, "since I've been here, no quality meetings have been held, but I think we were in compliance here, the lack of food complaint was not substantiated by OHFC." The CIA stated she would need to look at the 4th quarter to determine when a quality meeting should have been held, or when their 4th quarter ended. The administrator and CIA, were asked, whether there was a plan to ensure at least minimum payment for vendors to continue services so residents can receive cares. They were also asked whether that plan included repaying employees for items purchased, which included milk, Wanderguards and side walk salt. There were also asked whether there was a plan to pay the unpaid pharmacy bills to ensure delivery of medications as there were complaints from the residents about not receiving medications because of unpaid bills. The CIA stated two to three weeks ago, corporate started a centralized accounts payable (AP) process, where bills would all go to corporate to be processed. The administrator stated, "The food director purchased milk, the nursing director bought Wanderguards, as far as I know they were reimbursed. Linens were taken out at one time due to nonpayment. To be fair with that the linen service was nasty about it, they came in the back door and just started loading linens, there was no communication to me at all. The environmental director caught them and brought them to the administrator who said, "let me call corporate and get this cleared up." We did have proof of payment in our hands, but they had loaded up and left, and were just being nasty about it.	F 493	**Accounts Payable specifically mentioned in the 2567L:** Double Team Carpet Cleaning - We have not used April 2013 Turf Tigers Snow Plowing - $100.00 current Net 30 Extreme Pest Control - $96.55 current Net 30 G&K Services - No longer use them for laundry we have not used since July 2013 Plunkets - $0 We have not used them since July 2013 "NAC" – Corporate accounts payable is working on payment arrangements with this service provider and an agreement will be reached. Conway Fire and Summit - $0 current NES Electric - Have not used since Feb 2013 and have not had any contact from them Midwest Lighting - $0 current Iron Mountain - $52.98 current Net 30 Cummins Generator - $0 current	

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F 493	Continued From page 304 Corporate had chosen vendors: Medline and US foods, Ameripride linens, PharmMerica for drugs." "For the medications, I think no-one has communicated to me that medication service has stopped, on Saturday they faxed over a letter (from attorney office regarding PharmMerica's unpaid bill), they hadn't even called me. You can't just stop medication service to a nursing home." On 3/17/14, at 11:40 a.m. The administrator and corporate interim administrator (CIA) were interviewed regarding what training/orientation had been provided to the social services director (SSD) so that she could successfully carry out the job. The administrator stated, "When I started here with [SSD], I asked CIA if she was being supervised. CIA stated, 'I told you she was, because the corporate social workers (CSW) were going to mentor her.' "The administrator stated, "When corporate came into town on 2/11/14, (facility owner and CSW) were here, and I asked when are you going to counsel SSD? The CSW acted like she did not know what was happening and stated, 'I can't supervise her', the facility owner stopped the conversation and stated, 'you will supervise her', it was very alarming to me, a new social worker (without a mentor)." CIA interjected, "When I got here in November she was already hired and here." The administrator stated "social work is so essential to proper discharge planning, and I was downright angry that she was not supervised, and mentored. My regional administrator stated he had hired her with the understanding that CSW was going to be her supervisor." On 3/17/14, at 12:00 p.m. CIA stated the last quality meeting was held in 9/9/13, they had attempted to hold a quality meeting in December	F 493	Metro Sales – A payment plan has been made with this service provider and we are within the agreed payment plan. B SAFE locks - $0 current PharMerica – we pay PharMerica weekly a negotiated amount. Medication deliveries are current and there has been no direction to interrupt service. The survey team was provided with this type of documentation during the survey and that is stated in the 2567L. Responsible: Governing body in concert with the Administrator Compliance date: 4/28/2014	

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F 493	Continued From page 305 2013, but OHFC came in and it was postponed. They then attempted a quality meeting after that but the medical director (MD-B) broke her leg and they had to cancel. On 3/18/14, at 3:15 p.m. chief operations officier (COO) stated she did not attend or conference into the quality meetings because they are a small company and she was the "boots on the ground at all facilities," but did ensure she got the meeting minutes quarterly. The COO stated she did not know what training was provided for the SSD, she was hired by prior administrator and DON. The CSW was available as consultant and had been onsite with all SSD in all buildings to meet the DSW personally, and was provided telephone support. A resignation letter was provided from the current administrator dated 3/13/14. The administrator indicated she had resigned her position with a 30 day notice given on 3/13/14. The reason given was "unable to care for residents without resources." Hill, Jonathan T. The facility failed to pay vendors in a timely manner, accruing a potential balance of $232,865.38 owed to 16 vendors and the pharmacy. On 3/18/14, at 12:02 p.m. a professional facility staff (O)-P was asked regarding unpaid bills for the facility. At 3:45 p.m. a sheet of paper labeled Outstanding Bills For Videll Healthcare Camden LLC was provided with attached copies of corresponding invoices and receipts. The sheet	F 493		

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F 493	Continued From page 306 identified 16 vendors with outstanding bills. The list of vendors was as follows: - Double team carpet cleaning - Turf Tigers snow plowing - Xtreme Pest Control - G&K services - Plunketts - Guardian - "NAC" - Conway Fire & Summit Companies - N.E.S. electric - Midwest Lighting - Iron Mountain - "LVC" - Cummins generator service - Metro Sales - B-SAFE locks - Direct supply In addition, the list included a potential amount of money owed to facility staff that had purchased supplies for the facility out of their own pockets. O-P verified the staff waiting to be paid had accumulated the dollar amounts from purchases made last "November." The approximate total of the dollar amount owed to the 16 vendors and facility staff was $94, 918.44. O-P further stated Videll Corporation had directed facility staff to "try seeking different vendors" even though there were outstanding bills to vendors. O-P verified the listed vendors provided services to Camden care essential for maintaining quality of care and quality of life for all 84 residents admitted to the facility. The unpaid bills information was reviewed and the following noted: - On 3/14/14 at 2:17 p.m. (Eastern Time) the PharMerica attorney letters were reviewed.	F 493		

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F 493	Continued From page 307 - On 3/14/14 at 1:22 p.m. (Pacific Time) the letters were forwarded to the facility owner of Videll-Camden Care and copied to an attorney at Breslin and Young. - On 3/16/14, at 4:01 p.m. the facility owner forwarded the Pharmerica [sic] letters to an attorney-A at Frost Brown Todd LLC. - On 3/17/14, at 7:51 a.m. the facility owner sent an email to attorney-A at Frost Brown Todd LLC., "I know you are swamped with stuff this morning and travel, but I wanted to remind on the below-this one is critical to the going forward; and also something we should tee AHI up on for the Mass facilities and they will have to address. " -On 3/17/14, at 9:05 a.m. attorney-A at Frost Brown Todd LLC. Sent an email to attorney-A at Frost Brown Todd LLC.-B which revealed: "as discussed last night. Critical/urgent-. " - On 3/17/14, at 9:08 a.m. the email reply from the attorney-A at Frost Brown Todd LLC.-B revealed: "Understood. What kind of payment plan can we offer to them? Please get me the details so I can talk to their attorney." - On 3/17/14, at 10:09 a.m. the email reply from the facility owner dated. revealed: "Just want to open discussions. Nothing definite yet. Want to have a plan where we pay them weekly, but characterized differently than CoD (collect on delivery), so as not to crate [sic] any angst with regulators." - On 3/18/14, at 7:20 a.m. an email to the facility owner and COO from a Frost Brown Todd LLC.-B revealed: "I just got off the phone with Fultz Maddox Hovious & Dickens . Here's the deal:" "1. He thinks PharMerica will work with us. He said we need to be transparent and need to communicate with them. Apparently, PharMerica feels like we've ignored them and haven't been	F 493		

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F 493	Continued From page 308 totally up front with them on the financial situation." "2. In similar situations, PharMerica has entered into forbearance agreements. He thinks PharMerica will be willing to enter into a forbearance agreement with us. In order to enter into forbearance agreements with us, PharMerica needs to : (a) understand Videll's current financial position; (b) have a general understanding of Videll's business plan and projections going forward, and (c) a payment this week; and (d) a commitment to continue weekly payments." "3. I told him the Massachusetts locations were taken over by AHI (unknown reference) yesterday and the Videll is not in a position to pay PharMerica for those locations. He thinks PharMerica will be willing to enter into a forbearance agreement that doesn't include Massachusetts. However, he said that PharMerica would want some assistance from us in attempting to get paid from AHI and/or MidCap (unknown reference) for Massachusetts. I told him that we'd attempt to assist them if we can come to an agreement on the other locations (I know there is very little we can do to help Pharmerica [sic] with AHI and MidCap)." "4. I know that (COO) is dealing with (employee) from PharMerica. Fultz Maddox Hovious & Dickens told me that this matter is several levels about (employee) at PharMerica as far as decision making is concerned." "I told Fultz Maddox Hovious & Dickens that we'd get back to him as soon as possible. In order to be productive we need to produce a relatively current financial statement and some money. Can someone provide us with a financial statement? Also, how much money can we pay PharMerica this week? Please let me know. Also, please le me know if you want to set up a time to	F 493		

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F 493	Continued From page 309 discuss." On 3/18/14, at approximately 11:50 a.m. DON provided a letter from Fultz Maddox Hovious & Dickens dated for 3/14/14, and verified the letter was from legal firm representing the pharmacy (PharMerica). The letter indicated the firm represented PharMerica "in connection with amounts owed by Camden for pharmaceutical goods and services provided to the facility..." The letter identified the facility was "currently in default" due to "its failure to pay invoices as they came due for goods and services provided by PharMerica." The letter identified the "principal amount owed" by the facility through 1/31/14, was "$137,946.49." The letter identified interest was accruing at "10% per year" and indicated "Camden" may also be responsible for attorneys' fees and costs. The letter indicated PharMerica would only provide goods and services for which Camden was responsible on a "prepayment basis" and outlined a potential payment schedule of $7,803.79 weekly before the "following week ' s shipment." On 3/18/14, at 12:10 p.m. the pharmacy (PharMerica) was contacted via telephone and the pharmacy director was contacted. The pharmacy director was unclear on billing questions and stated billing was managed corporately and stated he could not offer concrete evidence regarding outstanding bills. The pharmacy director stated his job was to fill prescriptions, ensure the medication was accurate and delivered. The pharmacy director stated he had not been directed by his supervisors to not fill prescriptions or send medications to the facility "as of this date." The pharmacy director referred the surveyor to speak	F 493		

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F 493	Continued From page 310 with a corporate account executive. On 3/18/14, at 12:25 p.m. an account executive for PharMerica verified he oversaw the payment account between PharMerica and Videll (specifically Camden Care Center). The account executive verified the facility owed the approximate amount of money identified in the letter, but was unclear on the exact amount. The account executive stated "at this point" the pharmacy was working with "Videll" and "it was positive." The account executive verified the pharmacy had not received the requested payment and the "two parties" were in talks "above my level." The account executive stated if the pharmacy services were stopped to the facility, the residents may be "in jeopardy." The account executive requested the surveyor email him with further requests for information on the outstanding bills. At 12:37 p.m. an email was sent to the account executive requesting information on outstanding bills, last payment, and any details of an agreed payment plan. On 3/20/14, at 5:08 p.m. a manager over facility collections for PharMerica contacted the surveyor via telephone. The manager stated the matter of the overdue bill was turned over to "their attorney." The manager stated the attorney was "handling negotiations of payment plan" with Videll/Camden. The manager verified the facility was "in collections" and there was "no current plan accepted [for payments to PharMerica]."	F 493		
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12	F 497	F 497 For employees #1, 2, and 3 and for all employees the facility shall ensure a job performance evaluation is completed annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 497	Continued From page 311 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to provide annual evaluations for 3 of 5 employees reviewed for staff that have worked in the facility for greater than 12 months. This had the ability to impact all 84 residents in the facility as the facility was a one story facility and the staff could work on all of the units. Findings include: Employee 1: last evaluation was dated 6/2/12, employed since 6/30/07. Employee 2: last evaluation dated 3/16/12, employed since 3/30/11. Employee 3: had no evaluations in her file and had been employed since 5/20/08. On 3/17/14, at 2:00 p.m. licensed practice nurse (LPN)-A stated that the prior director of nursing (DON) spent the last months in the office and rarely came out, everything fell behind. On 3/18/14, at 4:00 p.m. the current DON stated	F 497	Job performance evaluations shall be completed on employees #1, 2, and 3 and all employees that have not had one completed in in the 12 months of their employment year. The facility now has a standardized job performance evaluation form. Department heads are responsible to ensure job performance evaluations are completed timely. Human resources coordinator is responsible to ensure the department head receives at the beginning of each month, performance evaluations for all employees due during that 30 day period. The facility administrator is responsible to ensure all evaluations are completed. The human resources coordinator will report to the QA committee monthly the number of job performance evaluations due in any month and the corresponding number of evaluations completed. The QA committee will review this information and make further recommendations as indicated. This process will be ongoing. Responsible: Administrator, all department heads Compliance date: 4/28/2014	

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F 497	Continued From page 312 she had discovered that "as things fell behind, the deadlines were extended, and things still did not get done." She was not surprised that evaluations and education requirements were not met.	F 497		
F 500 SS=F	483.75(h) OUTSIDE PROFESSIONAL RESOURCES-ARRANGE/AGRMNT If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in section 1861(w) of the Act or an agreement described in paragraph (h)(2) of this section. Arrangements as described in section 1861(w) of the Act or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and the timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide specific services for resident with mental illness diagnoses and behavioral concerns for 3 of 3 residents (R11, R56, R63) for refusals of care and to address roommate behaviors. In addition, the facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and	F 500	F 500 For sampled residents R11, 56, 63, and 91 and for all residents at the facility, the facility shall ensure outside professional services are obtained to care for residents if the services are not provided in house. This relates to but is not necessarily limited to residents with mental illness diagnosis and behavior concerns. The facility has a policy titled, "Medical Services" that was effective 05/2012 and was reviewed 05/2013. The policy has been reviewed and revised 04/2014 to include mental health services. This policy will be made operational. The facility signed a contract with Associated Clinic of Psychology on 3/14/2014. The facility shall ensure sampled residents R11, 56, 63, and 91 are assessed by these professionals. If the residents refuse the risk vs benefits of this behavior on the part of the resident will be reviewed with them by the IDT. If the resident continues to refuse their right to refuse will be honored, the appropriate documentation will be completed, and the care planned will be revised and updated appropriated.	

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F 500	Continued From page 313 aggressive behavior. The facility did not employ a qualified professional to furnish medically-related social services for the residents to attain or maintain their highest practicable physical, mental, and psychosocial well-being as the facility employed a social service designee and/or services were not completed in a timely manner. This had the potential to affect all 84 residents. Findings include: Residents of the facility were exposed to behavioral outbursts of residents who were not receiving psychiatric services for diagnosed mental illness, by interactions in the hallways, at dining, and on the smoking patio. R11 was not provided medically related social services to address behaviors of refusal/rejection of cares, or calling staff derogatory names. On 3/11/14, at 9:48 a.m. during the initial stage one interview R11 stated, "I don't like people" and his roommate "wakes him up at night screaming." R11 further verified he did not allow facility staff to assist him with activities of daily living, bathing or range of motion. R11 verified he had a contracture of his left hand. R11 stated he did not take showers "due to pain" on his left side and the facility staff did not offer bed baths. R11 explained he was not aware if he could take a tub bath. - At 10:12 a.m. surveyor asked to see R11's left hand. R11 was observed to have a contracture of the left arm, wrist and hand. R11 stated the contracture was due to an aneurysm and stroke. Stated he "didn't let them [facility staff] touch it" and only allowed staff he "trusted" to cut the nails (of the contracted hand). R11 stated he cleaned	F 500	For all residents in the facility, the Associated Clinic of Psychology will make scheduled visits. Resident with mental health diagnoses/concerns or with behavior issues will be scheduled for evaluation and/or follow up. Documentation of this visit will be kept in the medical record. The social service department will conduct audits of all residents with mental health diagnosis/concerns and/or behavior problems to determine if this service has been offered, is being used, and that the documentation and care planning reflect the current status. Responsible: Administrator, DON, RCM, ward secretary, social service Compliance date: 4/28/2014	

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F 500	Continued From page 314 his left hand (inside the contracture, to prevent potential breakdown) under the faucet with running water, but was unclear on how frequently he cleaned the left hand. R11 verified he did not allow staff to monitor the skin of his hand for potential breakdown. - At 12:32 p.m. R11's hair was observed to be long, uncombed and appeared to be unwashed. R11 wore a dark colored baseball cap. R11's nails were long on the right hand with dark colored debris observed under the nails. R11 was observed to be wearing a dark colored coat, t-shirt and dark sweat pants. On 3/13/14, from 8:00 a.m. to 9:00 a.m. R11 was observed to be wearing the same baseball cap, t-shirt, dark colored sweat pants and coat as the initial interview. R11 appeared to have unwashed, uncombed hair. At no time during the observation were staff observed to approach R11 and offer assistance with grooming or range of motion. During the observations, R11 was observed to be in bed and fully dressed in the same clothing. On 3/13/14, at 9:42 a.m. a nursing assistant (NA)-M stated R11 "refuses everything." NA-M explained "today was [R11's] shower day" and stated R11 refused the shower. NA-M stated when staff approach R11, he was verbally abusive and verified he would make derogatory statements to staff. NA-M stated staff was expected to "reapproach" R11. "We usually come back and ask, but he always refuses." NA-M was unclear how R11 was bathed/cleaned and explained staff usually took care of R11 on the evening shift. On 3/13/14, at 10:00 a.m. NA-E stated R11 "refused all cares" and stated she went back to	F 500		

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F 500	Continued From page 315 R11 to reapproach if there was a refusal. NA-E stated she offered all means of bathing (shower, bed bath, and tub bath) and R11 refused "all." NA-E explained she then reported refusals to the nurse and documented "refused" on the shower sheet. NA-E stated R11 refused the shower because it "hurt him." NA-E was unclear if risks of his frequent refusals were explained to R11. Review of R11's undated NA group sheet (an assignment sheet used by NA staff to identify individual resident care needs) indicated R11's "Bath Day" was Thursday morning, he required one staff assist for toileting and dressing; as needed assistance with grooming, was non ambulatory, independent with transfers and "Resident is prejudiced. Please alert Nurse if behaviors present." R11's Medicine Admission History and Physical dated 12/31/13, included information regarding R11 prior to admission to the facility. The form identified R11 had a chronic problem with homelessness and R11 had "lost his medical respite bed at Harbor Lights [a shelter facility for the homeless] due to refusal to shower in their facilities." The form indicated R11's left sided spasticity was "Worse since he has not taken any of his medications since 12/24" and directed to resume baclofen. The Admission Record indicated R11 was admitted to the facility on 12/31/13. A Therapy Screening Form dated 1/2/14, indicated R11 was screened upon admission to the facility. The form indicated R11's activities of daily living (ADLs), and mobility were impaired. The cognition section was left blank;	F 500		

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F 500	Continued From page 316 communication and swallowing were not impaired and none of the identified concerns were a "change" in R11's condition. The "Other Impairments" section of the form indicated R11 "denied" problems with pain, falls, pressure sores/open areas, and denied a "decline in ROM [range of motion]." The form indicated R11 "declines" splint/orthotic. The "Comments" section of the form indicated, "Pt [patient/R11] repeatedly declined offer of therapy services, stating he doesn't like people. Declines needing or wanting help for any ADL's, waiting for electronic scooter to arrive, is independent with manual w/c [wheelchair]. Requests not to have therapy services, no orders requested." The form indicated therapy services for physical therapy, occupational therapy, or speech therapy was "Refused." Although the form was dated 1/2/14, at the top of the form, the bottom of the form was signed by a therapist and dated for 3/11/14. The screening form indicated R11 was identified to refuse care and services shortly after admission. R11's admission Minimum Data Set (MDS) dated 1/6/14, indicated R11 was cognitively intact, had a mood problem of feeling tired, and had no behavior problems. The MDS indicated R11 was independent with bed mobility, transferring, locomotion on the unit and eating; required supervision with locomotion off the unit, dressing and toilet use; R11 was identified as requiring extensive physical assistance from staff for personal hygiene. The Care Area Assessment (CAA) for nutrition dated 1/7/14, identified diagnoses of spastic hemiplegia on left side, history of alcohol abuse and congestive heart failure. The CAA identified R11 had "no upper teeth and few lower teeth" and, "He does not wish to receive a mechanically altered diet." The CAA	F 500		

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F 500	Continued From page 317 for ADL Functional/Rehabilitation Potential dated 1/13/14, identified the CAA was triggered due to R11's need for supervision with ADLs. The CAA identified R11 had left sided hemiplegia due to a history of cerebrovascular accident (CVA, stroke). The CAA identified R11's other pertinent diagnoses to include altered mental status, and homelessness. The CAA identified R11 "was eval [evaluated] for therapy" and refused. The CAA identified R11 was continent of bowel and bladder, had no skin issues or falls. The CAA for falls and pressure ulcers (both dated 1/13/14), recapitulated the same data as ADL CAA. Although R11 initially refused therapies upon admission, and was identified to refuse therapy in the CAAs, the MDS and did not identify refusal of care behaviors. Although the behavior of refusing therapies was identified in the CAA, the clinical record lacked evidence R11 was assessed for refusals and interventions were developed to address potential risks of associated with refusing therapy, such as but not limited to, the left sided contracture getting worse, or skin breakdown of the left hand. The Social Services Comprehensive Assessment Packet dated 1/13/14, included: a LOA (leave of absence) Safety Assessment, Smoking Assessment and Vulnerable Adult Assessment dated 1/2/14. No behaviors of refusing cares were identified in the assessments. The Vulnerable Adult Assessment appeared incomplete. Although R11 was identified to have refused to take showers at the homeless shelter (resulting in R11 losing a respite bed there) and R11 had behaviors of not taking medications such as baclofen, the assessment didn't identify R11 had any behaviors, such as calling staff derogatory names and refusal/rejection of cares.	F 500		

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F 500	Continued From page 318 The clinical record did not identify a potential risk factor for R11 vulnerability. The Safety Risk (Fall) Assessment dated 1/4/14, indicated, "Resident does display behaviors calling staff 'Niggers', refuses cares and treatments. Nsg [nursing] to continue to monitor & update." Although the assessment identified abusive behaviors towards staff and refusals of care, the clinical record lacked evidence R11 was monitored for the behaviors. The undated Range of Motion Assessment identified "complete impairment" of R11's arm, hand, leg and foot on the left side. Review of R11's Weekly Audit (an evaluation of a residents' skin to identify potential changes, such as pressure ulcers or skin breakdown of the left contracted hand) form dated for both "12/31" and "1/01" indicated "Refuses body audit." The audit dated 1/9/14, and 1/16/14, both indicated R11 refused his bath/shower. Although R11 was admitted to the facility on 12/31/13, and R11 was scheduled for showers/baths weekly, the clinical record lacked evidence facility staff attempted to reapproach R11 for bathing after 1/16/14. The clinical record lacked evidence R11 was evaluated/assessed by a nurse practitioner or physician within the required time frames. R11's care plan only had a focus for activities dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's concerns with roommate, refusals of care nor behaviors of calling staff derogatory names. The clinical record lacked evidence R11 had care	F 500		

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F 500	Continued From page 319 plans developed (including goals and interventions) to address his clinically related social service needs, such as, but not limited to: R11's identified behaviors of refusals/rejection of cares, R11's identified behavior of calling staff derogatory names, and identification of R11's increased vulnerability due to physical limitations and individual psychosocial needs (such as a history of homelessness). In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming and skin assessments/evaluations and refusals of doctor visits. Review of the IDT Progress Notes from 12/31/13, through 3/17/13, indicated the following: - On 12/31/13, an admission note at 10:47 p.m. identified R11 was admitted to the facility, identified R11 was cognitively intact, continent of bowel and bladder, and transferred independently. A note at 11:53 p.m. identified R11 was able to make changes in body position when in bed to "release pressure." Although R11 had left sided weakness and a contracture of left arm and lower leg, the note incorrectly identified R11 was "able to independently walk to and from toilet." - On 1/1/14, a Late Entry note at 3:43 a.m. indicated R11 refused three attempts at a "body audit" and indicated R11 stated, "'I do not have anything on my skin, no wound.'" At 1:43 p.m. a note identified R11 required one staff physical assist with ADLs. At 10:20 p.m. a note identified R11 "refused make change of clothes and went to bed with his street clothes." - On 1/2/14, at 6:29 a.m. a note identified,	F 500		

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F 500	Continued From page 320 "Resident vehemently refused vital sign to be obtained, even when reapproached. Noted some blood show on his nares but he adamantly rejected nursing intervention, instead he placed a tissue papper [sic] in the nose, he refused to use 4x4 [gauze]. We will continue to encourage with care and support at this moment." At 10:13 p.m. a not indicated, "Resident refused cares and re-approached throughout the shift but he refused stating to be left alone." - On 1/4/14, a note at 10:40 p.m. indicated R11 refused "all attempts for the vital signs to be taken and cares to be provided." The note identified R11 "Requires help with ADLs but refuses." Although a behavior of refusing/rejecting cares was voiced by R11, the note indicated, "No behavioral problems noted." - On 1/20/14, at 3:16 p.m. a social services note indicated social services designee (SSD) met with R11 and discussed R11's discharge plan to remain in the facility "short term [sic]." The note identified R11 had determined his stay was short-term and identified R11 "is homeless" but would "like to find placement." The note indicated SSD would assist with discharge planning. - On 2/4/14, at 12:54 p.m. a social services note indicated the county public health nurse and SSD met with R11 regarding relocation options. At this time the note indicated R11 would "like to return to the streets when it gets warmer outside." R11 refused assistance from both. The note identified SSD "explained the risks of returning to the streets." - On 2/5/14, at 11:01 p.m. R11 was identified to be abusive to staff "using N-word to the nursing staff." The note indicated staff attempted to speak with R11, but R11 cursed at staff, refused to allow staff to assist with cutting his nails "stating he [would] look for qualified person to cut his finger	F 500		

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F 500	Continued From page 321 nails." - From 2/5/14, through 2/24/14, all notes indicated when R11 had nose bleeds or if no nose bleeds were noted. The notes identified period, but consistent refusals of assistance with nose bleeds. The notes did not indicate the physician was notified of potential nose bleeds. - On 2/25/14, at 3:17 p.m. a note from medical records indicated, "[R11] has refused all medical appt [appointments] since admit to include cardiology on 1-19-14. He has refused all offers of appts at the Indian Health Board for Primary care follow up. D.O.N. (director of nursing), clinical care manager and Admin [administrator] updated. Plan is for pt [patient] to be seen by the Medical Director." - From 2/25/14, through 3/17/14, notes address monitoring for nose bleeds. Although R11 was noted to refuse all cares, treatments, interventions and assistance, the clinical record lacked evidence R11's refusals were assessed and clinically related social services were provided. The Follow Up Question Report for 3/1/14 - 3/13/14, identified the daily NA documentation from Care Tracker. The report indicated the following: - "Bathing: Self Performance - How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower" was documented "Not applicable" daily. - NA's documented a behavior of both "Rejection of Care" and "Abusive Language" as "Yes" daily. - "Dressing: Self performance - How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis or TED hose (anti-embolism stockings). Dressing includes putting on and changing pajamas and	F 500		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 500	Continued From page 322 housedresses" was documented "Resident Refused" for 16 out of 18 opportunities. - "Personal Hygiene: Self Performance - How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands (Excludes baths and showers)" indicated "Resident Refused" eight times, "Not applicable" two times, "Independent - No help or staff oversight at any time" eight times out of 18 opportunities. On 3/13/14, at 2:24 p.m. the licensed practical nurse (LPN)-D verified there was no monitoring for behaviors towards staff, such as inappropriate/derogatory name calling of staff. On 3/13/14, at 2:37 p.m. a facility staff member (O)-E verified there were no physician's visits for R11 in the clinical record. O-E stated R11 refused referrals to "Indian services," cardiology and the medical director. O-E stated R11 had expressed he was in the facility until the weather warmed, then he "planned to return to the streets." On 3/13/14, at 2:40 p.m. LPN-D stated monitoring for refusal of care was in the NA "kiosks" and documented in "Care Tracker [a computer based data collection tool for the electronic medical record]" and should report the refusals of care to the nurse. LPN-D verified refusals should be documented in the clinical record. LPN-D was unclear on evaluation of the refusals. On 3/14/14, at 10:41 a.m. SSD stated she was not aware of R11 refusing any or all cares. SSD stated R11 was "easy to communicate with" and her first impression of R11 was he "wouldn't refuse." SSD further stated she "believes if [R11]	F 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 500	Continued From page 323	F 500		

was reapproached [when refusing]," R11 would "go for it." SSD stated facility staff should have been reporting the refusals to her and stated she would then have "approached and explained the risks and benefits" to R11. SSD stated she reviewed the (interdisciplinary team, IDT) progress notes, but stated the behaviors were not appropriately being documented in the clinical record. SSD stated "documentation was missing" and there "wasn't appropriate documentation [on behaviors]." SSD stated it was "very important for staff to document" and further stated she "relied heavily" on the documentation. SSD stated she was "not closely interactive with residents and staff." SSD verified she had access to "PCC [Point Click Care, the electronic medical record or EMR], and stated she did not know the NA staff documented R11's refusals daily "at the kiosks [in Care Tracker]." SSD stated she did not have access to the "kiosk" or Care Tracker. When asked about R11's discharge plan, SSD stated, "When [R11] came, I did my psychosocial assessment, offered him services." Although SSD stated she was unaware of R11's refusal, R11 was "easy to communicate with" and R11 would "go for it" if reapproached during a refusal of a care or treatment, SSD stated, "He [R11] refused services and said he was going to back to the streets." SSD confirmed she was aware of R11's unsafe discharge plan and stated she "referred him to the county for relocation services." SSD further verified her awareness of R11's refusals and stated the "Public health nurse attempted to visit with him, he refused for the moment." The clinical record lacked evidence of SSD's psychosocial assessment.

On 3/14/14, at 11:20 a.m. a physical therapist (PT)-J who provided a copy of R11's Therapy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 500	Continued From page 324 Screening Form verified the evaluation was "back dated" due to not being documented at the time of admission and problems with lost documentation. PT-J verified R11 refused therapy. PT-J stated risks and benefits were provided to R11, but were unclear on documentation of the risk/benefits. On 3/18/14, at approximately 2:05 p.m. the DON verified medically related social services were not provided for R11. R111 was not provided clinically related social services to address derogatory roommate behavior. On 3/10/14, at 6:38 p.m. during the initial stage one interview, when R111 was asked if there was a problem with a roommate or any other resident, R111 stated his roommate called him a "nigger" and "we got into it." When ask if he reported the incident and what happened, R111 stated, "They [the facility staff] told me if I don't like it, I should have to move." R111 stated he "doesn't want to move" because he was admitted to the room first and R111 "didn't cause the problem." R111 stated he and his roommate were on "non speaking terms right now." R111 stated the incident occurred the prior week. R111 further stated "he [the roommate] came to move in here" and the roommate was the cause of the problem. R111 described feeling "penalized" for what "he did." Stated he feels like it's more of a "punishment" to have to move and to remain in the room with roommate and not a "solution." R111 stated he hoped it was the "last time" the roommate called him a name.	F 500		

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 500	Continued From page 325 R111's Admission Record dated 1/10/14, identified diagnoses to include head injury and depressive disorder. The admission MDS dated 12/23/13, indicated R111 was cognitively intact; had mood concerns of: feeling down/depressed, trouble falling asleep, trouble concentrating, and feeling tired. The MDS identified R111 had no behavioral concerns and required physical assistance from staff for transferring, toilet use, personal hygiene, dressing and locomotion on and off the unit. The CAA for pressure ulcers dated 12/26/13, identified R111's closed head injury was "following an assault." The CAA for ADL Functional /Rehabilitation Potential dated 12/27/13, identified R111 was able to voice his needs and identified R111's specific ADL needs. The CAA for psychotropic drug use dated 12/27/13, identified R111 had vision impairment due to diabetes mellitus diagnosis and from the assault. Review of R111's care plan revealed appropriate care plan development. A copy of the care plan requested and not provided by the facility. Review of the IDT Progress Notes indicated on 3/6/14, at 12:06 a.m. a note identified R111 had "an argument with his roommate. According to his roommate the television (TV) was loud. He was very upset with his roommate for calling him the 'N' word. The nurse filled out an incident report. The administrator and DON were [sic] informed via text messag [sic]." Although the note identified an incident report, the facility lacked evidence of the notification or incident report. On 3/14/14, at 9:40 a.m. the LPN-A stated she was not aware of R111 being called derogatory name and stated "social services should be handling it." LPN-A stated room changes "are	F 500		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 500	Continued From page 326 done by social services." When asked regarding determining who should move when roommates report behavioral problems, LPN-A stated staff report the behavior to the social service designee and determine "who is the best to move." LPN-A further stated, "Our policy has been, the complainer is the one to move." On 3/14/14, at 10:59 a.m. SSD stated she was aware of a verbal altercation and stated she was notified by night shift. SSD stated she "met with both" residents separately the next morning and offered for R111 to switch rooms. SSD stated R111 refused to change rooms due to his potential discharge "next week." SSD stated R111 expressed he would keep to himself and "avoid the roommate." SSD stated she spoke with the roommate and believed the residents were friends and was "shocked" that the altercation had occurred. SSD stated she believed the roommate had just had a left below the knee amputation, was going through a rough time, lost all his belongings and he "took his frustrations out on [R111] due to the TV volume being too high." SSD stated she did not document the conversation and verified the roommate calling R111 a derogatory name would be considered verbal abuse. The Room and/or Roommate Change policy dated December 2013, directed "Residents are notified in advance of a new roommate." The policy indicated the social service director or designee was responsible to ensure a resident was informed of a new roommate, documentation in the clinical record would be completed indicating reasons for the move, residents/family input, agreement of resident/family, adjustment to the change in roommate would be monitored and	F 500		

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F 500	Continued From page 327 documented in the clinical record and the residents care plan would be updated. The undated Social Services/Social Work job description identified, "The social worker will work with residents in the facility by identifying their psychosocial, mental and emotional needs along with providing, developing, and/or aiding in the access of services to meet those needs." The job description indicated, "Advocacy 1. Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident. Prevent and address resident abuse as mandated by law and professional licensure." The job description identified clinical responsibilities of the social worker to be: complete social history and psychosocial assessment for each resident, develop a written plan of care for each resident that identified the needs from the assessment, ensure therapeutic interventions were provided to assist with coping in transition to the facility, provide support and education to residents/family, provide clinical interventions to address "catastrophic events" that occur during the resident's stay, and coordinate discharge planning. R56 had verbalized to facility staff recurrent fear from R63, and the facility did not take adequate precautions to protect R56 from the alleged physical, verbal and emotional abuse. R56 was observed and the following was noted: - On 3/11/14, at 1:54 p.m. R63 was observed to have yelled at R56 repeatedly and called her a liar. Registered nurse (RN)-B was immediately	F 500		

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F 500	Continued From page 328 notified of R63 yelling at R56. He said "ok" and did not leave the desk. - On 3/11/14, at 4:00 p.m. R56 had to be approached five different times to get the interview completed due to R63 would not let R56 talk without becoming upset. R63 pointed at R56 and stated "You better not talk." - On 3/12/14, at 8:10 a.m. R56 stated roommate was verbally abusive. R63 stated R63 slammed the foot of R56's bed with her hand and told her she knew "what murder feels like." That incident had happened on 3/9/14, and the police were called. - On 3/12/14, at 8:11 a.m. when R56 reported the incident to facility staff they told her to keep stuff on her bed. R56 did not make noise. - On 3/12/14, at 8:14 a.m. the facility still did not investigate or identify the emotional, physical or verbal abuse towards R56 from R63. - On 3/12/14, at 8:23 a.m. R56 was again interviewed and stated "I'm so glad she's not here." - On 3/12/14, at 1:53 p.m. R56 reported she "feels like s**t" when R63 verbally abused her and reported she was afraid of R63. - On 3/13/14, at 7:40 a.m. observed in room 147A in bed. - On 3/13/14, at 9:54 a.m. resident observed in bed 147A. R63 was in 147B. Maintenance staff was in the room setting up headphones with the TV and the activity director was sitting outside the room. At the start of the interview with R56, roommate (R63) yelled with an angry voice "Oh God" and R63 got up and left the room. The activity director went down the hall with her. - On 3/14/14, at 8:12 a.m. R56 observed in her bed. R56 stated they took her (R63) away last night and felt safer now. R56 reported she had been bedfast for the past one to two months.	F 500		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 500	Continued From page 329	F 500		

The care plan dated 3/6/13, indicated R56 needed social services (SW) due to recent admission to facility. The interventions noted the SW was to visit monthly and as needed (PRN), introduce self to others, encourage R56 to attend activities and the SW would make outside referrals to mental health professionals as needed. The medical record lacked evidence of how the facility intervened on keeping R56 safe from R63's physical, verbal, and emotional abuse. The medical record lacked any evidence of the SSD meeting with R56 to discuss the new roommate and/or adjustment of the room.

The care plan revised 4/21/13, incorrectly identified R56 as short stay resident to the facility and identified R56 as a vulnerable adult related to (r/t) physical limitations. The goal was to ensure R56 was safe within Camden Care Center and the interventions included "Nursing to provide cares, services according to resident needs, POS [Physician's orders] and POC [plan of care]," "Assistance in case of emergency" and "Vulnerable adult assessment per facility policy."

The Vulnerable Adult Assessment (VAA) dated 11/21/13, indicated R56 had physical limitations which made the resident susceptible to abuse. The physical limitations include wheelchair (w/c) bound and history of hip fracture. The form also identified R56 did not "have a history of any type of abuse towards others or self-abuse." The VAA was updated on 2/20/14, and noted the VAA was still current with no changes.

R56's progress notes were reviewed from 1/25/14, going forward to 3/14/14. On 3/14/14, the social worker designee met with R56 "as a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 500	Continued From page 330 follow up to provide an ongoing support." There was no supporting evidence of as to what "ongoing support" meant. R56's most recent MDS dated 2/20/14, identified R56 as being cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. R56 was totally dependent upon staff for transfers and bed mobility. behaviors directed towards staff only, no delusions, Patient Health Questionnaire (PHQ)-9 was 12 which noted moderate depression (PHQ-9 scores of 5, 10, 15, and 20 represented mild, moderate, moderately severe, and severe depression, respectively). R56's diagnoses included arthritis, cancer, and Parkinson's. R63: R63's Progress Notes were reviewed from 9/27/13, going forward and the following was noted: - On 3/9/14, at 5:34 a.m. noted staff was aware that R63 had threatened R56. "She [R63] stated 'I will kill you now', and she pound very hard on her bed. This resident verbally attack this writer for changing her room where she was having a good slumber. Updated the authority for a threatening comment directed towards coresident. We will continue to monitor the situation closely and vigilantly at this moment." - On 3/9/14, at 12:50 p.m. noted R63 was "not fine with present roommate and room environment. according to her [R63] , her roommate is very in appropriate , like to put call light on, turn television loud, and calling nar [nursing assistant/registered] in the room to assist her with cares etc." The police had been called previously and 'resident needed to be separated	F 500		

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F 500	Continued From page 331	F 500		

before something happen [sic] beyond our reach." The note indicated the facility staff was going to monitor the situation every 15 minutes, however, the medical record lacked evidence of the monitoring.

A Care Conference Quarterly note dated 10/22/13, depicted R63 as having behaviors which included "becomes irritated with staff at times, barricades herself in her room with boxes, she also isolates herself in her room." The continued to note R63 "is very sensitive to noise and that causes 'nausea'." The note revealed R63 independent in ambulation to all destinations.

R63's most recent MDS dated 1/8/14, noted R56's diagnoses included dementia with behavioral disturbances, anxiety, psychotic disorder, and depression. The MDS identified R63 as being cognitively intact with a BIMS score of 15. R63's PHQ-9 was 10 which noted moderate depression. According to the MDS, R63 had trouble sleeping, had a poor appetite, had little interest, trouble concentrating, felt tired, and felt down. R63 was depicted as having no behaviors.

R63 was unavailable for interview for the untoward behavior towards R56 as R63 was transferred out of the building on the evening of 3/13/14.

On 3/12/14, at 2:37 p.m. an interview was conducted with the SSD. She indicated R56 and R63 became roommates on 3/5/14, as both women were private pay and could pay the private pay fee for the private room. The SSD indicated she was made aware of the 3/9/14, altercation in the Monday morning report meeting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(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 500	Continued From page 332 on 3/10/14. The SSD revealed she did speak with R63 and stated, "[R63] used to being in her own room. She did warn us, I would not be able to get along with a roommate. 'I was brought into a private room and will not be able to get along.'" The SSD was not aware of R63's "I now know what murder feels like." and was aware of the police being called on 3/9/14. The SSD expected the staff to inform her of any situation that needed her attention. SSD stated she did meet with R63 on 3/11/14, and R63 stated "things were getting better, they are avoiding communicating with each other and talking to each other." The SSD did not put any interventions into place for the altercations between the two roommates and she was unaware if nursing had put any interventions in place to prevent the emotional, physical and verbal abuse of R63 towards R56. The medical record lacked evidence of the communication between R63 and the SSD as the SSD did not document any of the follow up conversations. It could not be determined if R63 received the monthly SW visits as indicated on the care plan revised 4/18/12, nor could it be determined if R63 adjusted to the new room and roommate as the medical record lacked evidence any SW intervention for the adjustment other than one visit on 3/11/14. On 3/17/14, at 10:00 a.m. the DON stated discharge planning was not done by SSD, she thought she only needed to call relocation services. - At 11:40 a.m. The administrator and corporate interim administrator (CIA) were interviewed regarding the SSD: what training/orientation was provided so that she could successfully carry out the job? The administrator stated, "When I started here with SSD, I asked CIA if she was	F 500		

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F 500	Continued From page 333 being supervised." CIA stated, "I told you she was, because the corporate social workers (CSW) was going to mentor her." The administrator stated, "When corporate came into town on 2/11/14, both of the two (facility owner and CSW) were here, and I asked when are you going to counsel SSD? The CSW acted like she did not know what was happening and stated, 'I can't supervise her.' The facility owner stopped the conversation and stated 'you will supervise her.' It was very alarming to me, a new social worker (without a mentor)." CIA stated, "When I got here in November she was already hired and here." The administrator stated a social worker was so essential to proper discharge planning, and "I was downright angry that she was not supervised, and mentored. My regional administrator stated he had hired her with the understanding that CSW was going to be her supervisor." R91: On 3/13/14, at 9:00 through 9:47 a.m. R91 was observed resting in bed with covers on her. R91 was being delivered supplemental oxygen to her through a nasal cannula. R91 nodded off during conversation with surveyor and did not respond to some questions. R91 flinched her shoulders twice and reported she had a lot of pain in her knees. R91 reported she was very depressed from living at the facility and wanted to go home. R91 explained she felt no one cared for her at the facility because, even though she was sick and in pain, no one came to check on her. R91 explained she had been prescribed antibiotics and pain medications by a physician yesterday but she did not take them because she did not trust the physician knew her well enough to	F 500		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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F 500	Continued From page 334 prescribe meds to her. R91 recounted how she was upset because a staff member lied to her yesterday about canceling a ride to the store for her. R91 reported it made her "angry" and "rude" when staff lied to her. R91 reported she planned on spending the rest of the day resting in bed and did not think any staff would assist her with any cares today. R91's admission MDS, dated 10/15/13, indicated the potential for moderate depression due to self-reported symptoms of little interest or pleasure in doing things, feeling down depressed or hopeless, trouble falling asleep or sleeping too much, feeling tired or having little energy and poor appetite or overeating. The MDS revealed R91 displayed verbal and physical aggression one to three days during the seven day observation period. R91's quarterly MDS, dated 1/9/14, indicated a potential for mild depression, with R91 reporting the same symptoms in addition to moving or speaking slow or being fidgety. The MDS noted verbal and physical aggression towards others occurred four to six days during the seven day observation period. Both the 10/15/13 and 1/9/14, MDS indicated R91 rejected evaluation or care on one to three days during the seven day observation period. R91's BIMS on her admission and quarterly MDS dated 10/15/13 and 1/9/14 indicated she was cognitively intact. R91's Care Area Assessments, dated 10/22/13, for Mood, Cognitive Loss/Dementia, Behavior, and Psychosocial Well Being included the same summary statement under the Care Plan Considerations section: "Resident has some behavior r/t [related] medical Dx [diagnosis]. Staff	F 500		

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	245544	A. BUILDING _____ B. WING _____	03/18/2014

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F 500	Continued From page 335 will monitor her behavior and ensure pt [patient] needs are met and she is safe." The sections for input from resident and family or representatives for resident were all left blank; despite R91's BIMS score indicating she was cognitively intact. Each care area assessment noted a referral to another discipline in the health care team (such as social services, medical or mental health professionals) was not necessary. The assessment did not include a thorough analysis including: specific behaviors exhibited by R91, what medical or mental health concerns would impact care, triggers to behaviors, events immediately prior to behavior, consequences of behavior or tactics known to decrease or minimize behavior. R91's current care plan, last reviewed 1/30/14, did not include problems, goals or interventions related to R91's mood, rejection of evaluation or care and verbal and physical aggression. On 3/14/14, at 2:14 p.m. the SSD reported the care area assessments for R91 were completed prior to her employment at the facility. SSD reported the care area assessments were not comprehensive, did not identify what behaviors were occurring, causative factors or how best to help. SSD reported she was not aware R91 exhibited verbal and physical aggression or rejection of cares. Surveyor requested any other documentation of behavior or mood assessments, not included in the care area assessments. None was provided. SSD confirmed R91's care plan did not address her aggressive behaviors or rejection of evaluation or care. On 3/14/14, at 3:53 p.m. R91's NA-G reported	F 500		

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F 500	Continued From page 336 R91 rejected cares because she valued her privacy and wanted to do as much as she could herself. NA-G reported R91 at times cussed at staff, called them unkind names or threatened to get them fired. NA-G reported R91 has said unkind statements to her roommates. NA-G explained R91 could be intrusive to her roommate's privacy during cares because she thought her roommate was her daughter. NA-G explained R91's behavior varied throughout the day and that at times she was very kind. NA-G was not aware of any physical aggression towards other residents from R91. The undated Social Services/Social Work job description identified, "The social worker will work with residents in the facility by identifying their psychosocial, mental and emotional needs along with providing, developing, and/or aiding in the access of services to meet those needs." The job description indicated, "Advocacy 1. Work with the interdisciplinary team and administration to promote and protect resident rights and the psychological well-being of each resident. Prevent and address resident abuse as mandated by law and professional licensure." The job description identified clinical responsibilities of the social worker to be: complete social history and psychosocial assessment for each resident, develop a written plan of care for each resident that identified the needs from the assessment, ensure therapeutic interventions were provided to assist with coping in transition to the facility, provide support and education to residents/family, provide clinical interventions to address "catastrophic events" that occur during the resident's stay, and coordinate discharge planning.	F 500		
F 501	483.75(i) RESPONSIBILITIES OF MEDICAL	F 501		

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F 501 SS=F	Continued From page 337 DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the medical director failed to collaborate with the facility staff to provide guidance in the development, implementation and evaluation of resident care policies and procedures. This had the potential to affect all 84 residents in the facility. Findings include: Refer to F309 - The facility failed to provide six days worth of physician ordered and care planned pain medications for 1 of 3 residents (R41) in the sample reviewed for pain. Refer to F314 - The facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater).	F 501	F 501 For sampled residents and for all residents at the facility, the facility shall ensure a medical director is involved in the operationalization of policies and procedures related to resident care, resident quality of life, and all other aspects of the facility. The facility has a policy titled, "Medical Director." This policy was effective 05/2012 and reviewed 05/2013. The facility and medical director shall ensure this policy and fully operational. The facility does have a Medical Director on contract. The facility and the medical director shall ensure this contract is in full force. On March..... a QA committee was held to discuss the results of the current survey. The Medical Director was available to the meeting via phone. On April 16, 2014 the medical director was present at the meeting to begin review and discussion of the POC for the current survey. The medical director has committed to be present either in person or over the phone for all QA committee meetings related to the POC for the survey.	

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F 501	Continued From page 338 Refer to F319 - the facility did not ensure treatment and services were provided to aid in healthy adjustment to living in the facility for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F323 - The facility did not ensure safe use of a mechanical stand lift for 1 of 2 residents (R64) in the sample. This practice resulted in an Immediate Jeopardy on 3/13/14, at 1:50 p.m. The Immediate Jeopardy was removed on 3/16/14, at 12:17 p.m. but non-compliance remained at the scope and severity of no actual harm with the potential for no more than minimal harm at a pattern. Refer to F328 - The facility failed to ensure the continuous positive airway pressure (CPAP-breathing machine that provides a continuous supply of air which is positively pressurized) and mask were cleaned and stored properly. In addition, the facility failed to address the use of the CPAP and monitoring of respiratory status in the comprehensive care plan for 1 of 1 resident (R111) reviewed for respiratory concerns. Refer to F329 - The facility failed to ensure 4 of 5 residents (R9, R89, R1, R91) were free from unnecessary medications; failed to ensure R9 had a gradual dose reduction (GDR) of Haldol (an antipsychotic) and Trazodone (used for sleep) or a documented clinical contraindication of a GDR and failed to ensure adequate monitoring of Haldol and Trazodone; failed to ensure R89 had target behavior monitoring for the use of Zyprexa (an antipsychotic); failed to ensure R1 was monitored for potential side effects, sleep patterns and mood monitoring related to use of	F 501	The medical director shall attend the annual QA committee meeting and all quarterly QA meetings her schedule will allow. If she is not able to be at a quarterly QA committee meeting personally she will phone in. The QA Committee and the facility Administrator shall ensure the medical director is aware of all QA committee meetings. The IDT shall consult with the medical director on a PRN basis based on judgment related to the specific issues at question. Documentation of this consultation will be kept in IDT minutes (care planning minutes) and the clinical records. Responsible: Administrator, DON, RCM, ward secretary Compliance date: 4/28/2014	

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F 501	Continued From page 339 Trazodone and Venlafaxine (anti-depressants) and Ambien (Zolpidem-sedative used for short term treatment of insomnia); and the facility failed to identify and monitor target behaviors for anxiety medications for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F353 - The facility did not provide sufficient staff to ensure residents received care per the care plans. This had the potential to affect all 49 of 84 residents who are consistently dependent for cares, and 2 of 2 residents (R11, R41) who occasionally need assistance for cares in the facility. Refer to F385 - The facility failed to ensure physician services were provided for 4 of 5 residents (R103, R115, R33, R71) out of a list of 16 residents after they were admitted to the facility. Refer to F386 - The facility failed to ensure resident care was fully reviewed for 4 of 5 residents out of 16 residents (R103, R33, R71, R82) who had both medical directors (MD)-A and MD-B as their primary physician. Refer to F387 - The facility failed to ensure physician visits were provided as required for 3 of 6 out of 16 residents (R11, R33, R82) in the sample reviewed for physician's visits. Refer to F441 - The facility failed to ensure appropriate glove changes during cares for 2 of 4 residents observed for cares (R64, R56); facility did not ensure 1 of 1 sharps container attached to the treatment cart was changed when full to prevent access to used syringes and needles this	F 501		

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F 501	Continued From page 340 had the potential to affect all 84 residents. On 3/13/14, at 12:20 p.m. the medical record coordinator (HIM) stated MD-A, gave notice in November 2013, and left in January 2014, and several patients were reassigned to MD-C who will only take residents 65 and older. "For those residents under 65 I attempted to re-assign them to doctors, and send them out to doctors, but they won't leave the building for appointments. Before MD-A left, I was told we were getting a new doctor, but the prior director of nursing (DON) told me it was a new medical director who was going to take the case load. One week before MD-A left, the prior director of nursing (DON) told me the new medical director was not going to see patients. When residents come to the building without a doctor, they default to the medical directors list (to be seen). Finally, we were able to get the medical director to see some people." On 3/14/14, at 2:45 p.m. the medical director was interviewed. The medical director was not aware she was expected to be the physician of record for the undoctored residents, on top of her other full time job. She was now seeing residents in the facility, until they could get some help, but had just returned from vacation. The signed but undated medical director contract identified Background: B. The facility requires the services of a medical director (the "Medical Director") to assist the facility in meeting the applicable standards established under state and federal law. D. The facility wishes to engage MD-B, to provide physical-related consulting services (the Consulting Services"), and to obtain the personal	F 501		

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F 501	Continued From page 341 services Phrygian to fill the position of medical Director in the facility. The signed but undated medical director contract listed the medical director duties as: a. Help promote appropriate attitudes. Objective: To foster attitudes among physicians and other staff at the facility and care processes that will help the facility meet its essential care objectives. The Medical Director policy dated 5/12, and review date of 5/13, indicated: "the medical director is responsible for: implementation of resident care policies; and coordination of medical care in the facility. The medical director collaborates with the facility leadership, staff, and other practitioners and consultants to help develop, implement and evaluate resident care policies and procedures that reflect current standards of practice. The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns."	F 501		
F 514 SS=F	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514	F 514 For sampled residents R 78, 32, 107, 42, 108, 48, 103, 9, 109, 114, 110, 79, 106, 87, 36, 1, 66, 11, 47, 64, 100, 75, 33, 89, 91, 63, 111, 117, 41, and 82 and for all residents the facility shall ensure a system to keep medical records complete, organized, accurate and maintained by authorized personnel.	

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F 514	Continued From page 342 This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have systems in place for complete, organized, accurate medical records and maintained by authorized personnel for 31 of 84 residents (R78, R32, R107, R42, R108, R48, R109, R114, R110, R79, R106, R87, R66, R11, R47, R64, R100, R89, R91, R63, R111, R117, R103, R36, R75, R41, R9, R1, R33, R71, R82). This had the ability to affect all 84 residents in the facility, discharged residents and potential future residents. Findings include: During the stage one closed record review the discharged resident records did not contain a capitulation of stay, or summary of cares and treatments while in the facility for 13 residents reviewed (R78, R32, R107, R42, R108, R48, R109, R114, R110, R79, R106, R87, and R66) whose discharged occurred between 10/31/13 to 2/14/14. R78 was admitted to the facility 11/26/13, and discharged to the community 12/20/13. R32 was admitted to the facility 10/30/13, and discharged to the community 11/18/13. R107 was admitted to the facility 10/17/13, and discharged to the community 1/17/14. R42 was admitted to the facility 9/26/13, and discharged to the community 10/15/13. R108 was admitted to the facility 10/30/13, and discharged to the community 11/13/13. R48 was admitted to the facility 11/4/13, and discharged to the community 11/26/13.	F 514	The facility has a policy titled, "Computer Documentation" that was effective 02/2014. The facility has a policy titled, "Records Management and Retention" that was effective 05/2012, reviewed 05/2013, and reviewed/revised 04/2014. The facility has a policy titled, "Nursing Documentation" that was effective 05/2012 and reviewed 05/2013. All of these policies will be made operational within the facility. The administrator, DON, RCMs, charge nurses, and medical secretary will be educated in these policies so they understand their responsibilities. The facility uses PointClick Care as an EMR. Additionally, Therapute is used by skilled therapy for their assessments and documentation. EZMar is a proprietary web based documentation system of PharMerica that is used as MAR/TAR documentation.	

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F 514	Continued From page 343 R109 was admitted to the facility 10/31/13, and discharged to the community 11/22/13. R114 was admitted to the facility 12/27/13, and discharged undocumented 1/31/14. R110 was admitted to the facility 11/15/13, and discharged to the community 12/30/13. R79 was admitted to the facility 1/23/14, and discharged to the community 2/14/14 R106 was admitted to the facility 10/16/13, and discharged to the community 12/04/13. R87 was admitted to the facility 10/07/13, and discharged to the community 10/31/13. R66 was admitted to the facility 9/26/13, and discharged to acute care status 10/18/13, readmitted on 10/28/13, and discharged to acute hospital 1/03/14. On 3/12/14, at approximately 1:00 p.m. health unit coordinator (HUC) was interviewed. The interview in the medical records room noted approximately 15 filing cabinets with approximately 10 to 12 boxes stacked on top of cabinets, and approximately five to seven boxes on large shelves. The HUC verified there was no system to medical record filing and stated the filing cabinets could be current, discharged, and/or expired residents. One of the cabinets included facility staff files. The HUC indicated the director of environmental services also had a key to medical records. On 3/12/14, at 3:01 p.m. the DON stated the facility was aware that assessments were not completed, overdue and inaccurate. A list of not completed care plans included: R11, R96, R111, and R47. A list of overdue care plans included: R39, R75, R84, R15, R70, R98, R46, R2, R72, R56, R35, and R94.	F 514	On a monthly basis, the Administrator, DON, and/or RCMs will randomly audit clinical records to ensure either computer documentation or paper documentation has occurred and is readily accessible either on the computer or in the chart. This audit will ensure the records are complete and accurate based on the current status of any resident at the time of the audit. These audits will be reported to the QA committee for 6 months for review and further recommendation as indicated. All MDS once locked and transmitted will be reduced to hard copy and kept in a separate notebook either at the nurses' station or in the MDS office. 15 months of MDS will be kept in the notebooks. Authorized personnel to have keys to the medical records storage are the administrator, the DON, off hours nursing supervisor, and the maintenance director. The maintenance director must have a master key in case someone loses a key. The maintenance director does not need to access the medical records storage for any reason.	

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F 514	Continued From page 344 On 3/13/14, at 3:37 p.m. the DON verified there was no filing system in place for medical records stated she was not aware employee files were stored with resident records and neither the HUC nor the maintenance should have access to employee files. The DON was aware that physician visits were behind, and they had been trying to catch up, but the medical director was on vacation. On 3/17/14, at 1:59 p.m. other (O)-C stated that approximately 1/1/2 weeks of daily therapy notes had been lost when the facility converted to a new therapy documentation system. O-C verbalized a notification from corporate had come to say that a new system would be implemented; however it did not give a specific start date. The therapy staff had started to print out the daily notes, but had not completed the task. The following Monday, February 10th, 2014, the new system was in place and we could not access the unprinted (lost) notes from the other system. The facility was not able to produce the daily therapy notes requested for the time period that was lost. Hill, Jonathan T. Access to medical records: The facility lacked a medical records system which was systematically organized. In addition, the pad-locked medical record storage area (in the basement of the facility) was accessible to unauthorized personnel. On 3/12/14, at approximately 1:00 p.m. the surveyor requested to see the medical records storage area. The health unit coordinator (HUC)	F 514	Offsite storage of medical records is contracted with Iron Mountain. This is a secured medical records storage company. An inventory off all off site stored documents is kept readily available in the facility administrator's office. This inventory list will be presented to the QA committee for review and further recommendation as indicated for 6 months. Responsible: Administrator, DON, RCM, ward secretary Compliance date: 4/28/2014	

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F 514	Continued From page 345 and surveyor observed the medical records storage area in the basement of the facility. The storage area consisted of a large caged area in the back corner of a storage room. HUC entered the maintenance area, retrieved a key and opened the pad lock to the door of the area. The area was observed to have many large shelves containing bags of clothing, boxes of belongings and boxes containing medical records. Approximately 15 cabinets were observed to be lined up against the left aspect of the caged area. Approximately 12 boxes containing various resident records in various stages of organization were observed to be stacked on top of cabinets. Many of the boxes were open and broken, with stacks of files falling out and loose papers (containing resident names) exposed. Approximately five boxes were observed on a large metal shelf directly across from the file cabinets. The boxes had no lids and contained resident files stored in the boxes. The boxes were stored amongst the bags of clothing and personal items of residents. During the observation, HUC explained the file cabinets contained resident records which "Could be current, discharged or expired residents," the boxes on the shelves across from the file cabinets were "current records" HUC had attempted to organize. HUC explained she was "in charge of medical records," but she did not have a key to access the storage area. When asked who had a key to the storage area, HUC stated the key was locked in the maintenance area and stated "maintenance" staff had access to the key. HUC stated she believed there were two keys, but then stated the "DON [director of nursing]" did not have access to the medical records. HUC there was no system for organizing the stored clinical records and the records were accessible by unauthorized staff.	F 514		

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F 514	Continued From page 346 HUC pointed to one file (in amongst file cabinets identified to contain resident records) and stated the file cabinet contained "employee records." HUC verified the resident medical records contained private information, including social security numbers which should not be accessible to all staff. HUC verified the bags of clothing were resident personal belongings and verified unauthorized staff accessed the caged area to retrieve these items. On 3/12/14, at 3:00 p.m. DON verified she did not have a key to access the medical records storage area in the basement and stated she was unclear who had the second key. On 3/13/14, at 3:37 p.m. DON stated only the maintenance staff had a key to the padlock and cages medical records storage area. DON verified maintenance staff was not authorized to have access to resident medical/personal information. DON further verified there was no filing system for medical records, stated she was not aware employee files were stored with resident records. DON verified HUC did not have a key and was expected to have access to the storage area. DON verified although the medical record storage area was locked with a pad lock, resident private and medical information was not secure. On 3/18/14, at 12:02 p.m. the director of plant operations (DPO) verified he had the key to access the medical record storage area and stated he believed there was "only one" key. DPO was unclear why he had access to the area and not the HUC or DON. DPO verified he and other maintenance staff entered the area to access resident personal belongings stored in the area.	F 514		

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F 514	Continued From page 347	F 514		

The Videll Healthcare, LLC Record Retention/Destruction policy dated as reviewed on 5/2013, indicated, "The Videll Healthcare, LLC facilities will retain and destroy medical records in compliance with all state and federal laws and regulations. Facilities will use AHIMA (American Health Information Management Association) as an authoritative resource and standard for medical record retention and/or destruction." The procedure directed the reader to the website address "For authoritative resource and guidelines regarding medical record retention and/or destruction..." Although the policy identified an authoritative source for reference to guidelines, the policy lacked practical procedural identification of the means for record storage, such as where, under what condition, security; what staff would have access to the resident medical records in storage, such as staff allowed access to the key; and organization of the medical records storage. Although the policy reference destruction of the medical records, the policy lacked practical procedural direction for when and how the facility would handle medical record destruction.

R11's clinical record contained a back dated therapy screening form, had an incomplete Vulnerability assessment, and lacked accurate and consistent documentation of behaviors.

The Admission Record indicated R11 was admitted to the facility on 12/31/13. A Therapy Screening Form dated 1/2/14, indicated R11 was screened upon admission to the facility. The form indicated R11 refused offers for therapy. Although the form was dated 1/2/14, at the top of the form,

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F 514	Continued From page 348 the bottom of the form was signed by a therapist and dated for 3/11/14.The screening form indicated R11 was identified to refuse care and services shortly after admission. An admission Progress Note dated 12/31/13, at 10:47 p.m. identified R11 was admitted to the facility, identified R11 was cognitively intact, continent of bowel and bladder, and transferred independently. A note at 11:53 p.m. identified R11 was able to make changes in body position when in bed to "release pressure." Although R11 had left sided weakness and a contracture of left arm and lower leg, the note incorrectly identified R11 was "able to independently walk to and from toilet." The Social Services Comprehensive Assessment Packet dated 1/13/14, included: a LOA (leave of absence) Safety Assessment, Smoking Assessment and Vulnerable Adult Assessment dated 1/2/14. No behaviors of refusing cares were identified in the assessments. The Vulnerable Adult Assessment was incomplete. Although R11 was identified to have refused to take showers at the homeless shelter (resulting in R11 losing a respite bed there) and R11 had behaviors of not taking medications such as baclofen, the assessment didn't identify R11 had any behaviors, such as calling staff derogatory names and refusal/rejection of cares. The clinical record did not identify a potential risk factor for R11 vulnerability. R11's care plan only had a focus for activities dated 1/8/14, and an identified problem for risk for impaired nutrition dated as revised on 3/12/14. Neither care plan focuses addressed R11's concerns with roommate, refusals of care and the	F 514		

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F 514	Continued From page 349 behaviors of calling staff derogatory names. The clinical record lacked evidence R11 had care plans developed (including goals and interventions) to address his clinically related social service needs, such as, but not limited to: R11's identified behaviors of refusals/rejection of cares, R11's identified behavior of calling staff derogatory names, and identification of R11's increased vulnerability due to physical limitations and individual psychosocial needs (such as a history of homelessness). In addition, R11 lacked a care plan to address the risks of refusals of care, such as potential increase in contracture due to refusals of therapies and/or range of motion, potential development of skin issues due to refusal of bathing/personal hygiene/grooming and skin assessments/evaluations and refusals of doctor visits. On 3/14/14, at 10:41 a.m. social service designee, (SSD) stated she was not aware of R11 refusing any or all cares. SSD stated she reviewed the (interdisciplinary team, IDT) progress notes, but stated the behaviors were not appropriately being documented in the clinical record. SSD stated "documentation was missing" and there "wasn't appropriate documentation [on behaviors]." SSD stated it was "very important for staff to document" and further stated she "relied heavily" on the documentation. SSD stated she was "not closely interactive with residents and staff." SSD verified she had access to "PCC [Point Click Care, the electronic medical record or EMR], and stated she did not know the NA staff documented R11's refusals daily "at the kiosks [in Care Tracker]." SSD stated she did not have access to the "kiosk" or Care Tracker. SSD verified R11's medical record was inaccurate.	F 514		

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F 514	Continued From page 350 On 3/14/14, at 11:20 a.m. a physical therapist (PT)-J who provided a copy of R11's Therapy Screening Form verified the evaluation was "back dated" due to not being documented at the time of admission and problems with lost documentation. PT-J verified R11 refused therapy. PT-J stated the risks and benefits were provided to R11, but were unclear on documentation of the risk/benefits. R47's weight(s) were lacking in the medical record since admission. On 3/12/14, at 9:15 a.m. during review of R47's both physical and electronic medical record, it was revealed R47's weight had not been taken since admission. R47 had been admitted to the facility on 1/24/14, obtained from the admission Minimum Data Set (MDS) dated 1/30/14. During further document reviewed it was revealed the weight from the hospital Discharge Health & Physical Progress was the one used for the Nutritional Assessment and initial MDS at the facility. When approached on 3/12/14, at 9:14 a.m. registered nurse (RN)-C who was the MDS coordinator verified R47's medical record lacked weights since admission to the facility but stated she would have the dietician come talk to this surveyor. -At 9:16 a.m. returned to surveyor stated the dietician was not on site but would let her know the surveyor was looking for her. -At 9:22 a.m. surveyor approached the director of nursing (DON) stated she had been at the facility	F 514		

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F 514	Continued From page 351 for four weeks and she thought the dietary manager (DM) would be more helpful as she thought DM pulled all the weights together. -At 9:24 a.m. when interviewed DM stated R47 refused and the staff would even re-approach but still he refused. She verified there were no weights taken for R47 since admission. She further stated "Nothing we can do." Refer to F157 as the facility failed to notify the physician and family member in a timely manner of the development of pressure ulcers for 1 of 1 resident (R64) reviewed for notification of changes. Refer to F204 as the facility failed to ensure 1 of 2 residents (R100) reviewed for admission, discharge, and transfer, was provided sufficient preparation and orientation prior to discharging from the facility. Refer to F221 as the facility failed to ensure 1 of 1 resident (R89) was assessed for the restraint of having both wheelchair brakes locked and having the wheelchair placed flush against a table or desk; in addition, the facility failed to ensure the restraint was the least restrictive and clinical indications for the use of the restraint. Refer to F272 as the facility did not comprehensively assess behaviors1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior. Refer to F275 as the facility did not comprehensively assess 1 of 1 resident (R63) who required a comprehensive assessment at	F 514		

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F 514	Continued From page 352 366 days. Refer to F279 as the facility failed to develop a comprehensive plan of care (POC) for 1 of 1 resident (R111) as the care plan did not address the respiratory interventions for use of a continuous positive airway pressure (CPAP-breathing machine that provides a continuous supply of air which is positively pressurized); the facility failed to develop a comprehensive POC for 1 of 1 resident (R117) to include lacked a comprehensive care plan related to the Care Area Assessments (CAA) areas triggered of falls, dental care and psychotropic drug use; the facility failed to develop a comprehensive POC for 1 of 1 resident (R103) to include interventions for urinary incontinence, ADLs, psychosocial wellbeing, and pain; the facility failed to develop a comprehensive POC for 1 of 1 resident (R1) to include interventions for ADLs and sleep medications. Refer to F280 as the facility failed to revise the care plan to implement smoking interventions for 1 of 3 residents (R36) reviewed for unsafe smoking and non-placement of a Wanderguard (an alert system to notify staff when a resident had left the building); and the facility failed to revise the care plan for 1 of 1 resident (R75) who received Hospice services. Refer to F280 as the facility failed to monitor for target behaviors for the use of Zyprexa as directed by the care plan for 1 of 1 resident (R89); the facility failed to ensure self-administered medications were safely administered for 1 of 1 resident (R36) observed to self-administer medications (SAM); the facility failed to ensure 1 of 3 residents (R41) who did not receive	F 514		

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F 514	Continued From page 353 medications as care planned for six days; the facility failed to ensure 1 of 3 residents (R64) was not provided assistance with repositioning, transfers and nail care as directed by the care plan. Refer to F314 as the facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). Refer to F329 as the facility failed to ensure 4 of 5 residents (R9, R89, R1, R91) were free from unnecessary medications; failed to ensure R9 had a gradual dose reduction (GDR) of Haldol (an antipsychotic) and Trazodone (used for sleep) or a documented clinical contraindication of a GDR and failed to ensure adequate monitoring of Haldol and Trazodone; failed to ensure R89 had target behavior monitoring for the use of Zyprexa (an antipsychotic); failed to ensure R1 was monitored for potential side effects, sleep patterns and mood monitoring related to use of Trazodone and Venlafaxine (anti-depressants) and Ambien (Zolpidem-sedative used for short term treatment of insomnia); and the facility failed to identify and monitor target behaviors for anxiety medications for 1 of 1 resident (R91) identified as having concerns related to mood and aggressive behavior.	F 514		

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F 514	Continued From page 354 Refer to F386 as the facility failed to ensure residents care was fully reviewed for 4 of 5 residents out of 16 residents (R103, R33, R71, R82) who had both medical directors (MD)-A and MD-B for their physician.	F 514		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure the quality committee met	F 520	F 520 For all residents the facility shall ensure the Quality Assurance committee is functional and meets at least quarterly. The QA committee may meet more frequently to manage any issue at the facility. The facility has a policy titled, "Quality Assessment and Assurance" that was effective 05/2012 and was reviewed on 05/2013. This policy will be made operational. A QA committee meeting was held related to this survey outcome on March..... The medical director was present via phone due to injury. An adhoc QA committee meeting was held on April 16, 2014 to discuss aspects of the survey POC. The medical director was at the committee meeting in person. During the POC process, QA committee meetings will be held at least weekly to review the POC process and ensure the POC is operational.	

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F 520	Continued From page 355 as required, and did not identify quality concerns, and did not develop/implement policies and systems to ensure quality of life and quality of care for 84 of 84 residents residing in the facility. Findings include: Refer to F223 as the facility failed to promote and enforce a resident environment that was free from physical, verbal, and emotional abuse of residents for 1 of 4 residents (R56) as R56 was not protected from another resident's (R63) wilful abuse. The lack of the facility's failure to protect R56 constituted an immediate jeopardy (IJ) at 5:00 p.m. Refer to F226 as the facility failed to operationalize the Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy and enforce a resident environment that was free from physical, verbal, and emotional abuse of residents for 1 of 4 residents (R56). R56 was not protected from another resident (R63); failed to conduct screening of 6 of 6 newly hired employees (licensed practical nurse [LPN]-G, nursing assistant [NA]-A, LPN-F, NA-K, NA-D, NA-I); failed to immediately report potential incidents of abuse, neglect and mistreatment to the administrator and the State agency (SA) for 4 of 5 residents (R21, R62, R71, R17) in the sample reviewed for abuse prohibition. In addition, the facility failed to report an investigation for an allegation of abuse in a timely manner to the SA for 1 of 1 resident (R117). Refer to F323 as the facility failed to provide adequate supervision and interventions to ensure safe smoking practices for 3 of 28 residents	F 520	Copies of the minutes of the QA Committee meeting and the attendance sign in sheet shall be sent to the corporate office via email for record keeping. Copies of all QA Committee minutes shall be kept in hard copy and readily accessible at the facility. Responsible: Administrator Compliance date: 4/28/2014	

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F 520	Continued From page 356 (R36, R1, R22) who currently smoked unsupervised in the facility. The facility's failure to provide supervision and a safe environment to prevent potential burns from unsafe smoking practices constituted an Immediate Jeopardy (IJ) for R36, R1, and R22 on 3/12/14, at 5:00 p.m. In addition, the facility did not ensure safe use of a mechanical stand lift (a mechanical device used for transfers) for 1 of 2 residents (R64) in the sample. This practice resulted in an IJ called on 3/13/14, at 1:50 p.m. the administrator was immediately notified of the IJ. Monitoring visits were completed on 3/15/14, and 3/16/14. Refer to F314 as the facility failed to provide repositioning, comprehensively assess skin risk factors, assess and notify the physician of new pressure ulcer development in a timely manner and provide pressure redistributing devices in the wheelchair for 1 of 1 resident (R64) reviewed for pressure ulcers. R64 experienced actual harm due to development of two stage II pressure ulcers (Partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). On 3/14/14, at 2:45 p.m. the medical director (MD-B) was interviewed and stated the new administrator, new director of nursing (DON) and herself were not part of the facility in December 2013, when there should have been a quality meeting. MD-B stated a quality meeting was coming up and the administrator would know the date. The medical director had been notified about the Immediate Jeopardy on 3/14/14, (early in the morning), by the facility administrator.	F 520		

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

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F 520	Continued From page 357 On 3/17/14, at 10:40 a.m. an interview with the administrator and corporate interim administrator (CIA); the administrator stated she had started February 4th, and there had not been a quality meeting held since, but stated "I think we are in compliance, the lack of food was not substantiated by OHFC (Office of Health Facility Complaints). The CIA stated she would need to look at the 4th quarter to determine when a quality meeting should have been held, or when their 4th quarter ended. On 3/17/14, at 12:00 p.m. CIA stated the last quality meeting was held in 9/9/13, they had attempted to hold a quality meeting in December 2013, but OHFC came in and it was postponed. They then attempted a quality meeting after that but the medical director (MD-B) broke her leg and they had to cancel. On 3/18/14, at 3:15 p.m. chief operations officier (COO) stated she did not attend or conference into the quality meetings because they are a small company and she was the "boots on the ground at all facilities," but did ensure she got the meeting minutes quarterly. On 3/18/14, at 5:00 p.m. the new DON and administrator were not aware that a quality meeting had not been held in December 2013 and were planning an April 2014 meeting. The DON stated both she and the administrator were new to the facility, and had been putting together a list of quality issues, which included focusing on medication safety, audits and training. The undated Behavior Monitoring procedure directed staff to report all incidents of abusive behavior, such as physical, verbal, theft, etc. The	F 520		

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F 520	Continued From page 358 staff was to report to the supervisor immediately. New behaviors were to be reported to the nurse for appropriate follow up. The procedure indicated the nurse and social worker were to review the information weekly and follow up as needed. The facility Smoking Policy dated as revised on 1/2014, directed, "2. All smokers shall be assessed related to smoking safety at the time of admission and then at least quarterly as outlined by OBRA assessment timeframe's."; "7. Residents who smoke shall wear a smoking apron if they are found not to be safe (i.e. drop lit cigarette or do not handle the ashes properly. a. If clothing is found to have cigarette burn holes the smoker must wear an apron to protect themselves from burns. 8. All smoking materials will be stored in a secure area to ensure they are kept safe. Based on the individual resident smoking safety assessment facility staff shall determine the most appropriate method to secure storage."; "10. All smoking sessions will be supervised by facility staff members only." The Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property policy dated as reviewed 1/2013, identified each resident had the right to be from mistreatment, neglect, involuntary seclusion and misappropriation of property. The policy identified appropriate definitions of abuse, neglect, misappropriation of resident property, and injuries of unknown source. - The policy identified employees would be screened prior to first day of employment including: license verification, registry search, criminal background check, reference checks. Screening for potentially abusive residents during the pre-admission process. The policy identified	F 520		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 359 training would be provided to employees through orientation and ongoing regarding abuse/neglect prevention, identification and recognition of signs/symptoms of abuse/neglect, protection, investigation, reporting and doc of abuse/neglect. The policy indicated residents would be educated on admission and during the stay on abuse/neglect. - The policy indicated reports would be made without fear of reprisal. The policy specifically directed to notify the administrator for injuries of unknown origin. - An addendum at the end of the policy indicated, "State of Minnesota" and, "The facility reports any reported, suspected, and/or validated occurrences of abuse/neglect or injuries of unknown source immediately to the administrator and to state agencies as required by individual state regulations." The policy did not identify the office of health facility complaints (OHFC), online reporting or Common Entry Point (CEP). The policy for quality assessment and assurance committee was requested and was not provided. There was no meeting held since 9/9/13, that would have identified potential quality deficiencies where the facility would have developed and implemented plans of action to correct those quality deficiencies, which would have included monitoring the effect of implemented changes and making needed revisions to the action plans.	F 520		

F5544023

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING 01 - MAIN BUILDING 01 B. WING	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Camden Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	POC ok TR 4-25-14 This provider was not singed up for epoc EPOC RECEIVED APR 23 2014 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Charlotte M. Cochran	Administrator	4-23-14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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K 000	Continued From page 1 Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Camden Care Center is a 1-story building with a partial basement. The 1 story building was constructed in 1990 and was determined to be of Type II(222) construction. This building is fully fire sprinklered. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 87 beds and had a census of 83 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and	K 029		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 029	Continued From page 2 doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect all patients. Findings include: During facility tour between 9:30 AM and 11:30 AM on 03/11/2014, observation revealed that the kitchen dry storage room door, which opens into the egress corridor, does not fully close and latch. This deficient practice was verified by the maintenance staff at the time of the inspection.	K 029	K 29 The kitchen dry storage room door is repaired. The closer was removed. All facility doors are checked monthly using a facility checklist to ensure all doors are properly functioning, repaired or replaced as needed. These monthly checklists will be reported to the QA committee for review and further recommendation as indicated. Responsible: Director of Maintenance, Administrator Compliance date: 4/28/2014	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of	K 038	K 38 The north wing exterior egress door was cleared of ice and snow on 3/28/2014. Facility maintenance staff were inserviced to keep all exterior egress doors free from snow and ice at all times. Emergency exit doors will open 100 degrees.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/11/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	**512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430**

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K 038	Continued From page 3 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect all residents. Findings include: On facility tour between 9:30 AM and 11:30 AM on 03/11/2014, observation revealed that the North Wing exterior egress door has not been fully shoveled. There is snow and ice preventing the door from fully opening. This deficient practice was verified by the maintenance staff at the time of the inspection.	K 038	A process for snow shoveling was developed. Responsible: Director of Maintenance, Administrator Compliance date: 4/28/2014 K69 Facility has contracted with Life Safety Systems. LSS will conduct all inspections and tests required by state and federal regulations. Kitchen hood UL-300 fire extinguishing system will be inspected. Director of Operations will keep updated records of LSS inspections and tests in the Fire and Life Safety Code Log Book, and will report any deficiencies to the Administrator.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's kitchen cooking equipment has not been maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect some residents if near the kitchen. Findings include: On facility tour between 9:30 AM and 11:30 AM on 03/11/2014, record review revealed that the last inspection of the kitchen hood UL-300 fire extinguishing system was in 05/05/2013. This deficient practice was verified by the maintenance staff at the time of the inspection.	K 069	Compliance Date: 4-28-2014 Responsible: Director of Operations, Administrator, Corporate K72 The facility has created a protocol for wheeled and non-wheeled storage. All staff will be educated and trained on the protocol by the Director of Operations. Director of Operations will do a daily check on all corridors and service egress	
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free	K 072		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 072	Continued From page 4 of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility has egress corridor obstructions which violates LSC 7.1.10. These obstructions could interfere with the convenient and effective removal of patients in an emergency situation. Findings include: On facility tour between 9:30 AM and 11:30 AM on 03/11/2014, observation revealed that there is wheeled and non-wheeled storage in the service egress corridor. There is also wheeled storage in the corridors throughout the facility. This deficient practice was verified by the maintenance staff at the time of the inspection.	K 072	corridors. The facility is taking advantage S & C bulletin 12-21 related to Life Safety 18/19.2.3 (LSC sections 18/19.2.3 Capacity of Means of Egress and more specifically the requirements at 18/19.2.3.4 which allow, under certain circumstances, projections into the means of egress corridor width for wheeled equipment and fixed furniture) for storage of wheeled equipment in our staff service hallway which has no handrails and is not accessible to residents. Staff will be educated on relocation of Items during an emergency. Director of Operations will provide education. Compliance Date: 4/28/2014 Responsible: Administrator, Director of Operations, All Staff	
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to comply with NFPA 70, The National Electric Code. This deficient practice could affect some residents.	K 147		

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	245544	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/11/2014

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K 147	Continued From page 5 Findings include: On facility tour between 9:30 AM and 11:30 PM on 03/11/2014, observation revealed that there are extension cords and multiplug adapters in use in the basement data closet and room 131. This deficient practice was verified by the maintenance staff at the time of the inspection.	K 147	K 147 All extension cords and multi plug units have been removed from the facility. Weekly audits of residents rooms will be completed to ensure there are no extension cords or multi plug units are in use. These weekly audits will be reported to the QA committee for review and further recommendation as indicated. Responsible: Director of Maintenance, Administrator Compliance date: 4/28/2014	

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

NOTICE OF REPEAT VIOLATIONS AND IMMINENT RISK TO RESIDENT CARE OR SAFETY

Electronically Delivered: April 4, 2014

Ms. Noreen Cochran, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5544023

Dear Ms. Cochran:

This is to inform you that due to repeat violations within the preceding two year period which created an imminent risk to resident care or safety, and due to repeat violations in the four highest daily fine categories prescribed in rule, the commissioner of health has the authority to initiate proceedings to suspend or revoke the nursing home license for Camden Care Center or refuse to renew the license. At this time the Minnesota Department of Health is considering options and what enforcement steps are necessary in addition to the ones set out in this letter.

The above facility was surveyed on March 10, 2014 through March 18, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

In accordance with MN Rules 144A.11 Subd. 2. (a) the commissioner of health shall initiate proceedings within 60 days of notification to suspend or revoke a nursing home license or shall refuse to renew a license if within the preceeding two years the nursing home has incurred the following number of uncorrected or repeated violations:

(1) two or more uncorrected violations or one or more repeated violations which created an imminent risk to direct resident care or safety; or

(2) four or more uncorrected violations or two or more repeated violations of any nature for which the fines are in the four highest daily fine categories prescribed in rule.

The following violations cited at the time of the survey completed on March 18, 2014 are repeat violations and were previously cited within the preceding two year period:

0165 - Licensee, Provision of Adequate Financing - MN Rule 4658.0050 Subp. 3.F.
0530 - Use of Restraints - MN Rule 4658.0300 Subp. 4.
0560 - Comprehensive Plan of Care, Contents - MN Rule 4658.0405 Subp. 2.
0830 - Adequate and Proper Nursing Care, General - MN Rule 4658.0520 Subp. 1.
1375 - Infection Control, Program - MN Rule 4658.0800 Subp. 1.
1695 - Plant Housekeeping, Operation and Maintenance - MN Rule 4658.1415 Subp. 4.
2000 - Reporting - Maltreatment of Vulnerable Adults - MN Statutes 626.557 Subd. 14 (a)-(c)

The following violations cited at the time of the survey completed on March 18, 2014 are repeat violations and carry fines in the four highest fine categories:

0530 - Use of Restraints - MN Rule 4658.0300 Subp. 4.
0560 - Comprehensive Plan of Care, Contents - MN Rule 4658.0405 Subp. 2.
0830 - Adequate and Proper Nursing Care, General - MN Rule 4658.0520 Subp. 1.
1375 - Infection Control, Program - MN Rule 4658.0800 Subp. 1.

In addition, repeat violations noted at the time of the survey completed on March 18, 2014 created an imminent risk to direct resident care or safety.

To assist in complying with the correction order(s), a “suggested method of correction” has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electonically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

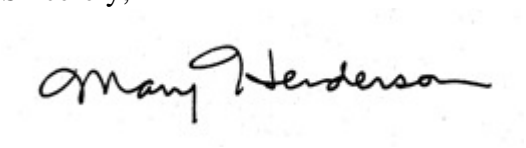
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,



Mary Henderson, Program Assurance Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651)201-4115 Fax: (651)215-9697
Email: mary.henderson@state.mn.us

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00166	A. BUILDING: _____ B. WING _____	03/18/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMDEN CARE CENTER	512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: A licensure survey was conducted by the Minnesota Department of Health on 3/10/14 through 3/18/14, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.	

Noted Gloria Dentz 4-8-14

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

Charlotte M. Cochran | Administrator | 4-8-2014