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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: K50X

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) **077938000**

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 **06/17/2015** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

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):

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 06/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/23/2015 (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
06/16/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245544

June 23, 2015

Mr. Austin Blilie, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

Dear Mr. Blilie:

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 May 26, 2015 the above facility is certified for:

87 Skilled Nursing Facility/Nursing Facility Bedss

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.

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 23, 2015

Mr. Austin Blilie, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544024

Dear Mr. Blilie:

On May 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 15, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On June 17, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 26, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 26, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 15, 2015, effective May 26, 2015 and therefore remedies outlined in our letter to you dated May 6, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7008 1830 0003 8091 4912

June 19, 2015

Mr. Austin Blilie, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544024

Dear Mr. Blilie:

On May 6, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 17, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 26, 2015, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 17, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 26, 2015. Based on our visit, we have determined that your facility has achieved substantial compliance with the Life Safety Code (LSC) deficiencies issued pursuant to our standard survey, completed on April 17, 2015.

However, compliance with the health deficiencies issued pursuant to the April 17, 2015 standard survey has not yet been verified. The most serious health deficiencies in your facility at the time of the standard survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Mandatory Denial of payment for new Medicare and Medicaid admissions effective July 17, 2015. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective July 17, 2015. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 17, 2015. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

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. A copy of the Post Certification Revisit Form (CMS-2567B) from the June 19, 2015 revisit is enclosed.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, 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 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Jan.Suzuki@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

(202) 565-9462A request for a hearing should identify the specific issues, 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. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Jan Suzuki, Principal Program Representative by phone at (312) 886-5209 or by e-mail at Jan.Suzuki@cms.hhs.gov

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 October 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Division of Compliance Monitoring
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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	6/17/2015

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 **F0166** Reg. # **483.10(f)(2)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **05/26/2015**
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **05/26/2015**
ID Prefix **F0333** Reg. # **483.25(m)(2)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0456** Reg. # **483.70(c)(2)** LSC	Correction Completed **05/26/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0514** Reg. # **483.75(l)(1)** LSC	Correction Completed **05/26/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **05/26/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	GD/kfd	06/23/2015	18622	06/17/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 4/17/2015

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**	5/26/2015

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 **05/26/2015**	ID Prefix	Correction Completed **05/26/2015**	ID Prefix	Correction Completed **05/26/2015**
Reg. # **NFPA 101**		Reg. # **NFPA 101**		Reg. # **NFPA 101**	
LSC K0029		LSC K0038		LSC K0050	
ID Prefix	Correction Completed **05/26/2015**	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. # **NFPA 101**		Reg. #		Reg. #	
LSC K0062		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	
ID Prefix	Correction Completed	ID Prefix	Correction Completed	ID Prefix	Correction Completed
Reg. #		Reg. #		Reg. #	
LSC		LSC		LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/kfd	06/23/2015	28120	05/26/2015
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?
4/15/2015	YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: K50X

Facility ID: 00166

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245544**
2.STATE VENDOR OR MEDICAID NO.
(L2) **077938000**

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 **04/17/2015** (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):

17. SURVEYOR SIGNATURE Date :
Cynthia Wentkiewicz, HFE NE II 05/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/16/2015 (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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7013 2250 0001 6356 7143

May 6, 2015

Mr. Austin Billie, Administrator
Camden Care Center
512 - 49th Avenue North
Minneapolis, Minnesota 55430

RE: Project Number S5544024

Dear Mr. Billie,

On April 17, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 27, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 27, 2015 the following remedy will be imposed:

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

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.

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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the 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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL 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 Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 17, 2015 (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 October 17, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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.

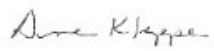
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,



Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	04/17/2015

NAME 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 000	INITIAL COMMENTS The facility's plan of correction (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 on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.**	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to promptly resolve individual grievances, related to a resident bathing preferences for 1 of 4 residents (R31) reviewed who expressed greivances. Findings include: R31 was interviewed on 4/14/15, at 10:10 a.m. during which time she stated she was not satisfied with her bathing routine. R31 stated the nursing assistants were no gentle enough when washing a sore area on her abdomen, and that the water was not always warm enough.	F 166	• **Resident # 31 has been interviewed by the SW and her grievance has been documented. The grievance is proceeding through the grievance process, with efforts to resolve.** • **SW/Activities will meet with CCC residents to review the resident's right to formulate a grievance, and the right to prompt efforts to resolve the grievance. Residents have been notified where to find grievance forms, and that staff will assist them with submitting a grievance if necessary. Residents are encouraged to notify the administrator and/or SW with concerns.**	5-26-15

Accepted 5-19-15 Lori Dahlen

Scanned JT 5/19/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Austin Schlie — TITLE: Administrator — (X6) DATE: 5-15-15

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 166	Continued From page 1 During the interview, R31 stated she had actually struck nursing assistant (NA)-B during cares the prior Friday because she was rubbing her abdomen too hard, and used cold water on the wash cloth. R31 said she had told the health unit coordinator [HUC]/scheduler at the front desk who had spoken to the add and the night nurse. R31 reported they had wanted to call the "boss" also but R31 said she hadn't wanted them to. On 4/15/15, at 7:35 a.m. morning cares were observed for R31 as provided by NA-B. During the observation, R31 asked NA-B whether her skin was still split down in the abdomen area. After observing the area, NA-B gently wiped R31's abdomen. R31 stated "Ooh that hurts, is it open?" NA-B responded "a little bit." NA-B was observed to gently pat the front area of R31's abdomen then was done. NA-B was interviewed on 4/15/15, at 10:26 a.m. NA-B stated sometimes R31 does not like the aides to wipe her abdominal area, and when you touch that area, R31 will state she has pain. "Everyone knows she complains. Same thing happened this morning." NA-B verified R31 had hit her in face, but stated R31 had apologized, and she (NA-B) understood. NA-B said R31 accuses people of things. On 4/15/15 at 1:41 p.m., the administrator and director of nursing (DON) were interviewed regarding R31's grievance about cold water and staff care. The administrator and DON stated they had not heard about this complaint. On 4/15/15 at 2:05 p.m., the HUC/scheduler stated R31 had expressed this grievance to her. The HUC also stated that R31 had complained	F 166	**• Staff have been re-educated regarding the grievance process, and the resident's rights to bring forward a grievance and the right to prompt efforts to resolve.** **• IDT will continue to review any grievances at daily stand up to seek prompt resolution of grievances.** **• Grievances will be reviewed at QAA monthly.**	

RECEIVED
MAY 19 2015
COMPLIANCE MONITORING DIVISION
LICENSE AND CERTIFICATION

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F 166	Continued From page 2 about lights not being answered about a week and a half ago and reported that to the nurse and administrator. The HUC stated she'd told RN-A and RN-B about R31's concerns. On 4/15/15 at 2:22 p.m., RN-A said R31 had told her about the concern with cares one day when RN-A was administering noon medications. RN-A said she'd told the social worker about the concerns. On 4/15/15 at 2:26 p.m., the social worker was interviewed and stated she had not been made aware of R31's concerns. On 4/16/15 at 2:37 p.m., the administrator stated he had spoken to R31 yesterday morning about her concerns and that he'd filed a grievance internally regarding it. R31's care plan dated 2/12/15, indicated R31 needed total assist with activities of daily living (ADLs) related to hemiplegia amputation of lower limb, pain, dementia, impaired mobility, with goal of encouraging to participate in ADLs to tolerance and receiving assistance at any level to completion of task, and intervention of: allowance to participate in ADLs to tolerance, providing assistance with completion of task at any level, assistance with personal hygiene, allowance to participate to tolerance and assistance in completion of task, providing with choices regarding clothes to wear, bath times, providing with dignity by pulling shirt down or covering her with blanket, providing privacy during cares, using Hoyer lift for transfers. Care plan indicated chronic pain related to myalgia and offering cold or warm packs.	F 166		

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F 166	Continued From page 3 R31's Minimum Data Set (MDS) dated 3/12/15, indicated R31 had intact cognition, and required extensive assist with bed mobility, transfers, personal hygiene and total dependence with dressing and locomotion on and off unit.	F 166		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to conduct an assessment to determine whether a resident was capable to self-administer medications (SAM) for 1 of 2 residents (R47) observed to self-administer an inhaler during a random observation. Findings include: On 4/13/15, at 3:15 p.m. R47 was observed to put her call light on during interview and stated, "I can't breathe with the paint smell." Registered nurse (RN)-E answered the call light and then left the room briefly. When she returned at 3:16 p.m., she'd brought an inhaler back for R47. RN-E was observed to hand R47 the inhaler and to allow R47 to self-administer two puffs. When R47 was asked by the surveyor whether she routinely self-administered the inhaler, R47 stated yes, she did it herself. R47 further stated, "I have been doing it since I was small." RN-C then stated that after R47 had self-administered the	F 176	• **Self-Administration of Medication assessment has been completed for Resident #47.** • **Resident #47 has had the MD order clarified in regards to Self-Administration of Medications.** • **The care plan for Resident #47 has been revised for consistency with the assessment and clarification of the MD order.** • **All current residents with inhalers or nebulizers have been re-assessed for ability to self-administer medications, MD orders and care plans have been reviewed and revised as necessary.** • **Licensed nurses received education on self-administration of medication, obtaining physician orders and assessing residents to properly administer their own medications.**	5-26-15

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F 176	Continued From page 4 inhaler, it was kept in the medication cart. An Assessment for Resident Self-Administration of Medications and Respiratory Inhalants had been completed for R47 on 11/19/14. The assessment was marked "NO" under the heading, "Resident has requested to self-administer medication." The assessment also identified that a diagnosis that may interfere with R47's ability to self-administer was "hemiplegia/hemiparesis (paralysis)." R47's other diagnoses included: asthma unspecified with exacerbation, bronchitis, hemiplegia and persistent mental disorder condition as docuemnted on the annual Minimum Data Set (MDS) assessment dated 2/10/15. The MDS also indicated R47 had intact cognition. A subsequent care area assessment (CAA), assessing activities of daily living (ADL) functional/rehabilitation potential dated 2/20/15, indicated R47 was unable to perform ADLs without extensive to total assistance related to a cerebrovascular accident with hemiplegia. R47's Medication Orders dated 3/3/15, revealed R47 had an order for: - "Proair HFA 90 mcg [micrograms] Inhaler inhale 2 puffs by mouth every 4 hours as needed for asthma *MAY TAKE ON LEAVE OF ABSENCE [LOA] AND SELF ADMINISTER*- USE WITH SPACER." The current care plan dated 3/13/15, directed staff to administer medications for R47 as ordered. The care plan did not address R47's ability to SAM including the inhaler.	F 176	• **The community IDON or designated QA representative will conduct an audit monthly for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 176	Continued From page 5 On 4/16/15, at 9:35 a.m. RN-C who was the MDS coordinator stated he was responsible for completing MDS assessments however, other assessments were the floor nurses responsibility. RN-C stated he thought the SAM assessment was supposed to be done quarterly, but would need to verify in facility policy. During an interview on 4/16/15 at 9:38 a.m., the facility's consultant registered nurse stated a SAM assessment should have been done, and was supposed to be done quarterly. The consultant stated the facility policy did not specify how often the assessment for SAM should be conducted, however if a resident was self-administering medications they were supposed to be assessed to ensure they remained safe to administer the medication. At 9:39 a.m. on 4/16/15, RN-A verified that although R47 had an order to SAM the inhaler when on leave, the facility's last SAM assessment completed on 11/19/14 had indicated R47 was not able to SAM. On 4/16/15 at 4:19 p.m. the director of nursing stated, "I think what happens is that a doctor says it's okay to have something at bedside, but when we assess we find it's not okay. There should be an assessment that says yes, or no and why not." The facility's Self Administration of Medication policy dated April 2008, included: "An individual resident may self administer medications if the resident requests and the interdisciplinary team has determined that the resident is safe in this practice." The policy also included:... "The resident's care plan is revised to enable the resident to self administer the specific	F 176		

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F 176	Continued From page 6 medications."	F 176		
F 241 SS=D	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 a dignified dining experience for 1 of 33 residents (R35) observed during dining. Findings include: On 4/15/15, at 12:50 p.m. R35 was observed to be eating lunch in the dining room. Although R35 was still eating, at 1:29 p.m. dietary aide (DA)-B was observed to sweep and mop the floor around where R35 was sitting. R35 was the only resident still in the dining room. On 4/16/15, at 8:15 a.m. R35 was brought to the dining room for breakfast. At 9:15 a.m. DA-A was observed to clear all of the tables except for R35's table. At 9:30 a.m., DA-B was observed to sweep and mop the floor around where R35 was still eating breakfast. R35's record was reviewed. The face sheet in R35's record indicated he'd been admitted to the facility on 12/29/10, with diagnoses of dementia without behavioral disturbance, polyneuropathy from diabetes, and diabetes mellitus.	F 241	• **Housekeeping staff have received additional training on resident dignity in the dining room.** • **Dietary Manager met with resident #35, and together reviewed and revised his meal and diet plan.** • **The community Dietary Manager or designated QA representative will conduct an audit 3x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	5-26-15

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F 241	Continued From page 7 A quarterly Minimum Data Set (MDS) assessment dated 3/17/14, indicted R35 had severe cognitive impairment, rarely or never was understood, had short and long term memory problems and had severely impaired decision making. The MDS also depicted R35 as being tired or having trouble concentrating. In addition, the MDS indicated R35 required extensive assistance of two staff for bed mobility and transfers, extensive assistance of one staff for dressing, toilet use, locomotion on and off the unit, but remained independent with eating after setup. R35's care plan dated 2/9/15, indicated R35 had potential alteration in nutrition and eats slowly. The interventions included: encourage resident to eat 75% or more at meals, allow adequate time for R35 to finish his meal. The care plan also indicated R35 had verbal outbursts toward staff, yells and swears, and was redirectable. R35 spent time in his room and went to the dining room most of the time for his meals. R35 was dependent on staff for cares and locomotion on the unit. Care Conference note dated 3/31/15, indicate R35 ate slowly and needed encouragement as he ate all meals in the main dining room.. On 4/16/15, at 10:15 a.m. the director of nursing (DON) was informed of the observations above and stated "Its part of what we do, it should be on his time. [R35] should take as long as he needs. I will use this feedback immediately." On 4/17/15, at 3:15 p.m. the administator stated that sweeping and mopping around a resident	F 241		

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F 241	Continued From page 8 who was still eating was a violation of the resident's dignity. The administrator further stated R35's care plan indicated he was a slow eater and that staff should have kept that in mind. A policy for dignity was requested but not provided.	F 241		
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 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 interview and document review, the facility failed to identify a significant decline in toilet use, personal hygiene, and locomotion as a significant change in status for 1 of 1 resident (R20) reviewed in the sample experienced a significant change. Findings include: R20's annual Minimum Data Set (MDS)	F 274	• **Resident # 20 has been reviewed for a significant change of condition MDS.** • **Resident #20 has had new assessments completed and care plan has been reviewed and revised as indicated.** • **The facility will continue current practice of review and discussion of residents with clinical changes to determine if a significant change of condition has been indicated.** • **The community IDON or designated QA representative will conduct an audit weekly for three months of the documentation of residents identified as having a potential change in condition and to ensure the completion of assessments and revising of the care plan as necessary. The audit results will be reviewed at QA council and recommendations will be made for continued review or**	5-26-15

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F 274	Continued From page 9 assessment dated 5/16/14, indicated R20 had diagnoses including: benign prostatic hyperplasia (BPH), hypertension (HTN), and arthritis with no functional limitations in range of motion (ROM). This MDS also indicated R20 was cognitively intact, had scored 0/0 with locomotion- independent with locomotion on and off the unit; scored a 1/2 with toileting- requires supervision but no staff assist; and had scored a 2/2 for personal hygiene- limited assistance of one. The corresponding Activities of Daily Living (ADL)/Functional Rehabilitation Potential care area assessment (CAA) dated 5/28/14, indicated: "(R20) has decreased ADL ability. Staff will continue to support resident to achieve as much independence as possible while maintaining current level of functioning." The CAA for urinary incontinence dated 5/28/14, indicated: "staff will continue to assist resident to use bathroom." The quarterly MDS for R20 dated 11/16/14, indicated the resident had declined to a 3/2 in locomotion on and off the unit- requiring extensive assistance of one staff; a 3/2 in toileting- requiring extensive assistance of one staff; and a 3/2 in personal hygiene-required extensive assistance of one staff. R20's quarterly MDS dated 2/10/15, identified R20 had improved to independent with locomotion on and off the unit, but remained dependent on extensive assistance of one staff with toileting and personal hygiene. Although R20 had declined from the time of the annual MDS to the quarterly MDS 11/15, no significant change assessment had been completed. On 4/16/15 at 10:55 a.m., registered nurse (RN)-C stated that when a new resident	F 274	**compliance.**	

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	245544	A. BUILDING _____ B. WING _____	04/17/2015

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F 274	Continued From page 10 comes in the admission assessments are used in addition to resident and staff interview and observation. RN-C verified that he completes all of the MDS assessments at the facility and does the careplan updates. RN-C stated the nurses should identify any changes and he really relies on the staff for this information. RN-C stated he looks back at most recent MDS when completing a new MDS to compare and look for changes between the two, but he does not look back to last annual or comprehensive MDS and compare that to current MDS being completed. RN-C verified he had not noticed the need for significant decline.	F 274		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify appropriate services to maintain as much normal urinary function as possible for 1 of 1 resident (R20) reviewed in the sample for urinary incontinence. Findings include:	F 315	• **Resident # 20 has been reassessed for bladder and continence function, and care plan has been reviewed and revised.** • **The IDON/designee will meet with resident #20 on a weekly basis to review the resident #20 revised plan of care and to ensure the resident continues to agree and allow the incontinent plan of care. Follow up documentation will be placed in the resident record weekly for 4 weeks and as needed thereafter.**	5-26-15

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F 315	Continued From page 11 The Treatment South and East book dated of 1/29/15, indicated, "Resident [R20] wants to be checked at night between midnight and 3AM (morning) to see if he needs help with voiding." R20's annual Minimum Data Set (MDS) assessment dated 5/16/14, indicated R20 had diagnoses including: benign prostate hyperplasia (BPH), hypertension (HTN), and arthritis; R20 was identified as cognitively intact, and required supervision for toileting, required limited assistance for transfers and personal hygiene, and was frequently incontinent of bladder-but no formal toileting program. The MDS also identified R20 received a diuretic (a medication that promotes the production of urine). The Activities of Daily Living (ADL)/Functional Rehabilitation Potential CAA dated 5/28/14, identified, "[R20's name] has decreased ADL ability. Staff will continue to support resident to achieve as much independence as possible while maintaining current level of functioning." The Care Area Assessment (CAA) for urinary incontinence dated 5/28/14, identified R20 had incontinence "at times" related to impaired mobility and pain; The CAA identified R20 preferred to use the bathroom and directed, "staff will continue to assist resident to use bathroom." A Bowel and Bladder Data Collection dated 8/15/14, indicated that R20 was incontinent, experienced urgency (except at night), used a diuretic, and used a "pull-up" incontinence product. The Analysis and Summary of Assessment Data (ASAD) dated 8/28/14, identified R20 was alert and oriented and able to make his needs known and use the call light. The	F 315	• **The community Administrator or designated QA representative will conduct an audit 1x/month for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 315	Continued From page 12 ASAD indicated R20 transferred and used the toilet independently and preferred to manage his own care. The ASAD also indicated R20 was "incontinent of bladder and occasionally incontinent of bowel." The summary identified use of Flomax (medication used to treat BPH) and Lasix (furosemide, a diuretic medication), and that R20 was independent with toileting during the day. A Bowel and Bladder Quarterly Review dated 11/18/14, indicated R20 continued to be incontinent of bladder and needed assistance for toileting. The form was checked "No" for toileting program, but indicated the resident required assistance at night, and had requested to be checked every two hours for "wetness" and "assistance." The care plan was modified to indicate the resident required increased assistance. R20's quarterly MDS dated 2/10/15, identified R20 had improved in some areas, but continued to require extensive assist of 1 with toileting, and continued to be frequently incontinent. The care plan dated 2/12/15, identified R20 had occasional bowel and bladder incontinence and directed, "Ask [R20] before breakfast, after lunch, and during the night when on rounds if he needs assistance with toileting or peri-care. [R20] is generally independent with toileting but occasionally [sic] needs assistance. He is at times resistant to accepting assistance.)" The falls focus, dated as initiated 2/12/15, "[R20] is independent in toileting at times with need for extensive assist of one staff, at others. Is occasionally continent of bowel and bladder. Encourage and remind to request and accept	F 315		

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F 315	Continued From page 13 assist as needed. See 'altered elimination' focus/problem." Although the care plan identified a focus for "altered elimination" (urinary incontinence), the care plan lacked the focus to include identification of the type of urinary incontinence, resident specific risk factors related to urinary incontinence, a specific measurable goal related to urinary incontinence, and resident specific interventions to obtain the goal. The electronic medical record (EMR) Progress Notes dated 2/19/15, 13:23 (1:23 p.m.) indicated, "Camden Health Status Resident status: Quarterly MDS assessment completed. [R20] is anticipating discharge soon to the community. Recently [R20] has a few days where he did not feel like himself. He did not have any abnormal vital signs or acute symptoms of distress other than not feeling quite himself. He did incur two falls recently with minor injury. He continues to work with Therapy for strengthening and gait training. Has issues with incontinence and receives extensive assist in the early morning hours with toileting and personal hygiene. [R20] states that he does not have pain and is on a pain regimen which is currently effective for him." On 4/13/15, at 4:30 p.m. R20 was interviewed and stated, "I have incontinence issues"..."I wear a pull-up and a Poise (brand of incontinence pad) pad on top of that and then about three wash cloths on top of that." R20 pointed to the garbage next to him which was observerd to have a wet pull-up in it. R20 stated the housekeepers had not come to empty the garbage can yet. On 4/15/15, R20 was continuously observed from 7:23 a.m. until 9:57 a.m. (two and a half hours). At 9:57 a.m., R20 notified the surveyor he was	F 315		

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F 315	Continued From page 14 going to use the bathroom, stating he was wet and it was time to get changed. R20 explained to the surveyor that he takes himself into the bathroom and "changes his things," which he had indicated consisted of a pull-up with a Poise pad on the outside of the pull-up, and two to three wash cloths over the Poise pad. R20 stated that he had developed this plan to keep his clothes dry and free from urine and that it keeps his skin dry "for the most part." On 4/15/15, at 11:54 a.m. nursing assistant (NA)-B stated R20 was incontinent of urine and added, "He does not want you to touch him or help him until he calls you." NA-B also stated R20 was incontinent of urine "a lot" and "every day he has been incontinent." When asked what incontinent products R20 utilized, NA-B stated R20 used a pull up and "calls for help and the aide changes the pull up and puts a new one on." NA-B stated, "Anytime (R20) is wet (R20) puts his call light on and we go help him but we don't touch him until he tells us what to do, to reach something for him or to put pull-up on for him." NA-B stated the aides supply R20 with pull-ups and stock some in his room. When NA-B was informed that R20 stated he used the Poise pads and washcloths in addition to the pull ups, NA-B denied having been aware of that. On 4/15/15, at 1:17 p.m. licensed practical nurse (LPN)-C was interviewed and verified R20 was incontinent of urine sometimes and that staff had to wait for R20 to give them permission to help. LPN-C acknowledged she was unaware of what incontinence products R20 utilized and stated to ask the aides as they would know which products the resident used.	F 315		

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F 315	Continued From page 15 On 4/16/15, at 10:24 a.m. registered nurse (RN)-A stated she was unsure of how incontinence was assessed or frequency of assessment. During an interview with RN-A regarding R20's care plan, RN-A stated, "I did not see focus of urinary incontinence because he is continent with occasional incontinence so we did not have a focus (of urinary incontinence)." RN-A stated she would expect a urinary incontinence care plan to include, "check and change every so often, how much assistance they need, and which incontinence product is used." RN-A stated NA group sheets include what type of incontinence product each resident uses and verified that R20's NA group sheet indicated R20 used a "purple pad." When asked if she was aware R20 used different incontinence products (pull-up, Poise pad, and washcloths) RN-A stated she was not and stated she was unaware of R20 having an increase in urinary incontinence. When RN-A was asked why a consult with urology had been ordered, she stated she did not know. On 4/16/15, at 10:55 a.m. RN-C stated when a new resident is admitted, assessments are used in addition to resident and staff interview and observation. In addition, RN-C stated that upon admission there was an evaluation of bladder status that included reading the history and physical to see whether there was a diagnosis of incontinence, conducting a three day study to evaluate whether a resident was dry or wet, then determining a program based on the resident's ability to participate in a program. RN-C stated a three day bladder assessment was done on admission and annually. RN-C stated that if a resident who had previously been continent became incontinent, the resident would be reassessed. RN-C stated that even though R20	F 315		

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F 315	Continued From page 16 was incontinent, R20 usually managed his own incontinence. RN-C stated he had not interviewed R20 regarding his incontinence when he'd completed R20's most recent MDS, but that the NAs had reported to him that R20 performed his own cares. However, RN-C stated he had been told that R20 "keeps washcloths in his underwear".RN-C verified that he completed all the MDS assessments for the facility and that he documents the care plan updates. When RN-C was asked about R20's care plan regarding incontinence, RN-C stated, "I clump skin integrity and incontinence together." RN-C verified R20's care plan did not include any indication of R20's increase in urinary incontinence nor the use of the washcloths or Poise product. On 4/16/15, at 2:09 p.m. the director of nursing (DON) stated that for a while, "we had it (an incontinence program) down really well. We changed [R20's name] diuretic around. Got it to be earlier in the day. He reported for awhile that he was being continent at night, then he asked to be woken up at night to be toileted, and then a week later he did not want to be woken up." When informed of R20's incontinence product use, including the Poise pads and the washcloths, the DON stated, "I do not think we should care plan a pull ups with extra washcloths. I think we should come up with a different plan. There has got to be a better system than that. I would want a three day bowel and bladder diary to be done again. I would also talk to him about what was going on and why he was doing that. There is obviously something wrong." The DON stated he would expect R20 to be reassessed. The facility's policy titled Bowel and Bladder Management-HDGR, with a revision date of	F 315		

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F 315	Continued From page 17 3/1/14 indicated, "There is a system to ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services or maintain as much normal elimination as possible. All residents are to be assessed for bowel and bladder function upon admission, annually, and with a decline in continence status (Bowel and Bladder Functional Evaluation Tool). A three day bowel and bladder tracking tool to be completed for incontinent residents upon admission, annually, with any significant change in continence, significant change in condition, and after a Foley catheter is discontinued." The policy also indicated residents should have an individualized toileting program unless they are unable to participate in one; then they should have a supportive management such as check and change. The policy also indicated, "The bowel and bladder assessments will be reviewed quarterly for residents assessed to be incontinent of bowel and bladder." The facility failed to define specific interventions for R20 regarding urinary incontinence and recognize increased urinary incontinence. The facility did not identify that R20 was using Poise pads, pull-ups and washcloths to prevent his clothing from getting wet with urine due to an increase in urinary incontinence. R20's care plan directed to ask R20 at specific times if he needed assist with toileting or peri-care and observations did not support that and through interview with NA, it was indicated that NA's do not ask R20 about toileting but wait for R20 to ask them for help. R20 was not comprehensively assessed for the increased urinary incontinence.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323	• **Resident #28 and #15 grab bars were immediately tightened during the survey.**	5-26-15

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F 323	Continued From page 18 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 grab bars for positioning and transfers, were safely affixed to resident beds to assure safe use for 2 of 2 residents (R28, R15) reviewed who utilized grab bars. Findings include: R15's quarterly Minimum Data Set (MDS) dated 1/29/15 identified diagnoses including: peripheral vascular disease, dementia and hemiplegia. During the initial facility tour on 4/13/15, at 11:46 a.m. the right grab bar nearest the door was noted to be bow outward. R15 was observed to be asleep in his wheelchair. At 11:48 a.m. registered nurse (RN)-B and another staff were observed to enter R15's room shut the door, and then to come out again. As staff exited the room the bowing grab bar was still visible from the hallway. On 4/13/15 at 4:49 p.m., the right assist bar on R15's bed (one nearest door) was more closely observed. The grab bar appeared to be pulled	F 323	• **All residents currently using grab bars or side rails have had observational reviews to ensure that the rails are applied and functioning correctly.** • **Residents who use SR and grab bars will be assessed upon admission, and quarterly to assure safe use of assistive device.** • **Maintenance will make weekly checks to assure assistive devices are secure.** • **The community Administrator or designated QA representative will conduct an audit 1x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance.**	

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F 323	Continued From page 19 out from the bed approximately two to three inches. At that time the grab bar was manipulated by the surveyor and determined to flex from the bed to the mattress. On 4/14/15, at 2:15 p.m. R15 was observed lying in the bed on his back covered by a blanket. The bed was in a low position to the floor, The grab bar was observed to remain in a bowed out position. R15's falls Care Area Assessment (CAA) dated 11/3/14, indicated R15 required extensive assistance with all bed mobility, transfers, locomotion, dressing, eating and personal hygiene. In addition the CAA indicated R15 had history of cerebrovascular accident (CVA) with left hemiplegia and had history of falls. R15's care plan dated 3/10/15, identified R15 as at risk for falls related to hemiplegia, dementia, impaired mobility and cognitive impairments. The care plan indicated R15 required extensive total assistance with transfers and bed mobility to decrease potential for falls. The care plan also indicated R15 used "enabler bars when in bed." A facility assessment, Restraint Free Care- Half Side Rail/Bed Bar Assessment dated 4/13/15, identified R28 used bed enabler bars. The assessment was checked "Yes" for "If rails are to be used, do rails fit against mattress with no more than 2 inch gap?" On 4/14/15, at 3:49 p.m. the director of nursing (DON) stated he would expect the staff to report any safety concerns with resident care equipment. The DON further stated the staff "can write in the maintenance book or can ask	F 323		

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F 323	Continued From page 20 [maintenance director] and just let him know to fix it." On 4/14/15, at 3:54 p.m. registered nurse (RN)-A verified the grab bar was loose stating, "It is very loose." RN-A verified R15 used the grab bar for turning and repositioning and her expectation was the staff should have noted in the maintenance book that the bar needed to be tightened. On 4/14/15, at 4:10 p.m. the regional maintenance manager and the administrator both verified the grab bar on R15's bed was loose and stated a washer needed to be replaced and tightened. R28's quarterly MDS dated 2/10/15, indicated the resident had diagnoses including: traumatic brain injury, contracture of upper arm joint, generalized muscle weakness, aphasia, glaucoma. R28's falls CAA dated 11/24/14, indicated R28 required extensive assist of one to two staff in bed mobility using bilateral grab bars, had a hi-low bed in place, required extensive assist of one to two staff with transfers using the mechanical lift/E-Z (a brand of electronic lift) stand. In addition, the CAA indicated R28 had vision deficit of blindness in both eyes. R28's care plan dated 3/10/15, indicated R28 was at risk for falls related to immobility, traumatic brain injury, cognition, and blindness. The care plan directed staff to assist R28 with bed mobility, transfers, surface to surface transfers and toileting. The facility Restraint Free Care- Half Side Rail/Bed Bar Assessment dated 4/13/15, identified R28 used a bed bar. The assessment	F 323		

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F 323	Continued From page 21 was checked off "Yes" for "If rails are to be used, do rails fit against mattress with no more than 2 inch gap?" On 4/13/15, at 4:49 p.m. R28's right grab bar was observed to be loose, the bar moved back and forth one to three centimeters when touched. On 4/14/15, at 3:15 p.m. R28 was observed lying in bed, the bed was in the lowest position, and the grab bar continued to appear loose. On 4/14/15, at 3:58 p.m. nursing assistant (NA)-A verified the grab bar on R28's bed was loose. When asked who was supposed to report resident equipment concerns, NA-stated "for as long as I have worked here I have seen the maintenance staff each month going around and fixing concerns in the rooms or we can let them know." When asked if R28 used the grab bar NA-A stated "Yes he does." On 4/14/15, at 4:01 p.m. RN-A verified the grab bar on R28's bed was loose. When RN-A touched the grab bar, the bar was observed to flex back. RN-A stated, "definitely the aides are supposed to let maintenance know immediately to fix these issues (in reference to looseness of bar)." On 4/14/15, at 4:14 p.m. the regional maintenance manager and the administrator verified the grab bar on R28's was also loose and that it would be replaced immediately. When asked who was responsible for ensuring the grab bars/enabler bars were in good repair, the maintenance manager stated initially when the maintenance staff put the grab bars on the beds, the staff made sure they were tight. However, after the bars were applied, he said expected staff to report to his department either by writing	F 323		

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	245544	A. BUILDING _____ B. WING _____	04/17/2015

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F 323	Continued From page 22 in the maintenance log, or by verbally letting his staff know about any concerns. On 4/15/15, at 10:13 a.m. RN-C the MDS coordinator who completed assessments, stated the he was not sure but thought assessments related to the grab bars had been completed after the surveyors had brought their concerns to the facility's attention. At 10:15 a.m., the consultant RN approached the surveyor with RN-C and stated the side rail/bed bar assessments had been completed 4/13/15 after surveyors had asked the staff interview questions regarding side rails and loose grab bars for R28 and R15 had been noted to be loose. On 4/15/15, at 3:29 p.m. the DON stated he would expect the nurses to make sure assessments were complete and accurate. The DON verified the assessments for side rails dated 4/13/15, were not accurate as the grab bars remained loose even after the assessments had been completed and checked as fitting. Review of the Maintenance Requests dated 12/3/14 through 4/14/15, revealed neither R28's or R15's bed grab bars had been added to the requests for repair yet. The undated Maintenance Manual Helping Hints For Equipment procedure directed "Resident Beds: Check bed casters to make certain the brakes are locking. Check side rails to determine that they are working smoothly ... " The manual did not indicated who was responsible to ensure resident equipment including grab bars were in proper functioning manner and who was responsible to oversee equipment was inspected.	F 323		

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F 333	Continued From page 23	F 333		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on document review and interview the facility failed to ensure accurate administration of insulin per physician orders for 3 of 3 residents (R30, R15, R31) reviewed who required insulin injections to control diabetes. Findings include: R30, who was admitted on 3/26/15, had diagnoses including diabetes type II, chronic kidney disease stage V, hypertension, and chronic cardiac disease as listed on the Treatment Administration Record (TAR). R30's physician orders on admission, dated 3/26/15 included: Accu-checks three times a day (TID) with meals and hour of sleep (HS). Call physician (MD) or nurse practitioner (NP) for blood glucose less than 75 or greater than 300. Lantus 100 units/ml vial 20 units subcutaneous (SQ) every (Q) hour of sleep (HS). Insulin would be administered only during meals according to the blood sugar (BS) per the physician ordered insulin sliding scale coverage: Novolog 100 units/ml, inject 0-10 units subcutaneous 3 times with meals; (1) Blood sugar (BS) 70-149= no insulin; (2) 150-199 = 2 units; (3) 200-249 = 4 units; (4) 250-299 = 6 units; (5) 300-349 = 8 units; and (6) 350 and greater =10 units and notify the MD (physician).	F 333	• **Resident # 15, 30 and 31 have had their insulin orders reviewed by their physicians and the consultant pharmacist to assure accuracy.** • **Licensed nurses received immediate education during the survey regarding documentation of medication, including insulin and insulin administration policy.** • **Licensed nurses were provided additional education related to medication administration, specific process for insulin and nebulizer and a post quiz on education provided.** • **A review of general medication administration, nebulizer and insulin administration has been completed for each licensed nurse.** • **Nurses will receive ongoing education and review of administration upon hire and annually.** • **The consultant pharmacist was in the facility on 5/6/15 and completed an insulin review. The consultant pharmacist will review insulin administration on each pharmacist visit.**	5-26-15

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F 333	Continued From page 24 Medication Administration Record (MAR) review: R30's April MAR revealed the following: (2) On 4/2/15, documentation was lacking to indicate the scheduled Lantus 20 units SQ at hour of sleep (HS) was administered; (3) On 4/6/15, at 4:30 p.m. the BS was documented as 283 with additional Novolog insulin 2 units administered instead of the 6 units ordered per the sliding scale (4 units less). When interviewed on 4/16/15 at 2:50 p.m. LPN-B confirmed the insulin administered on 4/6/15, at 4:30 p.m. for a BS of 283 should have been 6 units instead of the 2 units given. (4) On 4/6/15, the BS was not recorded at HS and the HS Lantus 20 units was not documented as administered; (5) Sliding scale coverage of Novolog insulin was administered according to accuchecks at bedtime during the following days when there were no physician orders for sliding scale coverage at bedtime: (a) 4/3/15- 2 units (BS-177); (b) 4/10/15- 4 units (BS-226); (c) 4/11/15-4 units (BS-216); (d) 4/13/15-2 units (BS-168), (e) 4/14/15- 8 units (BS-326) without physician notification of BS over 300 and (f) 4/15/15- 4 units (BS-209). When interviewed on 4/16/15, at 2:45 p.m. licensed practical nurse (LPN)-A confirmed R30 had been administered both the scheduled HS Lantus insulin and the sliding scale insulin on 4/14/15 and 4/15/15 and that the sliding scale order had been inaccurately transcribed on the April TAR. However, after review of the physician orders dated 3/26/15, LPN-A confirmed there was no physician order for coverage of HS sliding scale insulin so this was a medication error.	F 333	• **The IDON will review and follow up on all recommendations made by the consultant pharmacist.** • **The community IDON or designated QA representative will conduct an audit 2x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 333	Continued From page 25 When interviewed on 4/16/15, at 3:00 p.m. RN-A confirmed the incorrect doses of insulin coverage per sliding scale and the documented omissions of insulin for R30. During interview with the director of nurses (DON) on 4/16/15, at 3:45 p.m. verified the above findings. When interviewed on 4/17/15, at 3:00 p.m. R30's physician (medical director of the facility) agreed with the medication errors related to the omissions of insulin, the administration of the incorrect insulin dose and the extra dose of insulin per the sliding scale at HS. Staff did not administer sliding scale and scheduled insulin per the physician orders consistently for R15. R15 diagnoses listed on the admission record dated 6/9/14 included: diabetes type II, long term use of insulin and hemiplegia due to cerebrovascular disease. The physician (MD) orders dated 2/10/15 and 3/6/15, for R15 indicated accuchecks (blood sugar readings) should be conducted 4 times/day, prior to meals and at bedtime; Humalog (changed to Novolog on 3/4/15) 11 units subcutaneous (sub-Q) twice daily (BID) 8:00 a.m. and 12:00 p.m. and Humalog 13 units at 5:00 p.m. Lantus 25 units at bedtime (hour of sleep HS). A sliding scale of insulin administration (Humalog) based on blood sugar (BS) reading was ordered three times/daily prior to meals: (1) BS-200-250 = 3 units; (2) 251-300 = 6 units; (3) BS- 301-350 = 9 units; (4) BS 351- 400 = 12 units; and (5) BS 401 or greater = 14 units; hold Humalog if resident's blood sugar is less than 90	F 333		

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F 333	Continued From page 26 and resident does not eat meal. When the resident's insulin was changed to Novolog on 3/4/15, sliding scale orders were modified to include: 3 additional units of Novolog every 50 count of blood sugar above 200. The TAR dated 3/5/15, indicated sliding scale insulin to be administered at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and included: 0-249 = 0 units, 250-299 = 3 units, 300-349 = 6 units, 350-399 = 9 units, and BS 400-449 = 12 units. Documentation on the February TAR for R15 indicated the following: (1) On 2/1/15, at 8:00 p.m. Lantus 25 units insulin administration was not documented as having been administered; (2) On 2/3/15, at 5:00 p.m. the BS was 376 and 9 units of Humalog insulin was administered instead of 12 units per physician order; (3) On 2/26/15 and 2/27/15, documentation was lacking to indicate whether the Lantus 25 units was administered. The March TAR identified that scheduled insulin was not consistently documented as having been administered: (1) On 3/3/15, at 8:00 a.m. documentation was lacking to indicate whether the scheduled 11 units Humalog was administered; (2) On 3/3/15 & 3/4/15, at 12:00 p.m. scheduled doses of Humalog 11 units was not documented as administered; (3) On 3/5/15 & 3/14/15, at 5:00 p.m. documentation was lacking to indicate the scheduled Novolog 11 units had been administered; (4) On 3/12/15, at 12:00 p.m. the scheduled Novolog 11 units was not documented as given;	F 333		

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F 333	Continued From page 27 (5) On 3/31/15, at 8:00 a.m. the scheduled 11 units of Novolog was not documented as administered. The April 2015 TAR identified that scheduled and sliding scale insulin was not documented as administered: (1) On 4/1/15, at 4:30 p.m. the BS recorded was 275, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (2) On 4/4/15, at 4:30 p.m. the BS recorded was 269, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (3) On 4/9/15, at 5:00 p.m. the scheduled dose of Novolog 11 units was not documented as administered; (4) On 4/10/15, at 4:30 p.m. the BS recorded was 261, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (5) On 4/12/15, at 4:30 p.m. the BS was 294, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (6) On 4/12/15, at 5:00 p.m. the scheduled dose of Novolog insulin 11 units was not documented as given; (7) On 4/12/15, at 8:00 p.m. the scheduled insulin dose of Lantus 25 units was not documented as given; (8) On 4/15/15, at 4:30 p.m. the BS was 331, the sliding scale insulin dose should have been 6 units according to the BS, but instead, 3 units were documented as given. On 4/16/15, at 5:18 p.m. the scheduled 5:00 p.m. Novolog insulin dose and the Lantus 25 unit dose	F 333		

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F 333	Continued From page 28 at 8:00 p.m. were documented as given after facility staff had been notified of the missing documentation by the surveyor. When interviewed on 4/16/15, at 11:00 a.m. RN-A verified these findings. When interviewed on 4/16/15, at 11:18 a.m. the DON verified the identified insulin doses were not administered and/or documented as ordered and should have been stating, "Its disappointing." When interviewed on 4/17/15, at 12:53 p.m. LPN-C stated that on 2/4/15, R15 probably refused the extra dose, subsequently R15 did not get the sliding scale insulin per physician order; LPN-C, who worked during this shift, indicated a zero to indicate the refusal should have been documented. When interviewed on 4/17/15, at 1:25 p.m. RN-F indicated she administered insulin on 3/5/15 and 3/15/15 to R15 as documentation was evident on the injection site document, but that she failed to record the BS and amount of insulin administered per sliding scale. When LPN-D was interviewed on 4/17/15, at 1:29 p.m. LPN-D stated 3 units of insulin was given for a 331 BS on 4/15/15 and confirmed it should have been 6 units. LPN-D stated, "I didn't understand the order, sometimes I ask the supervisor but she had left, I didn't ask the other nurse." When interviewed on 4/17/15, at 2:45 p.m. RN-D stated R15 received 11 units of insulin on 4/9/15, "I filled it in the other day." RN-D further stated she recalled giving the sliding scale insulin on	F 333		

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F 333	Continued From page 29 4/12/15 but must have forgot to document. RN-D had no response for the reason 9 units of insulin was administered on 2/3/15, instead of 12 units for a recorded BS of 376. On 04/16/2015, at 2:25 p.m. a message was left for R15's physician but a response was not returned yet as of 4/17/15, at 5:00 p.m.. During an interview on 4/17/15, at 2:16 p.m. the medical director stated although R15 was not his resident, the provider should be notified when insulin was not administered. The medical director indicated he been unaware of the missing documentation and errors related to insulin administration until identified by surveyors. R31, admitted on 10/3/14, had diagnoses which were not limited to: diabetes without complication type II, hypertension, vascular dementia, peripheral vascular disease and retinal disorder. R31 had the following 1/27/15, signed physician's orders: (1) Novolog 100 unit/ml vial (insulin aspart), inject 5 units subcutaneous TID with meals for DM-II (eq: insulin aspart) (dated 10/13/14); (2) Lantus 100 units/ml vial inject 22 units subq at HS DM, D/C's 2/18/15- Give insulin after resident eats to make sure she eats (dated 10/22/14); (3) Lantus 100 units/ml vial 25 units subq QHS (dated 2/18/15); (4) Novolog 100 units.ml vial 7 units subq TID with meals DM (dated 2/18/15); (5) Update GNP (graduate nurse practitioner) with blood glucose <100 (dated 2/15/15); (6) Diabetic orders: Accu-check before meals for DM Type II; (7) Lantus 30 units SQ QHS (dated 3/24/15);	F 333		

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F 333	Continued From page 30 (8) Novolog 100 units/ml, 5 units SQ with meds TID (dated 3/26/15); and (9) Accu-check QID before meals and HS (dated 3/28/15). Documentation omissions noted on the TARs for R31 were identified follows: (1) On 2/4/15, did not receive Novolog 5 units SQ at 12:00 noon; (2) On 2/19/15, HS Lantus 25 units ; (3) On 3/19/15 & 3/20/15, Lantus 25 units at HS insulin; (4) On 4/1/15, Novolog 5 units at 8:00 a.m. and 12:00 noon; (5) On 4/12/15, Lantus 30 units at HS; (6) On 4/15/15, Novolog 5 units at 5:00 p.m. Nursing staff were contacted regarding each of omitted documentation of the insulin administration doses and it was able to be verified that the insulin had generally been administered but not recorded as required. The facility's policy on Insulin Administration, dated 4/1/08, indicated "Medications given by injection will be physician ordered and will be administered following professional standards of practice by a licensed professional..."	F 333		
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 unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	• **Resident # 15, 30 and 31 have had their insulin orders reviewed by their physicians and the consultant pharmacist to assure accuracy.** • **The consultant pharmacist was in facility on 5/6/15 and reviewed all insulin orders.**	5-26-15

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F 425	Continued From page 31 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 document review and interview, the facility failed to ensure pharmaceutical services including accurate medication administration was conducted in accordance with physician ordes to meet the needs of 3 of 3 residents (R30, R31 and R15) reviewed who received insulin to manage their diabetes. Findings include: R30, who was admitted on 3/26/15, had diagnoses including diabetes type II, chronic kidney disease stage V, hypertension, and chronic cardiac disease as listed on the Treatment Administration Record (TAR). R30's physician orders on admission, dated 3/26/15 included: Accu-checks three times a day (TID) with meals and hour of sleep (HS). Call physician (MD) or nurse practitioner (NP) for blood glucose less than 75 or greater than 300. Lantus 100 units/ml vial 20 units subcutaneous	F 425	• **The community Administrator or designated QA representative will conduct an audit 1x/month for three months to ensure the recommendations from the consultant pharmacist are followed up on by the IDON. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 425	Continued From page 32 (SQ) every (Q) hour of sleep (HS). Insulin would be administered only during meals according to the blood sugar (BS) per the physician ordered insulin sliding scale coverage: Novolog 100 units/ml, inject 0-10 units subcutaneous 3 times with meals; (1) Blood sugar (BS) 70-149= no insulin; (2) 150-199 = 2 units; (3) 200-249 = 4 units; (4) 250-299 = 6 units; (5) 300-349 = 8 units; and (6) 350 and greater =10 units and notify the MD (physician). Medication Administration Record (MAR) review: R30's April MAR revealed the following: (2) On 4/2/15, documentation was lacking to indicate the scheduled Lantus 20 units SQ at hour of sleep (HS) was administered; (3) On 4/6/15, at 4:30 p.m. the BS was documented as 283 with additional Novolog insulin 2 units administered instead of the 6 units ordered per the sliding scale (4 units less). When interviewed on 4/16/15 at 2:50 p.m. LPN-B confirmed the insulin administered on 4/6/15, at 4:30 p.m. for a BS of 283 should have been 6 units instead of the 2 units given. (4) On 4/6/15, the BS was not recorded at HS and the HS Lantus 20 units was not documented as administered; (5) Sliding scale coverage of Novolog insulin was administered according to accuchecks at bedtime during the following days when there were no physician orders for sliding scale coverage at bedtime: (a) 4/3/15- 2 units (BS-177); (b) 4/10/15- 4 units (BS-226); (c) 4/11/15-4 units (BS-216); (d) 4/13/15-2 units (BS-168), (e) 4/14/15- 8 units (BS-326) without physician notification of BS over 300 and (f) 4/15/15- 4 units (BS-209). When interviewed on 4/16/15, at 2:45 p.m.	F 425		

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F 425	Continued From page 33 licensed practical nurse (LPN)-A confirmed R30 had been administered both the scheduled HS Lantus insulin and the sliding scale insulin on 4/14/15 and 4/15/15 and that the sliding scale order had been inaccurately transcribed on the April TAR. However, after review of the physician orders dated 3/26/15, LPN-A confirmed there was no physician order for coverage of HS sliding scale insulin so this was a medication error. When interviewed on 4/16/15, at 3:00 p.m. RN-A confirmed the incorrect doses of insulin coverage per sliding scale and the documented omissions of insulin for R30. During interview with the director of nurses (DON) on 4/16/15, at 3:45 p.m. verified the above findings. Staff did not administer sliding scale and scheduled insulin per the physician orders consistently for R15. R15 diagnoses listed on the admission record dated 6/9/14 included: diabetes type II, long term use of insulin and hemiplegia due to cerebrovascular disease. The physician (MD) orders dated 2/10/15 and 3/6/15, for R15 indicated accuchecks (blood sugar readings) should be conducted 4 times/day, prior to meals and at bedtime; Humalog (changed to Novolog on 3/4/15) 11 units subcutaneous (sub-Q) twice daily (BID) 8:00 a.m. and 12:00 p.m. and Humalog 13 units at 5:00 p.m. Lantus 25 units at bedtime (hour of sleep HS). A sliding scale of insulin administration (Humalog) based on blood sugar (BS) reading was ordered three times/daily prior to meals: (1)	F 425		

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	245544	A. BUILDING _____ B. WING _____	04/17/2015

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F 425	Continued From page 34 BS-200-250 = 3 units; (2) 251-300 = 6 units; (3) BS- 301-350 = 9 units; (4) BS 351- 400 = 12 units; and (5) BS 401 or greater = 14 units; hold Humalog if resident's blood sugar is less than 90 and resident does not eat meal. When the resident's insulin was changed to Novolog on 3/4/15, sliding scale orders were modified to include: 3 additional units of Novolog every 50 count of blood sugar above 200. The TAR dated 3/5/15, indicated sliding scale insulin to be administered at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and included: 0-249 = 0 units, 250-299 = 3 units, 300-349 = 6 units, 350-399 = 9 units, and BS 400-449 = 12 units. Documentation on the February TAR for R15 indicated the following: (1) On 2/1/15, at 8:00 p.m. Lantus 25 units insulin administration was not documented as having been administered; (2) On 2/3/15, at 5:00 p.m. the BS was 376 and 9 units of Humalog insulin was administered instead of 12 units per physician order; (3) On 2/26/15 and 2/27/15, documentation was lacking to indicate whether the Lantus 25 units was administered. The March TAR identified that scheduled insulin was not consistently documented as having been administered: (1) On 3/3/15, at 8:00 a.m. documentation was lacking to indicate whether the scheduled 11 units Humalog was administered; (2) On 3/3/15 & 3/4/15, at 12:00 p.m. scheduled doses of Humalog 11 units was not documented as administered; (3) On 3/5/15 & 3/14/15, at 5:00 p.m. documentation was lacking to indicate the	F 425		

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F 425	Continued From page 35 scheduled Novolog 11 units had been administered; (4) On 3/12/15, at 12:00 p.m. the scheduled Novolog 11 units was not documented as given; (5) On 3/31/15, at 8:00 a.m. the scheduled 11 units of Novolog was not documented as administered. The April 2015 TAR identified that scheduled and sliding scale insulin was not documented as administered: (1) On 4/1/15, at 4:30 p.m. the BS recorded was 275, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (2) On 4/4/15, at 4:30 p.m. the BS recorded was 269, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (3) On 4/9/15, at 5:00 p.m. the scheduled dose of Novolog 11 units was not documented as administered; (4) On 4/10/15, at 4:30 p.m. the BS recorded was 261, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (5) On 4/12/15, at 4:30 p.m. the BS was 294, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (6) On 4/12/15, at 5:00 p.m. the scheduled dose of Novolog insulin 11 units was not documented as given; (7) On 4/12/15, at 8:00 p.m. the scheduled insulin dose of Lantus 25 units was not documented as given; (8) On 4/15/15, at 4:30 p.m. the BS was 331, the sliding scale insulin dose should have been 6 units according to the BS, but instead, 3 units	F 425		

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F 425	Continued From page 36 were documented as given. On 4/16/15, at 5:18 p.m. the scheduled 5:00 p.m. Novolog insulin dose and the Lantus 25 unit dose at 8:00 p.m. were documented as given after facility staff had been notified of the missing documentation by the surveyor. When interviewed on 4/16/15, at 11:00 a.m. RN-A verified these findings. When interviewed on 4/16/15, at 11:18 a.m. the DON verified the identified insulin doses were not administered and/or documented as ordered and should have been stating, "Its disappointing." When interviewed on 4/16/15, at 5:18 p.m. RN-D stated when documentation is missing on the MAR, it usually is due to staff forgetting to sign and/or resident refusal which then should be charted in the nursing progress notes. RN-D indicated, "Today I came in and noticed I forgot to put in that the insulin was given, so today I put it in." When interviewed on 4/17/15, at 12:53 p.m. LPN-C stated that on 2/4/15, R15 probably refused the extra dose, subsequently R15 did not get the sliding scale insulin per physician order; LPN-C, who worked during this shift, indicated a zero to indicate the refusal should have been documented. When interviewed on 4/17/15, at 1:25 p.m. RN-F indicated she administered insulin on 3/5/15 and 3/15/15 to R15 as documentation was evident on the injection site document, but that she failed to record the BS and amount of insulin administered	F 425		

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F 425	Continued From page 37 per sliding scale. When LPN-D was interviewed on 4/17/15, at 1:29 p.m. LPN-D stated 3 units of insulin was given for a 331 BS on 4/15/15 and confirmed it should have been 6 units. LPN-D stated, "I didn't understand the order, sometimes I ask the supervisor but she had left, I didn't ask the other nurse." When interviewed on 4/17/15, at 2:45 p.m. RN-D stated R15 received 11 units of insulin on 4/9/15, "I filled it in the other day." RN-D further stated she recalled giving the sliding scale insulin on 4/12/15 but must have forgot to document. RN-D had no response for the reason 9 units of insulin was administered on 2/3/15, instead of 12 units for a recorded BS of 376. On 04/16/2015, at 2:25 p.m. a message was left for R15's physician but a response was not returned yet as of 4/17/15, at 5:00 p.m.. R31, admitted on 10/3/14, had diagnoses which were not limited to: diabetes without complication type II, hypertension, vascular dementia, peripheral vascular disease and retinal disorder. R31 had the following 1/27/15, signed physician's orders: (1) Novolog 100 unit/ml vial (insulin aspart), inject 5 units subcutaneous TID with meals for DM-II (eq: insulin aspart) (dated 10/13/14); (2) Lantus 100 units/ml vial inject 22 units subq at HS DM, D/C's 2/18/15- Give insulin after resident eats to make sure she eats (dated 10/22/14);	F 425		

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F 425	Continued From page 38 (3) Lantus 100 units/ml vial 25 units subq QHS (dated 2/18/15); (4) Novolog 100 units.ml vial 7 units subq TID with meals DM (dated 2/18/15); (5) Update GNP (graduate nurse practitioner) with blood glucose <100 (dated 2/15/15); (6) Diabetic orders: Accu-check before meals for DM Type II; (7) Lantus 30 units SQ QHS (dated 3/24/15); (8) Novolog 100 units/ml, 5 units SQ with meds TID (dated 3/26/15); and (9) Accu-check QID before meals and HS (dated 3/28/15). Documentation omissions noted on the TARs for R31 were identified follows: (1) On 2/4/15, did not receive Novolog 5 units SQ at 12:00 noon; (2) On 2/19/15, HS Lantus 25 units ; (3) On 3/19/15 & 3/20/15, Lantus 25 units at HS insulin; (4) On 4/1/15, Novolog 5 units at 8:00 a.m. and 12:00 noon; (5) On 4/12/15, Lantus 30 units at HS; (6) On 4/15/15, Novolog 5 units at 5:00 p.m. Nursing staff were contacted regarding each of omitted documentation of the insulin administration doses and verified the insulin had been administered but not recorded as required. The facility's policy on Insulin Administration, dated 4/1/08, indicated "Medications given by injection will be physician ordered and will be administered following professional standards of practice by a licensed professional..." Although the facility's consultant pharmacist conducted monthly chart reviews, the pharmacist	F 425		

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F 425	Continued From page 39 failed to identify the issue of omissions, the errors related to sliding scale orders, the errors related to missed doses of insulin and the transcription error. The consultant pharmacist (CP) was interviewed on 4/16/15, at 4:30 p.m. The pharmacist concurred that he had not identified the absence of documentation on the TARs related to insulin administration or the errors with insulin adminstration. The pharmacist also stated the medication administration record (MARs) and the TARs are not always available to him for review. The consultant pharmacist confirmed that he should have caught the transcription error related to the sliding scale order documented on R30's April TAR. The consultant pharmacist verified he had not been aware of these errors until they were pointed out by the survey team.	F 425		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and document review, the facility failed to ensure 5 of 34 resident (R28, R56, R35, R19, R29) electric bed remote controls were in good repair. In addition, the facility failed to maintain refrigeration equipment in the main kitchen to promote food safety having the potential to affect 34 of 34 residents who received food prepared in the kitchen.	F 456	• **Resident # 28, #56, #35, #19 and #29 had their electric bed controls removed and replaced immediately during the survey.** • **The refrigerator in the main kitchen will be removed and replaced with a new refrigerator by May 26, 2015.** • **All electric bed controls in the facility were audited immediately during survey to check for frayed wiring protection, and were replaced as needed.** • **Maintenance will audit the electric bed controls on a weekly basis.**	5-26-15

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F 456	Continued From page 40 Findings include: On 4/13/15, at 4:49 p.m. during R28's room observation the electric bed remote cord hanging on the grab bar was observed almost to the entire length approximately 30 centimeter to be frayed exposing the blue, red, black covered wires underneath. On 4/14/15, at 8:20 a.m. the bed remote cord remained stripped exposing the wires underneath all along the entire length of the cord above the bed. The remote was observed hooked on to the grab bar bed was in up position and bed was made. On 4/14/15, at 3:15 p.m. R28 was observed lying in bed the remote control cord remained frayed along the entire coiled length above the bed approximately 30 centimeter and bed was lowered to the floor. R28's diagnoses included traumatic brain injury, contracture of upper arm joint, generalized muscle weakness, aphasia, glaucoma, blindness obtained from quarterly Minimum Data Set (MDS) dated 2/10/15. In addition the MDS indicated R28 had severely impaired cognition. On 4/14/15, at 3:58 p.m. nursing assistant (NA)-A indicated "we just got him up" verified the remote was stripped and exposed the wires underneath. When asked who was supposed to report resident equipment concerns NA-A stated "For as long as I have worked here I have seen the maintenance staff each month going around and fixing concerns in the rooms or we can let them know."	F 456	• **The community Administrator or designated QA representative will conduct an audit 1x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 456	Continued From page 41 On 4/14/15, at 4:01 p.m. registered nurse (RN)-A verified the remote control plastic covering was frayed and exposed the wires underneath. RN-A further stated "definitely the aides are supposed to let maintenance know immediately to fix these issues." On 4/14/15, at 4:14 p.m. the regional maintenance manager and the administrator verified the bed remote control was frayed and exposed the colored covered wires underneath. Maintenance manager stated the covering was breaking down from being rubbed to the bed. Both indicated the bed would be replaced immediately. When asked who was responsible for ensuring the bed remotes were in good repair maintenance manager stated he expected the staff to report to his department by either writing in the maintenance log or let his staff know on the concern. R56's bed remote cord was observed on 4/14/15, at 4:45 p.m. during random room checks to be frayed and exposed white, blue, red wires underneath. R56's diagnoses included cerebrovascular accident (CVA) and heart failure obtained from 14 day Medicare MDS dated 4/2/15. In addition the MDS indicated R56 had intact cognition and required extensive physical assistance of two staff with bed mobility, transfers and needed extensive physical assistance of one for personal hygiene. On 4/14/15, at 4:48 p.m. the maintenance manager verified stated "again this should have been reported" when asked if there was any likelihood of a resident being shocked with those	F 456		

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F 456	Continued From page 42 wires being exposed maintenance manager stated when the current came out of the wall it was reduced when going through the motor and there was less than 120 volts that went through the remote itself. When asked if someone would be shocked maintenance manager stated the wires underneath had to be completely exposed for a shock to happen which was not the case at the time. On 4/14/15 at 4:30 p.m. an audit of resident rooms in the West hallway revealed: -R19's bed remote control had exposed red, green, and black wires approximately 2-3 inches in length. The bed remote was tied to the top grab bars on the right side of the bed. -R29 had black electrical tape around bed remote cord, electrical tape is loose and hanging. -R35 had red electrical tape wrapped 5 times around a frayed bed remote cord, a section of frayed cord had escaped from the electrical tape and formed a duck billed shape, which had the potential to be caught on bedding or in the side rail. The bed remote was tied onto the left grab bar near the top of the bed. At 4:40 the administrator entered the West hallway and was shown the frayed bed remote control in R35's room, the administrator removed the bed remote control from the room. The administrator was shown the frayed bed remote control and exposed red, green and black wires in R19's room, and removed the bed remote control from the room. The administrator was told of the frayed remote in R 29's room, and removed the bed remote control from the room. R35 R35 was admitted to the facility on 12/29/10, with admission diagnoses of dementia without	F 456		

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F 456	Continued From page 43 behavioral disturbance, polyneuropathy in diabetes, and diabetes mellitus. The Minimum Data Set (MDS) dated 3/17/14, indicted severe cognitive impairment, rarely or never understood, short and long term memory problems and severely impaired decision making. Little interest or pleasure, feeling hopeless and depressed, short tempered and easily annoyed. 2-6 days. tired or having trouble concentrating 7-11 days, Rejects care 1-3 days. R35 required extensive assistance of two staff for bed mobility and transfers, extensive assistance of one staff for dressing, toilet use, locomotion on and off the unit, and was independent with eating after setup. The Care Area Assessment (CAA) for significant change dated 12/27/14, indicated R35 has severe cognitive impairment with delirium, difficulty with short term and long term memory recall. Staff offer cues and redirection as appropriate. The Care Plan dated 2/9/15, indicated R35 had verbal outbursts toward staff, yells and swears, and was redirectable. R35 spends time in his room and goes to dining room most of the time for his meals. R35 was dependent on staff for cares and locomotion on the unit. 4/14/15, at 5:33 The regional manager for maintenance (RMEVS) was interviewed and had not conducted an audit of the beds and was not aware of who had put red electrical tape on the bed remote control cords, or when it had been done. The administrator had started in the facility on 10/1/14, had not conducted an audit of the beds, was not aware of who put the electrical tape on and when it had occurred. Both the administrator and the RMEVS stated they would	F 456		

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F 456	Continued From page 44 expect the staff to report frayed remote bed controls, and they should be removed from the patient rooms. R19 R19 was admitted to the facility on 3/17/14, with diagnoses of anemia, hypertension, hyperlipidemia, Alzheimer's Disease, dementia, and depression. The quarterly MDS dated 3/25/15, indicated R19 was cognitively intact, required extensive two person assist with bed mobility and transfers, extensive one person assist with dressing, toilet use, and personal hygiene. On 4/15/15, at 7:24 a.m. when asked about bed remote control, R19 stated she was able to hit the buttons to operate it. R19 further indicated she had never had any problems with the remote or felt a shock when touching it. R29 R29 was admitted to the facility on 4/28/13, with diagnoses of anemia, viral hepatitis, hyponatremia, and Parkinson's disease. The quarterly MDS dated 3/12/15 indicated severe cognitive impairment, required extensive two person assist with bed mobility, extensive one person assist with dressing, and extensive one person assist with toileting and personal hygiene. On 4/15/15, at 7:28 a.m. when asked, R29 stated she was told remote had been making noise so facility had to change it. R29 further indicated she was able to operate the remote and never had any problems or felt a shock when touching it.	F 456		

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F 456	Continued From page 45 During the tour of the kitchen on 4/13/15, at 11:40 a.m. with the Director of Dietary (DD) the three section refrigeration unit approximately two feet in width and six feet in length labeled C, D and E had colored powdery metal like shavings on the left side two feet width of compartment C and in the front four feet in compartment C and D. The shavings were white, yellow and gray in color. On the left side of compartment C the metal surface was eroding and the galvanized bottom of the unit was raised approximately 1/4 inch, not firm to bottom of the unit, harboring the powdery, decomposing metal material. The front galvanized bottom piece was also decomposing, presenting a jagged, uncleanable surface. The unit contained fruit, vegetables, thawing nutritional supplements. The DD verified the findings, stating "I don't know what that is, it looks like its eroding, it probably needs to be replaced." During the second tour of the kitchen on 4/15/15, at 9:20 a.m. the same powder metal like shavings were noted to still be in the refrigeration unit and verified by DD. During an interview on 4/15/15, at 9:25 a.m. DD stated she didn't know what to do with this and stated she had contacted maintenance, but he stated it was out of his league and probably could not be fixed. DD stated, "I guess we could vacuum or clean it up." During interview on 4/15/15, at 11:35 a.m. the maintenance manager (MM) stated that it was brought to his attention this morning, and was not notified of the issue before the kitchen tour. MM	F 456		

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F 456	Continued From page 46 stated it looked like the insulation may be eroding and that it couldn't be fixed, will need to be replaced, "I put a bid out today." During interview on 4/15/15, at 11:37 a.m. DD stated that staff will let her know if a piece of equipment is in need of repair and she will let maintenance know. If it is not urgent, it is put in the maintenance repair book. DD confirmed that all staff was aware of the policy. The facility's policy titled Malfunctions and Repairs, dated 2010 indicated that when a piece of equipment malfunctions, the food service manager is notified, who notifies the maintenance department by phone or in writing letting them know how quickly the piece of equipment is needed.	F 456		
F 465 SS=C	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 the physical plan was maintained in a clean and orderly manner which had the potentional to affect 34 of 34 residents residing in facility . Findings include: The administrator and contracted regional	F 465	• **The exhaust vents in bathroom 144 and 151 were cleaned on 5/13/15** • **The south shower room, north shower room and west shower room exhaust vents were cleaned on 5/13/15** • **The caulking/tiles were repaired in the south and west shower room on 5/8/15** • **The caulking around the toilets in room 144 and 151 was repaired on 5/6/15.** • **The blinds in the dining room were replaced on 5/13/15.** • **The radiator in the dining room was repaired on 5-7-2015**	5-26-15

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F 465	Continued From page 47 maintenance manager (RMM) accompanied the surveyor on an environmental tour on 4/14/15 from 3:15 p..m. until 4:11 p.m. During the tour, RMM stated that resident rooms are cleaned daily and deep cleaned twice a month. He stated that their contract with the facility includes deep cleaning each resident room once a month, but each room is scheduled twice a month in case it cannot be done one of the scheduled times. He said this would ensure each room still gets deep cleaned once a month. RMM also stated that when a resident move out of a room, the room is checked by maintenance to make sure everything is clean and working and then they check it again before a new resident moves into that room. Exhaust vents in resident bathrooms 144 and 151 were observed to have thick dust-like material. RMM stated cleaning of the exhaust vents in resident rooms is to be done with the monthly deep cleans and is on checklist. RMM stated that in room 151 the housekeeper would not be able to dust way up in the vent where the thickest dust like material; the vent cover would have to be removed to dust the inner part and this would, "Actually be a maintenance thing." RMM stated that the housekeepers should tell maintenance directly or write it in the log book when they do the monthly cleaning of the vents and can not get it all cleaned with the duster they use. The exhaust vents in the south, north and west hall tub/shower rooms were observed to have a thick build up of dust. RMM verified the two exhaust vents in the south tub room needed to be cleaned. RMM verified the exhaust vent above the shower in the north hall tub room also needed to be cleaned and stated, "I am sure they are all the same." At that time the administrator	F 465	• **The grab bars, electric bed controls, exhaust vents, resident room toilets, shower room caulking/tile, window blinds in the dining room and radiators in the dining room were all placed on a weekly check system in which the Maintenance department will complete.** • **The community Administrator or designated QA representative will conduct an audit 1x/week for three months of the maintenance audit to ensure compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 465	Continued From page 48 stated, "I suppose the brushes get the outside but not way up there (exhaust vents); That probably hasn't been done in forever." RMM verified the dust build up on the exhaust vents in the west hall tub room. RMM stated that cleaning of the vents is supposed to be part of the monthly deep clean check list for the tub rooms. In addition, caulking and tiles in the south and west tub/shower rooms was missing/in disrepair. RMM verified tile was cracked and missing from the partial wall of shower in the west tub room exposing an area from one to three inches up from the floor. RMM stated, the missing caulking needs to be replaced and the tiles redone before water gets under the tiles. The administrator stated that there was no plan in place at this time to fix the tiles and caulking in these tub/shower rooms. The grout/caulk around the toilets in rooms 144 and 151 was noticed to be missing. RMM stated that the caulking is peeling off and stained and the remaining caulking needed to be removed and re-caulked. RMM stated he was not aware of this specific toilet needing to be re-caulked but has noticed in other bathrooms. RMM stated it is from age and wear and tear. RMM and administrator also verified the following concerns during the environmental tour: the blinds left of the patio door in the main dining room have grey, brown, and black splatters on them; radiator to left of patio door in main dining room was loose and there was a gap between two parts of the radiator in which a piece was missing. RMM stated that there is a log book at the main	F 465		

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F 465	Continued From page 49 nurses' desk where anyone can address issues for maintenance to address. He said this log is checked by maintenance several times throughout the day, including by the evening maintenance person who is at the facility until 9:00 p.m. each evening. RMM indicated the log consists of date of request, name of person who enters the request, a location and description of request, and a date and initial of when the request was completed and by whom. RMM stated when the log sheet is full it is entered into the computer system and kept track of on the computer. Following the tour, the maintenance log book was reviewed and it was noted one of the concerns noted during the environmental tour were included in the log. The facility policy titled Environment-Cleaning of Equipment (General), dated April 1, 2008, indicated the facility provides a clean environment and all unit equipment is cleaned on a routine basis.	F 465		
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	F 514	• **The documentation policy has been reviewed and revised that includes the process for documentation changes.** • **The nursing staff have been re-educated on the documentation policy.**	5-26-15

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F 514	Continued From page 50 preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facilty failed to ensure medical records were accurate, unaltered and complete. These practices had the potential to affect all 34 residents who reside in the facility. Findings include: Documentation review done from 4/13/15-4/17/15, revealed R20 to have a form from In-House Senior Services in his chart that had white out on the line following "Clinical Assistant " and on the line following "Date Sent," and this had a new date written over the white out. At the bottom of the form there was a phone number written in over white out. R20's April 2015 treatment record (TR) indicated to apply lotion to bilateral lower extremities (BLE) daily (start date of 1/16/15); initialed off as completed on 4/1/15. All other dates during the month of April were blank, and there was no documentation to indicate why. Documentation review done from 4/13/15-4/17/15, revealed R13 to have an undated assessment for resident Self Administration of Medications (SAM) in the medical record. On 6/16/15, at 10:24 a.m. registered nurse (RN)-A stated that she expected treatments to be signed off when the treatment was completed, and if a resident refused the treatment, to have	F 514	• **The community IDON or designated QA representative will conduct a documentation audit weekly for three months to monitor compliance with the documentation policy. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 514	Continued From page 51 the signature area circled by the nurse with a notation about the refusal documented on the back of treatment administration record (TAR). RN-A stated that R13's SAM assessment should have been dated when completed and further added, "Any documentation should be dated." RN-A stated if a form is recevied with white out on it from outside of the facility, they call the entity and ask them to fax a clean, corrected form back to them as it is their policy that documentation is not allowed to have white out on it. On 4/16/15, at 2:17p.m. the director of nursing (DON) stated, "I have no idea what the policy is regarding white out on documentation." The DON was shown a form in R20's chart that had white out on it. The DON stated he did not know what to say about this and also stated, the expectation is for treatments to be completed and signed off, and if a resident refused treatment, it should be documented as a refusal and then signed off on the back of the TAR as a refusal. The DON verified that R20's TAR was not signed off nor refusal documented regarding lotioning to lower extremities. The DON verified R13's SAM did not have a date on it. The DON stated he was "not surprised by this" and stated that if he would go into any chart he would not be surprised at all to find things not dated. The DON stated, "Open any chart and you will find missing dates." The facility's policy Clinical Records (General) dated 3/1/14, indicated that all clinical records are maintained in accordance with professional standards and practice, including complete records.	F 514		

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F 514	Continued From page 52	F 514		

R30, who was admitted on 3/26/15, had diagnoses including diabetes type II, chronic kidney disease stage V, hypertension, and chronic cardiac disease as listed on the Treatment Administration Record (TAR).

R30's physician orders on admission, dated 3/26/15 included: Accu-checks three times a day (TID) with meals and hour of sleep (HS). Call physician (MD) or nurse practitioner (NP) for blood glucose less than 75 or greater than 300. Lantus 100 units/ml vial 20 units subcutaneous (SQ) every (Q) hour of sleep (HS). Insulin would be administered only during meals according to the blood sugar (BS) per the physician ordered insulin sliding scale coverage: Novolog 100 units/ml, inject 0-10 units subcutaneous 3 times with meals; (1) Blood sugar (BS) 70-149= no insulin; (2) 150-199 = 2 units; (3) 200-249 = 4 units; (4) 250-299 = 6 units; (5) 300-349 = 8 units; and (6) 350 and greater =10 units and notify the MD (physician).

Medication Administration Record (MAR) review: R30's April MAR revealed the following:
(2) On 4/2/15, documentation was lacking to indicate the scheduled Lantus 20 units SQ at

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F 514	Continued From page 53 hour of sleep (HS) was administered; (3) On 4/6/15, at 4:30 p.m. the BS was documented as 283 with additional Novolog insulin 2 units administered instead of the 6 units ordered per the sliding scale (4 units less). When interviewed on 4/16/15 at 2:50 p.m. LPN-B confirmed the insulin administered on 4/6/15, at 4:30 p.m. for a BS of 283 should have been 6 units instead of the 2 units given. (4) On 4/6/15, the BS was not recorded at HS and the HS Lantus 20 units was not documented as administered; (5) Sliding scale coverage of Novolog insulin was administered according to accuchecks at bedtime during the following days when there were no physician orders for sliding scale coverage at bedtime: (a) 4/3/15- 2 units (BS-177); (b) 4/10/15- 4 units (BS-226); (c) 4/11/15-4 units (BS-216); (d) 4/13/15-2 units (BS-168), (e) 4/14/15- 8 units (BS-326) without physician notification of BS over 300 and (f) 4/15/15- 4 units (BS-209). When interviewed on 4/16/15, at 2:45 p.m. licensed practical nurse (LPN)-A confirmed R30 had been administered both the scheduled HS Lantus insulin and the sliding scale insulin on 4/14/15 and 4/15/15. After review of the physician orders dated 3/26/15, LPN-A confirmed there was no physician order for coverage of HS sliding scale insulin so this was a medication error. When interviewed on 4/16/15, at 3:00 p.m. RN-A confirmed the incorrect doses of insulin coverage per sliding scale and the documented omissions of insulin for R30. During interview with the director of nurses (DON)	F 514		

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F 514	Continued From page 54 on 4/16/15, at 3:45 p.m. verified the above findings. When interviewed on 4/17/15, at 3:00 p.m. R30's physician (medical director of the facility) agreed with the medication errors related to the omissions of insulin, the administration of the incorrect insulin dose and the extra dose of insulin per the sliding scale at HS. R15 diagnoses listed on the admission record dated 6/9/14 included: diabetes type II, long term use of insulin and hemiplegia due to cerebrovascular disease. The physician (MD) orders dated 2/10/15 and 3/6/15, for R15 indicated accuchecks (blood sugar readings) should be conducted 4 times/day, prior to meals and at bedtime; Humalog (changed to Novolog on 3/4/15) 11 units subcutaneous (sub-Q) twice daily (BID) 8:00 a.m. and 12:00 p.m. and Humalog 13 units at 5:00 p.m. Lantus 25 units at bedtime (hour of sleep HS). A sliding scale of insulin administration (Humalog) based on blood sugar (BS) reading was ordered three times/daily prior to meals: (1) BS-200-250 = 3 units; (2) 251-300 = 6 units; (3) BS- 301-350 = 9 units; (4) BS 351- 400 = 12 units; and (5) BS 401 or greater = 14 units; hold Humalog if resident's blood sugar is less than 90 and resident does not eat meal. When the resident's insulin was changed to Novolog on 3/4/15, sliding scale orders were modified to include: 3 additional units of Novolog every 50 count of blood sugar above 200. The TAR dated 3/5/15, indicated sliding scale insulin to be administered at 7:30 a.m., 11:30 a.m. and 4:30 p.m. and included: 0-249 = 0 units, 250-299 = 3 units, 300-349 = 6 units, 350-399 = 9 units,	F 514		

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F 514	Continued From page 55 and BS 400-449 = 12 units. Documentation on the February TAR for R15 indicated the following: (1) On 2/1/15, at 8:00 p.m. Lantus 25 units insulin administration was not documented as having been administered; (2) On 2/3/15, at 5:00 p.m. the BS was 376 and 9 units of Humalog insulin was administered instead of 12 units per physician order; (3) On 2/26/15 and 2/27/15, documentation was lacking to indicate whether the Lantus 25 units was administered. The March TAR identified that scheduled insulin was not consistently documented as having been administered: (1) On 3/3/15, at 8:00 a.m. documentation was lacking to indicate whether the scheduled 11 units Humalog was administered; (2) On 3/3/15 & 3/4/15, at 12:00 p.m. scheduled doses of Humalog 11 units was not documented as administered; (3) On 3/5/15 & 3/14/15, at 5:00 p.m. documentation was lacking to indicate the scheduled Novolog 11 units had been administered; (4) On 3/12/15, at 12:00 p.m. the scheduled Novolog 11 units was not documented as given; (5) On 3/31/15, at 8:00 a.m. the scheduled 11 units of Novolog was not documented as administered. The April 2015 TAR identified that scheduled and sliding scale insulin was not documented as administered: (1) On 4/1/15, at 4:30 p.m. the BS recorded was 275, the sliding scale insulin dose should have been 3 units none was documented as having	F 514		

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F 514	Continued From page 56 been administered; (2) On 4/4/15, at 4:30 p.m. the BS recorded was 269, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (3) On 4/9/15, at 5:00 p.m. the scheduled dose of Novolog 11 units was not documented as administered; (4) On 4/10/15, at 4:30 p.m. the BS recorded was 261, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (5) On 4/12/15, at 4:30 p.m. the BS was 294, the sliding scale insulin dose should have been 3 units none was documented as having been administered; (6) On 4/12/15, at 5:00 p.m. the scheduled dose of Novolog insulin 11 units was not documented as given; (7) On 4/12/15, at 8:00 p.m. the scheduled insulin dose of Lantus 25 units was not documented as given; (8) On 4/15/15, at 4:30 p.m. the BS was 331, the sliding scale insulin dose should have been 6 units according to the BS, but instead, 3 units were documented as given. On 4/16/15, at 5:18 p.m. the scheduled 5:00 p.m. Novolog insulin dose and the Lantus 25 unit dose at 8:00 p.m. were documented as given after facility staff had been notified of the missing documentation by the surveyor. When interviewed on 4/16/15, at 11:00 a.m. RN-A verified these findings. When interviewed on 4/16/15, at 11:18 a.m. the DON verified the identified insulin doses were not administered and/or documented as ordered and	F 514		

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F 514	Continued From page 57 should have been stating, "Its disappointing." When interviewed on 4/16/15, at 5:18 p.m. RN-D stated when documentation is missing on the MAR, it usually is due to staff forgetting to sign and/or resident refusal which then should be charted in the nursing progress notes. RN-D indicated, "Today I came in and noticed I forgot to put in that the insulin was given, so today I put it in." When interviewed on 4/17/15, at 12:53 p.m. LPN-C stated that on 2/4/15, R15 probably refused the extra dose, subsequently R15 did not get the sliding scale insulin per physician order; LPN-C, who worked during this shift, indicated a zero to indicate the refusal should have been documented. When interviewed on 4/17/15, at 1:25 p.m. RN-F indicated she administered insulin on 3/5/15 and 3/15/15 to R15 as documentation was evident on the injection site document, but that she failed to record the BS and amount of insulin administered per sliding scale. When LPN-D was interviewed on 4/17/15, at 1:29 p.m. LPN-D stated 3 units of insulin was given for a 331 BS on 4/15/15 and confirmed it should have been 6 units. LPN-D stated, "I didn't understand the order, sometimes I ask the supervisor but she had left, I didn't ask the other nurse." When interviewed on 4/17/15, at 2:45 p.m. RN-D stated R15 received 11 units of insulin on 4/9/15, "I filled it in the other day." RN-D further stated she recalled giving the sliding scale insulin on	F 514		

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	245544	A. BUILDING _____ B. WING _____	04/17/2015

NAME 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 58 4/12/15 but must have forgot to document. RN-D had no response for the reason 9 units of insulin was administered on 2/3/15, instead of 12 units for a recorded BS of 376. During an interview on 4/17/15, at 2:16 p.m. the medical director stated he been unaware of the missing documentation and errors related to insulin administration until identified by surveyors. R31, admitted on 10/3/14, had diagnoses which were not limited to: diabetes without complication type II, hypertension, vascular dementia, peripheral vascular disease and retinal disorder. R31 had the following 1/27/15, signed physician's orders: (1) Novolog 100 unit/ml vial (insulin aspart), inject 5 units subcutaneous TID with meals for DM-II (eq: insulin aspart) (dated 10/13/14); (2) Lantus 100 units/ml vial inject 22 units subq at HS DM, D/C's 2/18/15- Give insulin after resident eats to make sure she eats (dated 10/22/14); (3) Lantus 100 units/ml vial 25 units subq QHS (dated 2/18/15); (4) Novolog 100 units.ml vial 7 units subq TID with meals DM (dated 2/18/15); (5) Update GNP (graduate nurse practitioner) with blood glucose <100 (dated 2/15/15); (6) Diabetic orders: Accu-check before meals for DM	F 514		

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F 514	Continued From page 59 Type II; (7) Lantus 30 units SQ QHS (dated 3/24/15); (8) Novolog 100 units/ml, 5 units SQ with meds TID (dated 3/26/15); and (9) Accu-check QID before meals and HS (dated 3/28/15). Documentation omissions noted on the TARs for R31 were identified follows: (1) On 2/4/15, did not receive Novolog 5 units SQ at 12:00 noon; (2) On 2/19/15, HS Lantus 25 units ; (3) On 3/19/15 & 3/20/15, Lantus 25 units at HS insulin; (4) On 4/1/15, Novolog 5 units at 8:00 a.m. and 12:00 noon; (5) On 4/12/15, Lantus 30 units at HS; (6) On 4/15/15, Novolog 5 units at 5:00 p.m. Nursing staff were contacted regarding each of omitted documentation of the insulin administration doses and verified the insulin had generally been administered but not recorded as required.	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	F 520	• **IDON will continue to review all medication incidents and discuss with the medical director.** • **Medication reports will be reported to the QA committee that includes administration issues identified and actions taken for improvement each month for the Medical Director to review.**	5-26-15

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F 520	Continued From page 60 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 document review and interview, the facility failed to ensure quality assurance measures were initiated and implemented related to problems with insulin administration for 3 of 3 residents (R30, R15 and R31) reviewed who received insulin by injection.. Findings include: On 4/17/15, at 3:15 p.m. the administrator stated the facility had identified an issue with transcribing orders and had conducted education with staff on proper transcription of medications, clarification of orders, and notification of physicians if there were problems with medication administration. The administrator stated audits had been conducted and findings reported at quality meetings that had been held monthly since December 2014. He stated the audits were subsequently presented to the quality assurance committee (QA) as raw numbers however, no analysis or trending had been done.	F 520	• **Licensed nurses have received education related to medication administration and documentation** • **The community Administrator or designated QA representative will conduct an audit 1x/month for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance**	

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F 520	Continued From page 61 During the interview, the administrator stated the facility had stopped using the electronic medication records and had gone back to using paper records because of errors. However, since the change, insulin doses and administration had been moved to the treatment administration record (TAR) and had consequently not been reviewed. The administrator also stated during this interview that he would have expected leadership staff to follow up with individual staff when gaps in charting or errors in administration were identified related to omission of documentation. Through review of R30, R15 and R31's medication/treatment records and physician orders, it was determined that seventeen different staff members had been involved in the errors related to insulin administration that had occurred in the facility since 1/1/15. The errors included lack of documentation, omitted doses, incorrect doses of insulin, and transcription errors 3 residents who received insulin by injection. Although the survey team requested documentation of the medication administration record audits, the facility was unable to locate the audits that had been done. The only documentation available were the raw numbers that had been recorded as reported at monthly QA meetings.	F 520		

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	245544	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	04/15/2015

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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	**Preparation, submission and implementation of this Plan of Correction do not constitute an admission of or agreement with the facts and conclusions set forth on the survey report. Our Plan of Correction is prepared and executed as a means to continuously improve the quality of care and to comply with all applicable state and federal regulatory requirements.** POC ok 5-19-15 RECEIVED MAY 15 2015 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

DC: 5-8-15
Exit: 4-17-15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	5-13-15

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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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 73 beds and had a census of 33 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	The kitchen door was modified to include a magnetic door hold opener that will release upon activation of the fire alarm system on May 8, 2015. Staff will be re-educated on the appropriate use of the magnetic door holders, to ensure compliance.	5-26-15

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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 the residents. Findings include: During facility tour between 9:30 AM and 11:15 AM on 04/15/2015, observation revealed that the kitchen door leading into the dining room is being propped open. This deficient practice was verified by the administrator at the time of the inspection.	K 029	The community Administrator or designated QA representative will conduct an audit 1x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance	
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	The sidewalks on the north wing have been removed and re-poured to ensure they are level with the other sections of the sidewalk. This work was completed on April 30, 2015. Staff will be re-educated on the regulation for non-even sidewalks to ensure compliance going forward	5-26-15

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K 038	Continued From page 3 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:15 AM on 04/15/2015, observation revealed that the exterior egress sidewalks on the north wing have subsided. This deficient practice was verified by the administrator at the time of the inspection.	K 038	The community Administrator or designated QA representative will conduct an audit 1x/month for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance	
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 9:30 AM and 11:15 AM on 04/15/2015, record review revealed that fire	K 050	The Maintenance Director has created a scheduled date/time for fire drills for the rest of the year at Camden. These timeframes will be followed, with subsequent reports being completed for each fire drill that is conducted. The maintenance Director was re-educated on the policy and procedure for completing fire drills, to ensure compliance. The community Administrator or designated QA representative will conduct an audit 1x/week for three months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance	5-26-15

STATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 050	Continued From page 4 drill documentation could not be provided the second quarter or third quarter 2014, fourth quarter PM or Night 2014 or first quarter Night 2015. This deficient practice was verified by the administrator at the time of the inspection.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, the facility has failed to inspect and maintain the sprinkler system in accordance with NFPA 13 and NFPA 25. This deficient practice could affect the residents. Findings include: On facility tour between 9:30 AM and 11:15 AM on 04/15/2015, record review revealed that there was no documentation of the quarterly fire sprinkler inspection. This deficient practice was verified by the administrator at the time of the inspection.	K 062	The facility had a quarterly sprinkler test completed on May 4, 2015 with appropriate reports obtained and filed. The Maintenance Director was re-educated on the policy and procedure for ensuring sprinkler tests are completed and the appropriate paper work is obtained. The community Administrator or designated QA representative will conduct an audit quarterly for six months for continued compliance. The audit results will be reviewed at QA council and recommendations will be made for continued review or compliance	5-26-15