#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

1 TJC

18/19 SNF

87

(L38)

3 Other

245544

699435200

8. ACCREDITATION STATUS:

(L9) 11/12/2015

6. DATE OF SURVEY

(a):

(b):

12. Total Facility Beds

13. Total Certified Beds

18 SNF

(L37)

See Attached Remarks

17. SURVEYOR SIGNATURE

19. DETERMINATION OF ELIGIBILITY

Facility is Eligible to Participate

0 Unaccredited

2 AOA

From

To

NO.(L1)

(L2)

**CENTERS FOR MEDICARE & MEDICAID SERVICES** MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: KOXR PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00166 1. MEDICARE/MEDICAID PROVIDER 4. TYPE OF ACTION: 7\_(L8) 3. NAME AND ADDRESS OF FACILITY (L3) CAMDEN CARE CENTER 1. Initial 2. Recertification (L4) 512 49TH AVENUE NORTH 4. CHOW 3. Termination 2. STATE VENDOR OR MEDICAID NO. (L6) **55430** (L5) MINNEAPOLIS, MN 5. Validation 6. Complaint 7. On-Site Visit 9. Other 5. EFFECTIVE DATE CHANGE OF OWNERSHIP 7. PROVIDER/SUPPLIER CATEGORY 02 8. Full Survey After Complaint 01 Hospital 05 HHA 13 PTIP 09 ESRD 22 CLIA (L34) 02 SNF/NF/Dual 06 PRTF 10 NF 05/2/2016 14 CORF FISCAL YEAR ENDING DATE: (L35)(L10) 03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE 12/31 04 SNF 08 OPT/SP 11. .LTC PERIOD OF CERTIFICATION 10.THE FACILITY IS CERTIFIED AS: X A. In Compliance With And/Or Approved Waivers Of The Following Requirements: \_\_\_\_ 2. Technical Personnel Program Requirements Scope of Services Limit Compliance Based On: \_\_\_ 3. 24 Hour RN 7. Medical Director 4. 7-Day RN (Rural SNF) 1. Acceptable POC 8. Patient Room Size 87 (L18) \_\_\_ 5. Life Safety Code \_\_\_ 9. Beds/Room 87 (L17) B. Not in Compliance with Program Requirements and/or Applied Waivers: (L12)14. LTC CERTIFIED BED BREAKDOWN 15. FACILITY MEETS 19 SNF ICF IID (L15)1861 (e) (1) or 1861 (j) (1): (L39) (L42)(L43) 16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE): 18. STATE SURVEY AGENCY APPROVAL Date: Date: Jacob Mabera, HFE NE II 06/15/2016 Kamala Fiske-Downing, Health Program Representative (L19) (L20)

21. 1. Statement of Financial Solvency (HCFA-2572)

2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENC
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20. COMPLIANCE WITH CIVIL

RIGHTS ACT:

	•		F1 = 1 = 1 = 1 = 1 = 1 = 1 = 1	
2. Facility is not Eligib	(L21)			
22. ORIGINAL DATE	23. LTC AGREEMENT	24. LTC AGREEMENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING DATE	ENDING DATE	VOLUNTARY 00	INVOLUNTARY
01/01/1991			01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)	(L25)	02-Dissatisfaction W/ Reimbursement	06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVE SANCTIO	ONS	03-Risk of Involuntary Termination	OTHER
	A. Suspension of Admission		04-Other Reason for Withdrawal	07-Provider Status Change
		(L44)		00-Active
(L27)	B. Rescind Suspension Dat	e:		
		(L45)		
28. TERMINATION DATE:	29. INTERME	DIARY/CARRIER NO.	30. REMARKS	
	06201			
	(L28)	(L31)		
31. RO RECEIPT OF CMS-1539	32. DETERMIN	NATION OF APPROVAL DATE	-	
	03/09/201 (L32)	<b>6</b> (L33)	DETERMINATION APPROVAL	
	•			

#### 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

Facility ID: 00166

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

CCN: 24-5544

STATE AGENCY REMARKS

On May 3rd and May 5, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify your facility had achieved and maintain compliance with Federal certification deficiencies issued pursuant to the LSC and FMS surveys completed on January 26, 2015 and March 10, 2016. Based on our PCR, we have determined that your facility has corrected deficiencies pursuant to the LSC and FMS surveys effective May 2, 2016.



Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245544

June 16, 2016

Ms. Mary Hamer, Administrator Camden Care Center 512 49th Avenue North Minneapolis, MN 55430

Dear Ms. Hamer:

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 2, 2016 the above facility is certified for or recommended for:

### 87 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for the following waivers has been approved based on the submitted documentation: K18, K25, K27, K51 and K56.

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.

Camden Care Center June 10, 2016 Page 2

Please contact me if you have any questions.

Sincerely,

Kumalu Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Health Regulation Division Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

cc: Licensing and Certification File



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

Certified Mail # 7013 3020 0001 8869 1036

June 2, 2016

Ms. Mary Hamer, Administrator Camden Care Center 512 49th Avenue North Minneapolis, MN 55430

RE: Project Number S5544026

Dear Ms. Hamer:

On February 16, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 28, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

March 10, 2016, a surveyor representing the Region V Office of the Centers for Medicare and Medicaid Services (CMS), completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The most serious deficiencies at the time of the FMS were 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.

March 24, 2016, CMS forwarded the results of the FMS completed on March 10, 2016 and notified you that your facility was not in substantial compliance with the Federal requirements for nursing homes participation in the Medicare and Medicaid programs and that they were imposing the following enforcement remedy:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 28, 2016 (42 CFR 488.417(b))

Also, the CMS Region V Office notified you in their letter of March 24, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 28, 2016.

On May 2, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 3, 2016, 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 January 28, 2016 and the Federal Monitoring Survey (FMS) completed on March 10, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant

Camden Care Center June 2, 2016 Page 2

to our standard survey, completed on January 28, 2016 and FMS completed March 10, 2016, effective May 2, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in the CMS letter of March 24, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

 Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 28, 2016, be discontinued, effective May 2, 2016. (42 CFR 488.417(b))

Also, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from April 28, 2016.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 28, 2016, is to be discontinued, effective May 2, 2016. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 28, 2016, is to be discontinued, effective May 2, 2016.

Correction of the Life Safety Code (LSC) deficiencies cited under K18, K25, K27, K51 and K56 at the time of the March 10, 2016 Federal Monitoring Survey (FMS), had not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of May 31, 2016 for LSC deficiency cited at K25, date of completion of June 10, 2016 for LSC deficiencies cited at K18, K27, K56 and date of completion of December 31, 2016 for LSC deficiency cited at K51, have been approved.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

## POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
	A. Building B. Wing	Y	2	5/2/2016	Y3
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).

ITE	М		DATE	ITEM			DATE	ITEM			DATE
Y4			Y5	Y4			Y5	Y4			Y5
ID Prefix	F0156		Correction	ID Prefix	F0246	i	Correction	ID Prefix	F0254		Correction
Reg. #	483.10(b)(5) - ( 483.10(b)(1)	10),	Completed	Reg. #	483.15	(e)(1)	Completed	Reg. #	483.15(h)(3)		Completed
LSC	_		05/02/2016	LSC			05/02/2016	LSC			05/02/2016
ID Prefix	F0257		Correction	ID Prefix	F0279	ı	Correction	ID Prefix	F0280		Correction
Reg. #	483.15(h)(6)		Completed	Reg. #	483.20	(d), 483.20(k)(1)	Completed	Reg. #	483.20(d)(3), 48 (2)	3.10(k)	Completed
LSC			05/02/2016	LSC			05/02/2016	LSC			05/02/2016
ID Prefix	F0282		Correction	ID Prefix	F0309	ı	Correction	ID Prefix	F0314		Correction
Reg. #	483.20(k)(3)(ii)		Completed	Reg. #	483.25		Completed	Reg. #	483.25(c)		Completed
LSC			05/02/2016	LSC			05/02/2016	LSC			05/02/2016
ID Prefix	F0315		Correction	ID Prefix	F0323	ı	Correction	ID Prefix	F0334		Correction
Reg. #	483.25(d)		Completed	Reg. #	483.25	(h)	Completed	Reg. #	483.25(n)		Completed
LSC			05/02/2016	LSC			05/02/2016	LSC			05/02/2016
ID Prefix	F0353		Correction	ID Prefix	F0354		Correction	ID Prefix	F0356		Correction
Reg. #	483.30(a)		Completed	Reg. #	483.30	(b)	Completed	Reg. #	483.30(e)		Completed
LSC			05/02/2016	LSC			03/08/2016	LSC			05/02/2016
REVIEWE STATE AC		REVIEW (INITIAL	.S)	DATE		SIGNATURE OF				DATE	
REVIEWS CMS RO	ED BY	REVIEW (INITIAL	.S)	7/7/2016 <b>DATE</b>		TITLE	35456		EVENT ID:	DATE	5/2/2016

## POST-CERTIFICATION REVISIT REPORT

PROVIDE IDENTIFI 245544				STRUCTIO	N				DATE OF RE	EVISIT Y3
NAME OF			ER			STREET ADDRESS, C 512 49TH AVENUE NO MINNEAPOLIS, MN 55	RTH	DE		
program corrected	, to show d and the n number	those date and t	d by a qualified State sue deficiencies previously such corrective action whe identification prefix of .	reported ovas accom	on the CMS-2567 plished. Each d	<ol> <li>Statement of Deficiency should be full</li> </ol>	encies and Plan of Ily identified using of	Correction either the	n, that have regulation	e been or LSC
ITE	М		DATE	ITEM		DATE	ITEM		DA	TE
Y4			Y5	Y4		Y5	Y4		Y	5
ID Prefix			Correction	ID Prefix		Correction				
Reg. #	483.60(b	), (d), (	e) Completed	Reg. #	483.70(h)	Completed				
LSC	-		05/02/2016	LSC		05/02/2016				
REVIEW	ED RV		REVIEWED BY	DATE	SIGNATII	RE OF SURVEYOR		Ī	DATE	
STATE A			REVIEWED BY (INITIALS)	DATE		RE OF SURVEYOR	25456		DATE	
REVIEWI CMS RO	ED BY		GD/kfd  REVIEWED BY (INITIALS)	7/7/201 DATE	TITLE		35456	ı	5/2/2016 DATE	
FOLLOW 1/28/201		URVE	Y COMPLETED ON			CORRECTED DEFICIEN CIENCIES (CMS-2567)		IT\/0 -	□YES □	] NO

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVI	SIT
IDENTIFICATION NUMBER	A. Building 01 - MAIN BUILDING 01		ŀ		
245544 <sub>Y1</sub>	B. Wing	,	Y2	5/3/2016	Y3
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).

ITE		DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0022	04/18/2016	LSC	K0029		04/18/2016	LSC	K0033		03/11/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0038	04/05/2016	LSC	K0048		04/06/2016	LSC	K0050		03/14/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0052	04/18/2016	LSC	K0054		04/18/2016	LSC	K0062		04/18/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #	NFPA 101		Completed
LSC	K0067	03/11/2016	LSC	K0069		04/08/2016	LSC	K0076		04/14/2016
ID Prefix		Correction	ID Prefix			Correction	ID Prefix			Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 1	01	Completed	Reg. #			Completed
LSC	K0144	03/11/2016	LSC	K0147		03/11/2016	LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS)	DATE	0	SIGNATURE OF		40054		DATE	0040
REVIEWI CMS RO		TL/kfd REVIEWED BY (INITIALS)	6/2/201 DATE	<u>b</u>	TITLE		19251		5/3/ <b>DATE</b>	2016
<b>FOLLOW</b> 3/10/201		Y COMPLETED ON			R ANY UNCORRECTED DEFICIENCI					s 🗆 no

		POST-0	CERTI	FICATIO	N REVISIT	<b>REPO</b>	RT		
	ER / SUPPLIER / CL ICATION NUMBER	MULTIPLE COM A. Building 01 B. Wing					,	DATE OF RE	VISIT
	F FACILITY	71			STREET ADDRES	SS. CITY. STATI		72	13
	N CARE CENTER	₹			512 49TH AVENU		-, 332-		
					MINNEAPOLIS, M	IN 55430			
program correcte provisio	n, to show those de	by a qualified State seficiencies previousles charactive action identification prefix of	y reported was accom	on the CMS-2 plished. Each	567, Statement of D n deficiency should I	eficiencies and be fully identifi	d Plan of Corre	ection, that have the regulation	e been or LSC
ITE	EM	DATE	ITEM		DATE	ITEM		DA	TE
Y4		Y5	Y4		Y5	Y4		Y	5
ID Prefix	:	Correction	ID Prefix		Correction	on ID Prefix	·	Cori	rection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Complete	ed Reg.#	NFPA 101	Con	npleted
LSC	K0052	02/29/2016	LSC	K0062	03/08/201	6 LSC	K0074	01/2	8/2016
ID Prefix	:	Correction	ID Prefix		Correction	on ID Prefix	·	Cori	rection
Reg. #		Completed	Reg. #		Complete	ed Reg. #		Con	npleted
LSC			LSC			LSC			
ID Prefix		Correction	ID Prefix	_	Correction	on ID Prefix	·	Cori	rection
Reg. #		Completed	Reg. #		Complete	ed Reg. #		Con	npleted
LSC			LSC			LSC			
ID Prefix	:	Correction	ID Prefix		Correction	on ID Prefix	·	Cori	rection
Reg. #		Completed	Reg. #		Complet	ed Reg. #		Com	npleted
LSC	<u>-</u>		LSC			LSC			
ID Prefix		Correction	ID Prefix		Correction	on ID Prefix	(	Cori	rection

REVIEWED BY **REVIEWED BY** DATE SIGNATURE OF SURVEYOR DATE STATE AGENCY (INITIALS) 5/3/2016 6/2/2016 19251 **REVIEWED BY** DATE TITLE DATE **REVIEWED BY CMS RO** (INITIALS) 

Completed

Reg. #

LSC

FOLLOWUP TO SURVEY COMPLETED ON 1/26/2016 CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?

☐ YES ☐ NO

Completed

Reg. #

LSC

Completed

Reg. #

LSC



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

Certified Mail # 7013 3020 0001 8869 1036

June 2, 2016

Ms. Mary Hamer, Administrator Camden Care Center 512 49th Avenue North Minneapolis, MN 55430

Re: Enclosed Reinspection Results - Project Number S5544026

Dear Ms. Hamer:

On May 2, 2016 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on May 2, 2016. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

			STAT	E FORM: REV	ISIT REPORT				
_	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building B. Wing	ISTRUCTIC	DN			Y2	DATE OF RE	VISIT Y3
	F FACILITY N CARE CENTER				STREET ADDRESS, 0 512 49TH AVENUE NO MINNEAPOLIS, MN 5	ORTH	, ZIP CODE		
correctiv	ort is completed by a re action was accomp ation prefix code prev rm).	olished. Each def	iciency sho	ould be fully ident	ified using either the	regulation	or LSC provision	n number and	d the
ITE	М	DATE	ITEM	I	DATE	ITEM		DA	TE
Y4		Y5	Y4		Y5	Y4		Υ	75
ID Prefix	20555	Correction	ID Prefix	20565	Correction	ID Prefix	20570	Corr	rection
Reg. #	MN Rule 4658.0405 Subp. 1	Completed	Reg. #	MN Rule 4658.040 Subp. 3	5 Completed	Reg. #	MN Rule 4658.04 Subp. 4		npleted
LSC		05/02/2016	LSC		05/02/2016	LSC		05/0	2/2016
ID Prefix	20800	Correction	ID Prefix	20830	Correction	ID Prefix	20840	Cor	rection
Reg. #	MN Rule 4658.0510 Subp. 1	Completed	Reg. #	MN Rule 4658.052 Subp. 1	Completed	Reg. #	MN Rule 4658.05 Subp. 2 B	520 Con	npleted
LSC		05/02/2016	LSC		05/02/2016	LSC		05/0	2/2016
	·								

ID Prefix 20905

Reg. #

LSC

MN Rule 4658.0525

Subp. 4

Correction

Completed

05/02/2016

Correction

Completed

05/02/2016

ID Prefix 20900

Reg. #

LSC

MN Rule 4658.0525

Subp. 3

Correction

Completed

05/02/2016

ID Prefix 20865

Reg. #

LSC

MN Rule 4658.0520

Subp. 2 G

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

## CENTERS FOR MEDICARE & MEDICAID SERVICES

## MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: KOXR Facility ID: 00166

	IAKI I-	TO BE COMIT		IIIE SIAI	IE SURVET AGENCI		racinty ID. 00100
MEDICARE/MEDICAID PROVIDENO.(L1)     245544	DER	3. NAME AND AI (L3) <b>CAMDEN</b> (				4. TYPE OF AC	TION: 2 (L8)  2. Recertification
2. STATE VENDOR OR MEDICAL	D NO.	(L4) <b>512 49TH A</b>	VENUE NOR	ГН		3. Termination	4. CHOW
(L2) <b>699435200</b>		(L5) MINNEAPO	DLIS, MN		(L6) <b>55430</b>	5. Validation 7. On-Site Visit	6. Complaint 9. Other
5. EFFECTIVE DATE CHANGE OF (L9) <b>11/12/2015</b>	OWNERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEO 05 HHA	GORY 09 ESRD	02 (L7) 13 PTIP 22 CLIA	8. Full Survey A	
<ul><li>6. DATE OF SURVEY 01/</li><li>8. ACCREDITATION STATUS:</li></ul>	<b>28/2016</b> (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR EN	NDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	ON	10.THE FACILITY		AS:			
From (a):		A. In Complia			And/Or Approved Waivers Of	· ·	
To (b):		_	equirements e Based On:		2. Technical Personnel 3. 24 Hour RN	6. Scope o 7. Medical	f Services Limit
12 Total Facility Dada	<b>97</b> (I 19)	1. A	cceptable POC		4. 7-Day RN (Rural SN		
12. Total Facility Beds	<b>87</b> (L18) <b>87</b> (L17)	Y D. Natin Can			5. Life Safety Code	9. Beds/Ro	oom
13.Total Certified Beds	67 (L17)	X B. Not in Cor Requirements	and/or Applied	-	* Code: <b>B</b>	(L12)	
14. LTC CERTIFIED BED BREAKD	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	MARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY		Date:
Kathy Sass, HPR-Di	etary Specialist		03/15/2016	(L19)	Kamala Fiske-Downing	, Enforcement S	pecialist 03/25/2016
PA	ART II - TO BE	COMPLETED 1	BY HCFA RI	EGIONAI	OFFICE OR SINGLE S		
19. DETERMINATION OF ELIGIBI	ILITY		MPLIANCE WITH	H CIVIL	21. 1. Statement of Final	ncial Solvency (HCFA- ol Interest Disclosure S	
1. Facility is Eligible to	Participate	1001			3. Both of the Above		um (110111 1013)
2. Facility is not Eligib	le (L21)						
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 2	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)
OF PARTICIPATION	BEGINNING	3 DATE	ENDING DA	TE	VOLUNTARY 00	11,70	<u>LUNTARY</u>
01/01/1991					01-Merger, Closure		to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	on <u>OTHE</u>	<u>R</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal		vider Status Change
(L27)			(L44)			00-Act	tive
(227)	B. Rescind Si	uspension Date:					
			(L45)				
28. TERMINATION DATE:	29	). INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		06201					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	N OF APPROVAI	L DATE			
		03/09/2016		_			
	(L32)			(L33)	DETERMINATION APPI	ROVAL	



Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0732

February 16, 2016

Ms. Mary Hamer, Administrator Camden Care Center 512 49th Avenue North Minneapolis, MN 55430

RE: Project Number \$5544026

Dear Ms. Hamer:

On January 28, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

<u>Electronic 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;

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

Camden Care Center February 16, 2016 Page 2

## <u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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

#### 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 gloria.derfus@state.mn.us

Telephone: (651) 201-3792 Fax: (651) 215-9697

#### **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 March 8, 2016, the Department of Health will impose the following remedy:

State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 8, 2016 the following remedy will be imposed:

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

#### **ELECTRONIC PLAN OF CORRECTION (ePoC)**

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and

sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### **VERIFICATION OF SUBSTANTIAL COMPLIANCE**

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

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

### Original deficiencies not corrected

Camden Care Center February 16, 2016 Page 4

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 April 28, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 28, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

#### INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900 Camden Care Center February 16, 2016 Page 5

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

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

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:

Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections State Fire Marshal Division Email: tom.linhoff@state.mn.us

Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

**Health Regulation Division** 

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

PRINTED: 02/17/2016

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 01/28/2016 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245544 NAME OF PROVIDER OR SUPPLIER 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 CAMDEN CARE CENTER PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE CHOSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) PREFIX TAG Preparation, submission and F 000 implementation of this Plan of F 000 INITIAL COMMENTS Correction do not constitute an The facility's plan of correction (POC) will serve admission of or agreement as your allegation of compliance upon the with the facts and conclusions Department's acceptance. Because you are enrolled in ePOC, your signature is not required set forth on the survey report. at the bottom of the first page of the CMS-2567 **Our Plan of Correction is** form. Your electronic submission of the POC will prepared and executed as a be used as verification of compliance. means to continuously Upon receipt of an acceptable electronic POC, an improve the quality of care and on-site revisit of your facility may be conducted to validate that substantial compliance with the to comply with all applicable regulations has been attained in accordance with state and federal regulatory your verification. F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF 156 requirements. RIGHTS, RULES, SERVICES, CHARGES SS=C F156(C) R43 discharged from The facility must inform the resident both orally facility on 8/11/2015. and in writing in a language that the resident understands of his or her rights and all rules and All residents are at risk of not regulations governing resident conduct and responsibilities during the stay in the facility. The knowing rights as pertain to facility must also provide the resident with the payer source upon changes in notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be treatment plan (not receiving made prior to or upon admission and during the Advanced Beneficiary Notices resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in timely). writing. Leadership staff including The facility must inform each resident who is therapy were educated on entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the Medicare Compliance, resident becomes eligible for Medicaid of the Expedited Review, timeliness of items and services that are included in nursing issuing Denial Letters and the facility services under the State plan and for which the resident may not be charged; those Appeals Process on 2/22/16. other items and services that the facility offers

DIRECTOR'S OR PROVIDER/SUPPKIER REPRESENTATIVE'S SIGNATURE ABORATOR

Le recusive of Any deliciency statement ending with an exterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other saleguards 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 removing the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued If continuation sheet Page 1 of 79 program participation.

TITLE

(X6) DATE

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F 156		g resident abuse, neglect, and of resident property in the ompliance with the advance	F	156			
	name, specialty, physician respon	inform each resident of the and way of contacting the sible for his or her care.					
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ļ	record indica	ated R43 had received skilled occupational therapy. The reco	ord (		Facility ID: 00168	Ifhiming	tion sheet Page

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			·	FORM OMB_NO.	02/17/2016 APPROVED 0938-0391 E SURVEY
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		715, when H43 was diomary resident had then stayed in the			Facility ID: 00166	If continual	lon sheet Page 4 c

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	reviewed whas sistence.	10 fillited opti us			Findings will be reported	l at	
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1	l was observ	Ved off the new Amaria reach V	Vhen I		Corrections to deficient	t practice	3
\	wheelchall	and was out of H155 reached, H15 stated she needed her of H15 alls or help. H15 also stated	all light	l	will be made by March	8, 2016.	_ \
Ì	50 she col	d, R15 stated she hested her uld call for help. R15 also stated	A IL LINA		Facility IO: 00168	continuatio	n sheet Page

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEPICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	FIPLE CONSTRUCTION  NG	CON	IPLETED
		245544	B. WING			/28/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	IEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	left within reach, at before leaving the within reach. At the (NA)-I entered the not within R15's reand handed it to R supposed to be played.  R15's admission N12/30/15, indicated.  R10 was observed interviewed in her bed, and stated shwhen she needed call light but could (RN)-A nurse man1/26/16, at 11:25 capable of using the R10's call light. F was wrapped up i resident's bed. RI to place the call light was don't be call light. F was wrapped up i resident when the R10's admission R10 had moderated.  On 1/28/16, at 9:4 stated staff were were placed within The facility's call not provided.	ast that the call light was not and she needed to remind staff room to place the call light at point the nursing assistant room, verified the call light was each, picked up the call light was each, picked up the call light was aced always within residents  Minimum Data Set (MDS) dated d R15 was cognitively intact.  I on 1/26/16, at 11:17 a.m. and room. R10 was laying in her help. R10 then looked for the inot find it. Registered nurse are routinely used the call light help. R10 then looked for the inot find it. Registered nurse are not within reach, and looked the call light. RN-A confirmed as not within reach, and looked the bedding at the foot of the N-A stated staff were expected ght within the reach of the		254		

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION		MPLETED
		245544	B, WING			01	/28/2016
	PAOVIDER OR SUPPLIER			512	REET ADDRESS, CITY, STATE, ZIP CODE 2 49TH AVENUE NORTH NNEAPOLIS, MN 55430	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLÉTION DATE
F 254 SS∌D	GOOD CONDITION The facility must polinens that are in good to be served failed to ensure approvided for 1 of 1 who utilized a baristic which did not cover laying in her bed. The oversized bariatric which did not cover laying in her bed. The oversized bariatric which did not cover laying in her bed. The oversized bariatric which did not cover laying in her bed. The	rovide clean bed and bath ood condition.  ENT is not met as evidenced ation and interview, the facility propriate bedding was resident (R15) in the sample		254	F254 (D) Fitted sheets fitting bariatric beds were obtained and placed on R15's bed on 1/25/16. Six other bariatric beds in use in facility were checked for appropriate used clean bariatric bedding on 1/25/16. Bariatric residents at risk for lack of appropriations supply and use of clean fitting bed linens.  Staff was educated regarding the need to provide for clean well-fitting linens and notification when supply linens is low.  Bariatric linen supply will be audited weekly x 12 weeks a par supply of 3 bariatric bottom sheets for each bariatric bed.  Findings will be reviewed monthly by the QAP1 Committee x 3 months, wirfollow-up to Committee for supply of the particle of the committee for co	e of te are ting ng an tying y of e for c	
	sheets. The DON not have an adeq then went to R15' at 5:20 p.m., state bed was "not accesshe would have e	said she was unaware staff did uate supply of linens. The DON is room and when she returned at the lack of linens of R15's aptable." The DON also stated expected the staff to inform her			Findings will be reviewed monthly by the QAPI Committee x 3 months, wi		

					PRINTED: 0 FORM AF	ソトロウィーハ
	• •	AND HUMAN SERVICES			OMB NO. 0	938-03 <u>91</u>
)EPARTME	NT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	NO MULTIPLE	CONSTRUCTION	COMP	ETED
〜ピルITFRS (	OR MEDICALE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING _		01/2	8/2016
ND PLAN OF C	URINCOTTON		B. WING	OFFICE TIP C		
		245544	51	REET ADDRESS, CITY, STATE, ZIP C 12 49TH AVENUE NORTH		1
NAME OF PRO	OVIDER OR SUPPLIER		5			(X5)
	ARE CENTER			OBOVIDER'S PLAN UF CU	ARECTION N SHOULD BE	COMPLETION
(X4) ID PREFIX	TO MANAGEY (S)	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CONNECTION OF THE CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIALE	
TAG	HEGOLATOTT OT		F 25	Corrections deficie will be made by M	nt practice	
	Continued From		F 25	·		
F 257				F257 (D) Room temp for R46 and R12 were	e assessed	
Ju-5	ł			by maintenance on 1	1/28/16 and	
	temperature lev	1000 must maintain a		aroper adjustments	mage to	<u> </u>
	temperature rar	nge of 71 - 81° F		in stoase room temp	Setatnie in a	:
	į		1	comfortable level w	rere done.	
	This REQUIRE	MENT is not met as evidenced	nt	All residents are at	risk for	
	by: Based on obs	ervation, interview and docume sility faïled to ensure comfortable were maintaìned in a shared ro	3	uncomfortable roo	m	1
	Leamperatures	101 DAM ANTIQUED 101	1	temperatures.		
	environment \	dents (R46, R12) reviewed re- with room temperature concerns		Staff were educate	ed on	
1	Findings inclu	ıde:		assessing for and	reporting	
1	1	SD (201M) +- 0 - + -	ated tion.	uncomfortable ro temperatures for	residents.	
1	1 41/26/15, 109	IlCutor 14	1			
\	On 1/26/16.	at 9:37 a.m. when asked during	}	Random room te	mperatures X	•
	Lintarview II I	India was " ' - anything AlSt	3 11 1 11 15 1	will be audited 5	days a week A	
1	l buildinn Ma	t andotos ha interviet	W L	4 weeks and mo	nthly x z	•
	Lune not Wa	THE CHOOSE TO A THE N	1691	months. Finding	s will be	to
1	l park bed \	Mas opported ,	WILTI I	reported month	βγχ3 months.	••
1	i three neav	A Digital and an		the QAPI Comm	littee with	
1	l not facility	DISHIVOIS	ł	follow-up to re-		1
	On 1/28/1	5, at 7:40 a.m. R46 stated he ha	e staff	of Committee.		
	ranated I	ne colo toom to he	1	Deficient pract	tice will be	
	144000	A and 10 the	, g , ,	corrected by N	March 8, 2016	
	l Mankeis i	fo keeb warring	l l		li contin	uation sheet Page B
	R12's an	nual MDS dated 11/3/15, indica	rent ID:KOXA11	Facility ID: 00166	-	

									RINTED: 01 FORM AP MB NO, 01	LHOAFR.	
	DA 111	NAENIT ()	F HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES	_				NO DATE S	URVEY	
<u>C</u> E	NTE	AS FOR MEDICAL CORRECT	ENCIES	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA   IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	NG	STRUCTION		COMPL 01/2	3/2016	
AND	PLAIM (	), OO,		245544	B, WING		- OITY	STATE, ZIP CODE	<u></u>		
ı						STAFE	TH AVENUE NOF	ath .			1
2/	ME OF	PROVIDER	OR SUPPLIER		i	512 49   661NN	CADOLIS MN	55430		(XE)	┥
c	AMDE	N CARE	CENTER	<del> </del>	T ID	<del>!</del>	PROVIDER'S	PLAN OF CORRECT	ITD BE	(X6) COMPLETION DATE	١
-	(X4) ID PREFIX TAG	<del></del>	CHAMARY ST	ATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PAEI	e <b>ix</b>		CTIVE ACTION SHOUNCED TO THE APPR DEFICIENCY)	OPRIATE		-
	F 25	reside family On 1 inter were nois R12 to the R12 on envere recommendation of the R12 on	y was involved. A facility is comfortable accomprehe was not able to the common of the comporatures of the room. The facility's (General) degrees Flow of the facility is degrees Flow of the facility in the develop of the facility is the facility in the develop of the facility is the facility in the develop of the facility is the facility in the develop of the facility is the facility in the develop of the facility is the facility in the develop of the facility is the facility in the facility in the develop of the facility is the facility in the facility in the facility in the facility is the facility in the facility in the facility in the facility is the facility in the f	impaired cognitions as a result. ed in care decisions as a result. 1:28 a.m. during a family 12's family when asked if there ms with the temperature, lighting else in the building that affect family member stated during vise room was always cold which be to verbalize.  In 12:04 p.m. to 12:32 p.m., and tour was conducted with the ger (RM) and the administrator. If the RM checked the room twice. The first temperature real tobserved at 68 degrees and the second reading registere ahrenheit. Both the administrator erified the readings and stated the thermostat located by the detection of the second resuring maintened for resident concerns about rooms.	ding dat or hey por he ance 71-81 sment s	F 2	79 discha surve (Nurs care with	(D) R15 has be arged to home y. Care plans i sing Assistants I guides for thos indwelling cath	since the and NAR Registered e resident neters and devices, i.e	2.	Page 9 of 79
	- 1		1		ALID:KOX	H11	Facility ID: 00166	<b>)</b>			

						INTED: 02 FORM AP	PHOAFA
	المراسون	AND HIMAN SERVICES			0	MB NO. 09	HAVEY L
DEPARTM	ENT OF HEALIN	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIE/ACLIA	(X2) MULTIF	LE CONST	TAUCTION	COMPLI	EYED
CENTERS	FOH MEDICALLA		A. BUILDING	G		1	}
STATEMENT OF AND PLAN OF C	DEFICIENCIES CORRECTION	IDENTIFICATION NO.				01/28	3/2016
MIND I COM		245544	B. WING		ADDRESS, CITY, STATE, ZIP CODE		l
				STREET	H AVENUE NORTH		
NAME OF PR	OVIDER OR SUPPLIER			212 481	ADALIC MN 55430		(X5)
	CARE CENTER	- VOICENNIES	10		PROVIDER'S PLAN OF CORRECT	ON LD BE OPRIATE	COMPLETION
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED 8Y FULL LSC IDENTIFYING INFORMATION)	PREFI)	<b>*</b>	CROSS-REFERENCE DEFICIENCY		
PRÉFIX TAG	REGULATORY OR	LSO IDEIXI I I I		-+-	Cpaps, were reviewed and		\ \
\ <del></del>			F	279	revised to include care		1
F 279	Continued From I	page 9			interventions for indwellin	B	1
1 72/9	plan for each rest	ident that includes a resident's			catheters and assistive		
	l objectives and in	Included and neveropsocial	1		breathing equip; i.e. Cpap	S-	
1	medical, nursing	, and mental and payerned lentified in the comprehensive					
	Jaccossment.				All residents are at risk du	e to	
1	Į.	ust describe the services that a	re l	Ì	incomplete care planning	and	
1	The care plan must describe the services that to be furnished to attain or maintain the resider highest practicable physical, mental, and psychosocial well-being as required under psychosocial well-being as required under		it's	1	communication of care no	seds.	1
			l l	1		•	
	hevehosocial w	Clippen's a " Therwise otherwise	e	1	Staff were educated on	_	
	6483.25; anu ≥	III John Se but are not provide	d \	1	comprehensive care plan	ning	1
1	be required driv	der §483,25 but are not product dent's exercise of rights under ding the right to refuse treatmen	nt	<u> </u>	and timely communication	יט חס	1
	LEADA TI), INCIUN	THIR TO US.	-	1	care needs and the need	for	1
}	under §483.10	(b)(4)-		1	proper care of indwellin	g	\ \
		a - a cyldance	ed		catheters and the moni-	toring of	1
1	This REQUIA	EMENT is not met as evidence	_	1	residents using assistive	2	}
1	hir	documi	ent l	Ì	residents using apparent i	.e.	
\	Based on ob	servation, interview and docum- icility failed to develop a plan of interventions were in	Cale		breathing equipment; i	'	
	to ensure ind	IVIOLOGIA DE LA LA 1 resid	ieni i		Cpaps.	rde will	
	place to mee	lividualized interventions were not to the state of the s	and		All new residents' reco	TA SCELLE	
1	(A15) who have respiratory c	au an money			be audited x 12 weeks	. IU 435U10	
1	•				an individualized care	pian is	
\	Findings inc	lude:			completed by day 21	and care	
1	Catheter ca	I/O: IO7/16 at B:23 a.m	, laying		interventions are	_L +ba	
\	R15 was ob	are: oserved on 1/27/16, at 8:23 a.m During interview R15 stated she halways clean her properly in the	e felt		communicated throu	Ru are	1
	in the bed.	Dulling into the second in the	1 <b>e</b> i		NAR care guide. Find	lings will	
1	l marning a	INU SINC TOOCH	าสเกาแ		he reported monthly	TO AUP	\
•	l reduested	mem, which had an ind	JWelling I		committee x 3 mont	hs with	
:	the morning	ig and port good milliter (ml) b	ag (		follow-up to Commi	ttee	
	Foley cau	teter, with a 2000 finance to have to it. R15 stated she used to have the testions (LITI) in the past, and the testions (LITI) in the testions (LITI) in the testion (LITI) in the testion (LITI) in	and did		recommendations.		
, \	urinary tra	to it. R15 stated she used to have act infections (UTI) in the past, a suban staff supposed to care for	her	<u> </u>	*	If continual	ion sheet Page 10 o
	not know	when staff supposed to care for	eut ID:KOXH	11	Facility ID: 00168		

DEPARTMENT OF HEALTH	AND HUMAN SERVICES			- QUETON	OMB NO.	093B-0391	. :
CENTERS FUH MEDIONING		(X2) MULTI A. BUILDIN	PLE CONS	TRUCTION		l l	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSOR! LIFE IDENTIFICATION NUMBER:	A. BUILDIN			01/2	28/2016	
AND PLAN OF COMME	245544	B, WING_		ADDRESS, CITY, STATE, ZIP CO	)DE		
				A VAENUE NOH I H			\
NAME OF PROVIDER OR SUPPLIER		Ì	512 49 L			) (X5)	1
CAMPEN CARE CENTER		<u></u>		OBOVIDER'S PLAN OF CO	SHOULD BE	COMPLETION DATE	
ALTHUMANY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	X .	CROSS-HEPERENOZIONENCY)			1
TAG				Corrections to deficien	nt practice	•	l l
	_	F	279	will be made by Marc	h 8, 2016.		1
F 279 Continued From	page 10 to stated she preferred to use the had bowel movements, but	ne	}	Will be may			1
catheter. R15 als	o stated she prefer out to e had bowel movements, but ways had a bed pan available to						
I ataff have not an	Mayo The Die Mae	1					
1 1000 ()N (/2// 10	I WY THE ! I LAWA AND TECEIVED	1 \	1	•			1
l Interviewed ayar	19 Older Late After 1916 After 19		1			l	
today, no stan v	TOURS CALCULATION STATES	4 \					1
I related to titl 9	nd nau	N.					1
she had the urolog	theter for a long little, and the gist when in trouble with kidney	1		•			}
) failure.							1
DAS'e Hospital	Discharge Summary dated	for		•			1
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	iten , , , , , , , , , , a qiaquosi	is of	1				1
I I I I I WORSENIN	g remain tract		ļ				\
I Infaction (Date	Dellorania in Primaviel AUO		Ï			į	
\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		narv i				1	
· I had indicated	I U I D HM	iace				1	}
' I nrior to admi	5810111	<b>,</b>					}
1 1		nt and					1
1 dated 12/1/1	10, 100 mm	are i				}	1
history of U	ille, illetion aggist of	one					\
. 09190 date0	I CHILLIAN TO THE THE TOTAL TOTAL CONTROL OF THE TO	or i				}	1
Foley cathe	and failed to identify presented eter, any medical conditions rela- ted, and failed to identify					1	1
the urinary	tract, and failed to identify to care for the catheter.	1				1	l l
1 1		ange (					1
On 12/2/18	5, the Physician Order read "Ch [catheter] monthly. Catheter ca	res q					1
[every] sh	Campicit						1
' 1	) itsztainiek v	on					1
Review of	FR15's Medication Administration MAH) and Treatment Administra FAR) from 12/1/15 through 12/5	ation					
Record (	MAH) and Treatment Authorition TAH) from 12/1/15 through 12/5 TAH) from 12/1/15 through 12/5	he Foley			If continu	uation sheet Pa	ige 11 of 79
identified	TAR) from 12/1/15 through 12/2 catheter cares and to change to	vani ID:KOXI	711	Facility ID: 00166			

						E∩RM A	02/17/2016 \PPROVED	
	e A) Til	AND HUMAN SERVICES  & MEDICAID SERVICES			0	(X3) DATE	0938-0391	
DEPARTM	ENT OF HEALTH	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA		DI E CON	STRUCTION	(X3) DATE	PLETED	
CENTERS	FOR MEDICARE	THE PROPERTY OF THE PROPERTY O	A, BUILDIN	TE COM		1	Į.	
T O	こうただいたいしにゅ し	(X1) PROVIDERSON DEMINER:	A, BUILDIN	M3		04/5	28/2016	
AND PLAN OF	DONNECTION		B. WING_			<u> </u>	20/20:5	
		245544	1	STREE	T ADDRESS, CITY, STATE, ZIP CODE		1	
	OVIDER OR SUPPLIER		Į	249 AB	TH AVENUE NORTH		1	
b and a second and a			1	MINN	EAPOLIS, MN 55430	ION	(X5) COMPLETION	
CAMDEN	CARE CENTER		T 10		PHOVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU (EACH CORRECTIVE TO THE APPRO	LD BE	COMPLETION	
(X4) ID PREFIX TAG	CLIMMARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CHOSS-REFERENCED TO THE APPRODEFICIENCY)	)PHIATE	-	
				279			· ·	1
	Continued From I	nage 11	į.	213			1	1
F 279	Continued From	page 11 onth, however, the plan care wa t the catheter, balloon size,	5	\			}	1
	catheter every in	onth, however, the place if the catheter, balloon size, house signs and symptoms of	1	1			}	1
}	monitoring for ad	f the catheter, ballock steep lyerse signs and symptoms of adwarsening kidney disease.	1	1				1
1	pyelonephritis ar	lverse signs and symplement and worsening kidney disease.	1	\			1	1
	1	"-ad and readmitted on	\	1				1
ļ	R15 was hospite	e Admission Nursing	.	1			1	1
	12/23/15, per 11	e Admission Nursing ne form indicated history of UTI's ne was left incomplete, did not	5,	1				<b>\</b>
1	howaver ine ivi	ill was lot " thator urinary	' L	}			Ì	1
\ \	indicate present	m was left incomplete, and the ce of the Foley catheter, urinary	).	1				1
	tract related me	Uluar condition 1 12/23/15		1			ļ	1
	The Temporary	edical conditions of 2/23/15, care plan dated 12/23/15, and pad ung assist of two staff, and pad u	ise.	1			1	1
1	indicated totten	40/09/45	1	1				1
ļ	Review of R15	is MAR and TAR from 12/23/15	eter	1				1
	doing forward;	lacked life dominationer every	1		1		1	1
	cares and to c	manys will of t	ne i				Ì	\ \
1	month. In add	mon, the plant size, monitoring t	or				1	1
1	size of the car	ineter, balloon stast and symptoms of UTIs, and worsening kidney disease	\		1		1	1
1	adverse signa	and symptoms of 2113, and worsening kidney disease	.				1	1
	1	. Barra Boy (MDS) d	iated		1		1	- 1
1	R15's admiss	sion Minimum Data 35t (1115)	eter,				\	\
1	12/30/15, inc	ilicated is the sthowel, and was	}				1	1
l	was frequent	lly incommon statement with hed	1 1					- 1
	dependent o	If two staff's assistance with the first said toilet use. The MDS and toilet use. The MDS and the first and the first said to the first sa	also				1	1
	denicted R1	nsfers and toilet use. The interest and 5 as being cognitively intact and segment and segm	able				1	1
1	Las baya CICH	It COMParationer	20.0					1
	I to clearly su	9(¢ (1600a)	1				. \	1
	1		atheter				1	- 1
	The Urinar)	/ Incontinence and Incoming Assessment dated 1/4/16, indica and proceed to care plan for F	ated				1	}
.	Care Alea	Assessment dated 1/4/10, indeed would proceed to care plan for F	-OieA		\		}	ļ
\	catheter ca	would proceed to care parese are and monitoring of adverse	ter use.	Į	1		l l	1
	Loutcomes	9220Claren mini	, 2. •	•	<b>\</b>			ļ
	1		/23/15, 1					40.0470
	The comp	rehensive plan of care dated reheals and bladder needs, activities of	daily	<u> </u>	17. 17. 10.186	If continue	ation sheet Page	12 01 /8
. 1	for bowel	and hidden in .	PI ID: KOX81	11	Facility ID: 00166			

		LIUMANI SERVICES				OMB NO. 1	0938-0391	
DEPARTM!	ENT OF HEALTH	AND HUMAN SERVICES  8 MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTR	RUCTION	(X3) DATE	SURVEY	
CENTERS	FOR MEDICALIC	O TOTAL PROPERTY OF THE PARTY O	(X2) MULTI	10 ——— IPLE CONST			Ì	
STATEMENT OF		(X1) PROVIDENTIFICATION NUMBER:	A. DOICE.			01/3	28/2016	
, ·		245544	0. WING		DDRESS, CITY, STATE, ZIP CO			
	- SUPPLIES		_ \	512 49TH	AVENUE NOH 14		Ì	
1	OVIDER OR SUPPLIER			MINNEA	DOI 18 MN 55430	oTiON	(X5)	
CAMDEN	CARE CENTER		T 1D	<del></del>	PROVIDER'S PLAN OF COR	SHOULD BE	COMPLETION DATE	
(X4) ID PAEFIX TAG	SUMMARY ST. (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFI	^ L c	(EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFIGIENCY)	APPROPRIATE		
F 279	Continued From p	page 12 catheter use was not developed cinterventions identified to assis		279				
	nor was there and R15 with cares. I presence of Fole related to urinary	The care plan did not include y catheter, medical conditions tract, and did not indicate care						
	related to Cathete R15's care plan was a vulnerable and investigate void of the size monitoring for a UTIs, pyelonepidisease.	revised on 1/5/16, indicated R1 e adult and staff were to monito any concerns. The care plan we of the catheter, balloon size, dverse signs and symptoms of hritis and worsening kidney	5 r as					
	indicated H15 chronic indwell years due to in The note also recently of bla had urine and one organism ordered a thre (antibiotic). T was not adde monitoring al	s Progress notes dated 1/14/16 had chronic kidney disease and ling Foley catheter for the past in mobility, and had history of UT indicated R15 had complaints dder spasm, started on oxybuty lysis with mixed flora (more that isolated from urine culture), and ed ay course of Levaquin he newly diagnosed bladder spand to the plan of care nor was the interventions put into place of the than the medication to religious.	eix min, n d asms ere					
	toileting, an However, the indwelling f	assistant (NA) care sheet (und sist of two with grooming, dress d transfer with Hoyer to commone sheet did not indicate present of cares.	de. ce of ake					
	care of R11	ger were not available for inter	ryjeW- ni ID:KOXR1	rı F	acility ID: 00156	ll continue	tion sheet Page	13 of 79

		SERVICES				. OMB NO. 1	0938-0391	;
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			axes lection	(X3) DATE	SURVEY PLETED	
CENTERS	FOH MEDICATION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	1G		01/2	28/2016	
• • • •	l	245544	B. WING	- PWDCE	TADDRESS, CITY, STATE, ZIP C	ODE		
			1	440.40	TH AVENUE NOH IN		1	
	OVIDER OR SUPPLIER		1	MINN		ROECTION .	(X6)	
CAMDEN	CARE CENTER	THE CO	T ID		PROVIDER'S PLAN OF CO	N SHOULD BE	COMPLETION DATE	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)			
F 279	Continued From	page 13	F	279				
	On 1/27/16, at 2: nurse (LPN)-B w nursing assistant wice daily perior twice daily perior morning", get re and nurses were "everything is de stated she was that morning.  On 1/27/16, at (DON) stated se morning cares resident had F care along with aware R15 did morning.  On 1/28/16, at 21 of admissi comprehensi nurse. The D stated she w developed for (include grow care.  Respiratory R15's Admit admitted to including a Nursing As was no ind continuous machine (	og p.m. the licensed practical as interviewed and stated the ts were expected to complete are, "wipe the catheter every sident cleaned up in the morning responsible to make sure one" (meaning cares). LPN-B not told R15 did not receive cares as partial baths, and if a oley catheter to complete catheter to complete catheter to complete catheter to the pericare. The DON was not not receive those cares this are care plan written by the MDS on she would expect to see a construction of a positive and folially living care not not receive the period and spect R15 to have care por activities of daily living care not not not receive the portion and Foley catheter to see a complete catheter to see a positive and depression. The Administry and depression are gasily dependent of the person who has obstruction as positive airway pressure (CPA to help a person who has obstruction the resident utilized a control of the person who has obstruction and the person who has obs	day day day been gnoses nission there					14 of 79
,	sleep apn	ea loan storm the assessme	ent	<u> </u>	Facility ID; 00166	If continu	ation sheet Page	14 of 79
, l	sleep) at i	TIGHT. IN EXCHANGE	ent ID:KOXP	111	ESCHINA ID! no una			

						FORM	02/17/2016 APPROVED 0938-0391	
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES			- TOTAL OF THE STATE OF THE STA	CVO) DATE	SURVEY PLETED	
CENTERS		& MEDICAID SERVICES  (X1) PROVIDENSUPPLIEFICLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	1G	STRUCTION		28/2016	
		245544	B. WING		ADDRESS, CITY, STATE, ZIP CO			
	HOVIDER OR SUPPLIER			512 49	TH AVENUE NORTH			1
				MINNI	EAPOUS, MN 55430		(X5)	1
CAMDEN	CARE CENTER		7 10	$\top$	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION OATE	1
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION CHOSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE		
F 279	Continued From placked evidence or required oxygen is to the oxygen use on 12/1/15, the lashe use [sic] at the resident states a night."  The resident's lashe is night.  The dischard is night.  The dischard received oxy diagnosis of indicate Rts an indivedible is not received oxy diagnosis of indicate Rts an indivedible.	page 14 of oxygen use and if the resident saturation levels (O2 sate) due set the saturation levels (O2 sate) due set.  Physician Order read "Whatevertone for oxygen is fine and the uses 2 L [liters] with CPAP at satisfication of the coming, needed assist of one-trong, and two staff assist with the Temporary Care Plan did not ormation regarding O2 use or eat did not include indwelling D2 use or CPAP machine use.  The Physician Order noted the ered a chest xray, blood draws a regen levels between 2 to 4 L, at Sats over 90%. The information the plan of care nor was the bund on the MAR/TARs.  The MAR and TAR from 12/1/15 indicated use, or monitoring of R15's ge MDS dated 12/4/15, indicated year therapy at the facility, had in the cutilized CPAP, nor that she utiling catheter. The MDS information attent what the Admission Nursing attent was the page at the facility at t	t t d d wo tant	279				
	Assessmer	nt, dated 12/1/15.				If continua	tion sheet Page	15 of 79
1		Even	ID:KOXR11	i	Facility ID: 00166			

ADTMI	ENT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391	
DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			01/2	28/2016	
		245544	B. WING	STREET AD	DRESS, CITY, STATE, ZIP C	ODE	1	
NAME OF PR	OVIDER OR SUPPLIER		1	SAD AOTH A	MENUE NORTH			
	CARE CENTER		1	MINNEAR	PROVIDER'S PLAN OF CO	RRECTION	COMPLETION	
(X4) ID PREFIX	DUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	'^ [ rp	PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION OSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	DATE	
F 279	Continued From 1 The H&P (history 12/5/15, indicated "ID/Sepsis/Sever with sepsis; culturabx [antibiotic] state that been sent to readmitted to the principal diagnor included: "acute Discharge Sum treatment with antibiotics," has and needed a than before. The was observed positive airway and combined obstructive readmitted 12/9/19 and that she was no indicatemporary continued that the principal diagnor indicated 12/9/19 and that she was no indicatemporary continued the model of the medicate indicated 12/9/19 and that she was no indicated 12/9/19 and that she	page 15 I and physical) Summary dated of the resident was admitted with re Sepsis: Possible pneumonia ures have been sent and empiricated."  I scharge Summary indicated R15 of the hospital on 12/5/15, and re nursing home 12/9/16. The reses listed for the hospitalization of hypoxic respiratory arrest. The mary indicated R15 had required high the summary also indicated, "[R to take off her BIPAP [bilevel by pressure] at times when sleep if with her obesity could cause is spiratory arrest."  Admission Nursing Assessment of the summary also indicated R15's lungs were of was breathing easier however, ation of CPAP use.  I record lacked evidence of a rare plan from readmission on a little requests the face.	tent there	279				
	A discharge had been respectively the entire v	d after multiple requosite pride the document for review.  MDS dated 12/14/15, indicated e-admitted with a diagnosis of a bacterial infection spread the vascular system of the body), divided in the facility nor did R15, and had a diagnosis of respirate	d R15 rough d not utilize					
	failure.				acilly ID: 00166	lf conlinu	elion sheet Page	16 of 79
1		Eve	ni iD:KOXP	(11 F	BCHITA In . Ag 100			

DEPARTA	MENT OF HEALTH	AND HUMAN SERVICES				FORM OMB NO.	02/17/2016 APPROVED 0938-0391 E SURVEY
			(X2) MULTIPLE CONSTRUCTION A. BUILOING			COM	IPLETED
		245544	a. WING				2B/2016
	ROVIDER OR SUPPLIER			512	HEET ADDRESS, CITY, STATE, ZIP COD 2 49TH AVENUE NORTH NNEAPOLIS, MN 55430		
CAMDEN	CARE CENTER		ID ID	<del></del>	A STANSON OF AN OF CORRE	ECTION	(X5) COMPLETION
(X4) ID PREFIX TAG		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	ΙX	(EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE AP DEFICIENCY)		DAYE
F 279	12/15/15, indicate machine/O2 use, breathing.  The TAR dated 1: 12/13/15, identified oxygen sats as the over 92% and more and noted the call interventions that R15's recent dial sepsis with recemonitoring for lust shortness of breath of the plant hospitalizations there any intervential and/or readmissions represential and/or readmissions represent future care plans lack the hospitalization to implement of the date of	review dated 12/9/15, through of no use of the CPAP or monitoring of R15's  2/23/15 going forward to get the staff were monitoring the ney were to keep the sat level onitoring the BiPAP usage.  The dated 12/23/15, was reviewed are plan did not identify any at were put into place to monitor gnosis of pneumonia related in the hospitalization dated 12/14/15, and changes in breathing sounds, changes in breathing ath, and changes in vital signs.  The form of care was revised on 1/5/16 or the recent diagnoses, nor we rentions identified to minimize a prevent future hospital egarding her breathing status, ated sepsis, CPAP machine use reviewed on 1/26/16, at 4:07 p.m. so for care for R15. He verified the stion, or the reasons of the cares for R15 to minimize and on thospitalizations for R16. He also he care plans should have been atter resident admission, and any new interventions for R16. He also he care plans should have been atter resident admission, and any new interventions for R15. He also he care plans should have been atter resident admission, and any new interventions for R15. He also he care plans should have been atter resident admission, and any new interventions for R16. He also he care plans should have been atter resident admission, and any new interventions for R16.	So, or	279			
	abould have t	omprehensive care plan for R15 been completed by 1/14/16 ly two weeks ago).	VOVD11		Facility ID: 00166	If continuation	n sheet Page 17 of

	AND ULIMAN SERVICES				INTED: 02/ FORM APP VB NO. 093	38-0391
DEPARTMENT OF HEALTH	MEDICAID SERVICES		PLE CONSTR	UCTION	(X3) DATE SU COMPLE	LED L
CENTERS FOR MEDICATIC	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	IG		01/28/	
AND PLAN OF CORRECTION		B, WING_			U1/20/	2010
	245544	L	STREET AD	DRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			512 49TH	AVENUE NORTH		
I .		Ţ	MINNEAF	PROVIDER'S PLAN OF CORRECTION SHOULD	ON .	(X5) DOMPLETION
CAMDEN CARE CENTER	COCHOES	lD		PROVIDER'S PLAN OF CONHECTIVE ACTION SHOULE EACH CORRECTIVE ACTION SHOULE APPROPRIES TO THE APPRO	D BE	DATE
(X4) ID SUMMARY ST PRÉFIX (EACH DEFICIENT TAG REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	<b>~ )   &lt;</b>	EACH CORRECTIVE ACTION SHOULD LOSS-REFERENCED TO THE APPRO DEFICIENCY)		
F 279 Continued From	page 17	F	279			
The DON was Interested backs and the most what diagn note what the mupdate the nurse document circum DON also verification religions and intervention The DON also plan from 12/5 was responsive comprehensive R15's should two weeks agonate and intervention the point of the point	dicated when the resident was to the facility she expected the the assessments, treat the ew admission, monitor vital sign cels(es) they came back with, edical doctor (MD) ordered, e practitioner and MD, and metances of hospitalization. The ed the temporary care plan from 2/23/15, had "minimum and should have include all releving to the part of the lack of temporary certified the tempora	e ant si, are shin y ent's thour	F 280	F280(D) Comprehensi assessments including risk assessments and tolerance tests were for R10 and R34. Car Treatment Administr	tissue completed e plans, ation	n sheet Page 18 of 79

DEPARTME	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES	(X2) MULTIP	L CONSTR	O.	INTED: 02 FORM AP MB NO. 09 (X3) DATE 9 COMPL	38-0391
CENTERS STATEMENT OF AND PLAN OF C	FOH MEDION.	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	ì		01/28	1/2016
AND PLAN OF C	0011112	245544	e. WING		DDRESS, CITY, STATE, ZIP CODE		1
	l	245544		STREET AL	DDRESS, CITT, STATE		
WAVE DE PR	OVIDER OR SUPPLIER		}	612 49TH	AVENUE NORTH POLIS, MN 55430		
					OPOVIDER'S PLAN OF CORRECTS	D BE	COMPLETION
CAMDEN (X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	c c	(EACH CORRECTIVE TO THE APPRO AOSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
PREFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>		Records (TARs), wound car	e	
TAG					sheets and NAR care guide	s for	1
		-oge 18	\ F2	280	R10 and R34 were reviewe	ed	
F 280	Continued From I	care plan must be developed the completion of the		1	and revised to include		
	A comprehensive	er the completion of the ersessment; prepared by an			interventions towards her	aling	
1	i aamerahensiv⊽ •	association and the attending	g \	1	interventions towards had	. of	1
	Interdiscipiiiaiy	LOCATION AND A CONDINSIDILLY		1	of current and prevention	kin	
	I I I I I I I I I I I I I I I I I I I	0,000	•		future skin breakdown. S	ادما	
	I Alexielings HS U		of	\	checks were completed o	einua	
1	그 프로네 10 10년 보시다	THE PARTY OF THE PASSOR!	11.0 [		facility residents and con	lline	
1	Tako rosidenti vii	- Wayle reviewed	i,	1	on a weekly schedule.		
1	L PAY LEANISER DA	M tomin .	j.				
	each assessm	ent.		\	All residents requiring	-kin	
1			1	-	assistance are at risk for	Skiit	
	<b>\</b>		}		breakdown due to		
		EMENT is not met as evidence	ed \	1	untimely/incomplete	_	
	This REQUIR	FINEIAL 19 110 110	ont	1	acsessments, care plant	ក្សាទ្ធ,	
1	by:	servation, interview and docume	care	1	communication and mo	onitoring	1
	1 FOULDW THE 18	servation, interview and docum acility failed to revise the plan of idents (R10, R34) reviewed for ers and/or non-pressure related	į.	ļ	of interventions.		
	pressure ulconditions.	ats sugget from bross			Staff were educated or	n need	
	Findings inc	lude;			for timely reporting of	nent	<b>\</b>
1	<b>1</b>		to be		identified skin impairn	+- and	
	R10 was ob	pserved on 1/26/16 at 8:07 a.m. into the wheelchair. During the	period		timely skin assessmen	ILS BIIU	1
	l manetarren	IND IND WINDS	S		appropriate care plan	ning	1
	l transferi@0	TO DOO THE THE RESERVED CODS	ultan (		interventions and		
:	lam Redis	(Olan Haise / Line Parised I) by	11-W 1		communication of		
,	I (MC)-A SI	IO NOVINCE I	3111165		interventions; the ne	ed to	
: 1	were prese	on R10 stated, "my skin is falling	bed .		follow care planned		
	Hurts WDB	IT I SILILL INV	olace	1	interventions and fo	llow-up	
	l was obse	IVEN TO THE TANKS DISTON	/ Was	1	1		
	l aver the t	Hallico and the v	งกษษะ		monitoring.	II continue	ation sheet Page 19 of
	chair. Nu	in place over a cushion in the vising assistant (NA)-J turned R	ent ID: KOXA	11	Pacility IO: 00166	H advention	

					F	PINTED:	02/17/2016 PPROVED
		AND HUMAN SERVICES			(	OMB NO.	0938-0391
DEPART	MENT OF HEALTH	AND HUMAN SERVICES				CVOLDATE	SUAVEY PLETED
CENTER	AS FOR MEDICAHE	& MEDIO TIPE IEA/CLIA	(X2) MULI	r)PLE C	DNSTRUCTION	COMP	LETE
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG			
AND PLAN	OF COURSELLON	<b>\</b>	B. WING			01/2	28/2016
		245544	B. WING	STB	EET ADDRESS, CITY, STATE, ZIP CODE		1
ALL ALL OF	PAOVIDER OR SUPPLIER		ļ	517	49TH AVENUE NORTH		l l
				MIN	INFAPOLIS, MN 55430		T 0/51
CAMDE	N CARE CENTER		T ID		PROVIDER'S PLAN OF CORRECT	NTO BE LION	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE	iopriate 	
\					DON/Designee will audit		
		ooge 19	F	280	residents with skin breakd	lown	1
F 28	1	_4:a+ FMB!   HHC WG3 4	1	1	weekly x 12 weeks for		
	removed ner inco	t of bright red blood on the	,	1	appropriate assessments,	•	
	incontinent brief.	t of bright red blood strained have LPN-D stated there should have the resident's	'	ļ	monitoring and treatmen	t, and	
	been a dressing	over a would on the		ļ	monitoring and treatmen		1
1	buttock and that	no one had rope.	1		care plan and care guide	مط النا	
	buttocks was ob	served to be localized on scar			interventions. Findings v	All) ne	
	tissue and RN-A	measured the area to be 4	, \		reported monthly to QAI	기	
1	centimeter (cm)	long, 2 citt vido, and over the			committee x 3 months w	ith/	
1	depth. There wa	IS TOO /D to ushed F10's WOUNG	i )		follow-up to committee		}
-	wound bed. VIII	en LPN-D touched TTO by yetracted. RN-A stated the wour	10		recommendations.		
\	"could have bee	on caused by pressure, or more	1		recommendation		
1	likely friction." N	C-A stated if appoint the developm	ent				
1	and shearing p	ayed a big fole in the continent brief] if nce the brief [incontinent brief] if	ine				
l l	of the would be	nce the brief (incontinion service), I don't think it is a pressure ulc	er.		Corrections to deficient	practice	1
1	ļ.	According to the	1		will be made by March	3, 2016.	}
1	R10's record w	ras reviewed. According to the cord documentation dated 12/8/	15,		Will DC III.		
- 1	Admission Hed	oru documents facility on 10/21	/15,				1
	With diagnoses	admitted to the lability strains including: unspecified kidney	888				
	failure, hyperi	s including: unspectied kidito; ension, peripheral vascular dise	400,				1
1	and diabetes.		i				
1	A. Adminsion	Nursing Assessment document	t				
1	dated 10/21/1	5, indicated R10's left side was	lod				1
1	paralyzed, an	5, indicated ATVs for 5 led of the resident's skin risks included the resident's skin risks included the resident mobility and being characters.	air				
\	incontinence	impaired injudity, and marked to	,		\ \		\
	fast. A diagra	im of H10's body was matter seues in three areas; on the co	ссух.				
}	ldentily skill	buttock. The documented	45				
ļ	description r	buttock. The documents buttochoted for the left and right buttochoted from old pressure sore.	1/2		l l		
	∖ indicated, "S	Callud Hottl org brane	}				<b>\</b>
\	l l	Disable 40/26/15, did	not		\ \		
1	A temporar	y Care Plan dated 10/20, 15/19 stailed plan to prevent pressure	nicet				
	developme	etailed plan to prevent processing scheet, including a repositioning scheet, including a reposition reco	rds				on sheet Page 20 of 79
}	However, th	io tropilitetii autiliiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiiii	ID:KOXA1		Facility ID: 00166	il continuati	Ou suecri mas
1		EVent	10,110,111	-			

		AND HI MAN SERVICES				OMB NO.	0938-0391	
DEPART	NENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			DNSTRUCTION	(X3) DATE	PLETED	
CENTER	S FON MEDICARL	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	NG	JASTAGO		28/2016	
AND PLAN OF	CORRECTION		8. WING.				20/2010	
		245544	<u> </u>	STAR	ET ADDRESS, CITY, STATE, ZIP CO	DE		ĺ
NAME OF F	ROVIDER OR SUPPLIER		\	512	49TH AVENUE NORTH INEAPOLIS, MN 55430	·		Ĺ
1	CARE CENTER		T ID		PROVIDER'S PLAN OF COH	RECTION SHOULD BE	COMPLETION DATE	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION OF ICIDENCY)	(FPROFILING		
F 280	identified an appridirected "repositic chair"  The admission in assessment date dependent on two mobility, transfersing unhealed produced in the correspondated 11/9/15, INTERVENTICE DECREASING PRESSURE ABREAKDOWN ABRACTORY	Alinimum Data Set (MDS) ed 10/27/15, indicated R10 was vo staff for assistance with bed rs, and toilet use, did not have ressure ulcers, but was at risk f ressure ulcers; had functional ge of motion impairment on one a wheel chair for mobility.  ding Care Area Assessment (C. indicated "PLACE DNS THAT ASSIST IN THE POTENTIAL FOR REA AND OR OTHER SKIN N."  le (tool used to determine press ressure ulcer risk at a score of drisk for development of press lood dripping from area." The n ed the resident was laid down a repositioned/offloaded every two res Order dated 11/24/15, identification of: "apply silverstatin crea-	or e AA) sure ified of 16, ure mall] ote fiter o iied a m (a	280				
	and apply	d to treat wounds; to critical deficiency of the country of the co	osition d			Il continua	ilion sheet Page	21 of 79
	am [morni		nt ID:KOXF	11	Facility ID: 00166			

DEPARTN	MENT OF HEALTH	AND HUMAN SERVICES				FORM. OMB.NO.	02/17/2016 02/17/2016 0938-0391
CENTERS	S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUU A, BUILD		ONSTRUCTION	(X3) DATE	E SURVEY PLETED
VIAD LIDITA OF		ţ	B. WING			01/	28/2016
		245544	B. WING	STR	EET ADDRESS, CITY, STATE, ZIP COD	Ē	}
NAME OF PI	ROVIDER OR SUPPLIER			512	49TH AVENUE NORTH NEAPOLIS, MN 55430		
CAMDEN	CARE CENTER			MIL	THE PART OF THE PART OF CORP.	ECTION	(X6) COMPLETION
(X4) ID PHEFIX TAG		ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAC	IX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)		DATE
F 280	2 hrs [every two hated 12/16/15, incream to left buttand change q 3 c. The Physical The 12/28/15, indicat buttocks pain, an nursing staff to "hour to decrease coccyx ulcer," an cushion (special wheel chair use R10's care plan Records (TARs recommendation During interview (DON) on 1/28, she would expupdated.  The facility's upolicy included Conferences, adding/deleting to the individue R34 was observed: At 7:27 a.m. in R34's room a cares. At 7:30 was a pink did outer side of resident's income and care in the individual cares. At 7:30 was a pink did outer side of resident's income and care in the individual care in the individual cares. At 7:30 was a pink did outer side of resident's income and cares.	nours]." A Physician's Order included, "apply silverstatin ock and apply foam dressing days + PRN [as needed]."  erapy (PT) Daily Notes dated ed R10 had complained of right and indicated PT had educated perform position change every e pain and take pressure off and had recommended ROHO by pressure reduction cushion for hourly repositioning.  It and Treatment Administration with the director of nursing one for hourly repositioning.  It with the director of nursing of at 9:46 a.m., the DON states extresident care plans to be and discipline is responsible for all care plan as changes occur."  If Between Interdisciplinary each discipline is responsible for all care plan as changes occur."  If 8:42 a.m. the following was a continuously on 1/27/16, for a series of the continuously on 1/27/16, for a series of the continuously on the continuo	e di	280			wheel Page 29
	told R34 the	re was a tear under left abdome	D:KOXA11		Facility ID: 00166	If continuatio	n sheet Page 22

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) OAT CON	E SURVEY
AND PLAN	of Correction	IDENTIFICATION NUMBER:	a, Buildin	G		
		245544	B. WING _	OF OTHER PROPERTY.		/28/2016
	PROVIDEA OR SUPPLIER N CARE CENTER			STREET ADDRÉSS, CITY, STATE, ZÍF 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	-cobe	
(X4) ID PREFIX TAG	I FACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DAYE
F 280	fold, and verified to between R34's ab a.m. registered nu wound care. The soft wounds were at 1) Left breast: A clooked like a ruph centimeters (cm.) drainage. The wollsland dressing (sto a wound to pro 2) Abdominal slit long. b) 0.5 cm longroin slit c) slit in 3) Right ischial to measuring 1 cm. Slough. No drains "I will cover it with obtain orders from 4) Coccyx: Slit k cm. in length.  R34's care plant at risk for impaire of resolved pressincontinence, immeuropathy, chrosacral coccyx are previously healerstomach related interventions ins repositioning as change, encourage chair or in bed, rivey arise and slivith bath and as with bath and as	here was no gauze dressing dominal fold and groin, At 8:09 irse (RN)-A arrived to perform measurements and descriptions	s y dd es	30		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

STATEMENY	OF DEFICIENCIES F CORRECTION	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON IDENTIFICATION NUMBER: A. BUILDING			1 00		
		245544	B. WING				<u> 28/2016</u>
	PHOVIDER OR SUPPLIER			512	EET ADDRESS, CITY, STATE, 2IP COL 49TH AVENUE NORTH NNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	ACACH DESIGNA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD R⊨	(X6) COMPLETION DATE
F 280	required extensive with toileting, and incontinence issue R34 before break night on rounds o print date of 11/30 incontinence issue A Pressure Ulcer 8/5/15, Indicated breakdown related decreased sensareliance upon stated and service of defurther indicated bowel and bladd pressure ulcers. diagnoses including disease a The Nursing Assist of two to breakfast after incomplete or as near repositioning.  A Progress Note indicated, "Resident has progressition. Progressition	e assistance to total assistance instructed staff to manage es by checking and changing fast, after lunch and during the ras needed. The care plan with 1/15, did not address skin or		280			

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	SURVEY PLETEO
		245544	B. WING			01/2	28/2016
	PROVIDER OR SUPPLIER			51	REET ADDRESS, CITY, STATE, ZIP CODE 12 49TH AVENUE NORTH INNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 280	January 2016, instruction DRY ABDOMINAL 4X4 TO SKIN FOL Although the treatment in information was or NA Assignment. During interview or stated, "I was not a abdomen. There a the wounds develor on vacation. The neshould have called not a wound nurse I don't know if the skin eheets. It should have care pure the stated of the school of 1/27/15, at 11:15 frequently a resident stated, "I would new wound like R34's stated, "I would new wound like R34's stated, "at least even the states of the	ninistration Record dated ructed staff to "WASH AND FOLDS AND GROIN, APPLY DS [initiated 1/20/15]." nent was set up for every shift, is not updated on the care plan Sheet.  In 1/27/16, at 9:00 a.m. RN-A aware of the slits on her re no wound sheets because uped in December while I was urse who found the wounds I the MD (medical doctor). I am the director is a wound nurse, information is on the weekly uld be. The nurse should have plan."  Wed at 11:00 a.m. on 1/27/16, in't care plan turning and dules because it is a you cannot get the staff to e."  On am RN-A was asked how ent should be repositioned and sed to check the care plan." frequently a resident with a should be repositioned RN-A		280			

DEPARTMENT OF HEALTH	AND HUMAN SERVICES  MEDICAID SERVICES	over All II T	IPLE CONSTR	0	RINTED: 02 FORM API MB NO. 09 (X3) DAYE SI COMPLE	38-0391 URVEY
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	1G		01/28	0/2016
	245544	B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE AVENUE NORTH		
NAME OF PROVIDER OR SUPPLIER CAMDEN CARE CENTER	STOUTHOUSE	ID.	MINNEA	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCEO TO THE APPROPRIATE OF THE APPROPRI		(X5) COMPLETION DATE
(X4) ID SUMMARY ST PREFIX (EACH DEFICIENC TAG REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	'^   c	AOSS-REFERENCED TO TO THE PROPERTY OF THE PROP		
plan The individual schedule should and care plans."  The facility's Redated July 2012 repositioned evidocumented or assistant) a	positioning of resident's policy positioning of resident's policy included: "3. Residents will be ery 2 hours unless otherwise a care plan and NA (nursing grament sheets."  kin Care Protocol revised 6/28/6 resident who enters the facility are sores does not develop a unless the individual's clinical constrated that they were and "a resident having pressures able to provide, to promote ent infection, and prevent new string."	osores acility an of ument es in of	F 282	F282(D) - R12 was refor skin issues through completion of a Brade assessment and bowe bladder assessment. care plan and NAR cawere reviewed and raddress and include skin breakdown med All residents require assistance with mo cares are at risk for Facility 10:00166	h en risk el and R12's TAR are guide revised to preventive asures. ing bility and r decline.	₹,

						PINTED: (	02/17/2016 PPROVED 0936-0391
	05) 15ALTU	AND HUMAN SERVICES & MEDICAID SERVICES				WO DATE	suRVEY I
PARTM	ENT OF HEALTH	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	AVAL MULT	IPLE C	ONSTRUCTION	COMP	LETED
<u>NTERS</u>	FOH MEDICALLE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) (X2) 10 유니네 단테	NG.			<b>\</b>
	DEFICIENCIES CORRECTION	(X1) PROVIDENSOR POLICE IDENTIFICATION NUMBER:	H, BOILD			01/2	8/2016
PLANOR	January		B, WING		THE CODE		
		245544	<u> </u>	STR	EET ADDRESS, CITY, STATE, ZIP CODE		1
- + - 00	IOVIDER OR SUPPLIER		1	*40	ADTH AVENUE NORTH		
				MIN	NEAPOLIS, MN 55430	ION	(X5) COMPLETION
AMDEN	CARE CENTER		T 10		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU (EACH CORRECTIVE TO THE APPR	JLD BE	DATE
	SUMMARYST	TATEMENT OF DEFICIENCIES	PREF		(EACH CORRECTIVE ACTION SHOULD CHOSS-REFERENCED TO THE APPROPRIESE OFFICIENCY)	Orninie	
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IAC	<b>-</b>	521.01		
TAG	REGULATORY OF				Staff were educated on ne	ed	
			\ F	282	follow resident's plan of c	are in	1
	Continued From	oage 26	1 '		follow resident 5 plans:	occed	1 1
F 282	Findings include:	• - !	}	}	accordance with their ass	ران دارد	1
	Librarias moraco.	4/07/16	n Ì	ļ	poods and risks, particula	rıy	1
	R12 was observe	ed continuously on 1/27/16, from		'	those residents at high ri	sk for	\
	8 54 a.m. to 11:2	22 a.m. 12 was sitting in a Broda chair in	n		skin breakdown.		1
	1. Δt 8 54 a.m. H	12 Was simily in -			li de la constantia de		
	the dining four:	i /kia\_G took H3	2		DON/Designee will perfo	rm	1
	- At 8:59 and DU	ursing assistant (NA)-C to t upper dentures in R12's mouth to NA-G returned R12 to the	' \		random audits of 5 resid	lents	
	without adhesiv	t upper dentities in 1772 to the re. NA-G returned R12 to the			random audits di 5 resid		1
	dining room,	in the television (TV)	1		care plans with focus or	د د سمارئیم	
}	At 9:15 a.m. F	112 sitting in the television (TV)			residents with or at risk	tot skin	ļ.
1	room,	. R12 remained sitting in the TV	 		breakdown, and will me	onitor .	1
1	- At 10:37 a.m.	, III L TOTTO	-ika		care planned interventi	ions	1
1	700m asiecpi	. R12 sitting in the TV room awa	and		care planned me		
	and.		1		weekly x 12 weeks.		
1	- At 11:22 a.m	ı, R12 etill sitting in TV room	1		at he report	ed	\
1	l sleepi∩g.	d on 1/27/16, at	. }		Findings will be report	mittee	
1	The observati	ion was resulted on sleeping 12 sitting in TV room sleeping 2 caked licensed practical nurs			monthly to QAPI Com	Hitter	1
1	12:45 p.m. r.	12 sitting in TV room stocking n. asked licensed practical nurs n. asked been toileted and reposit	e		with follow-up to		1
	1 AL 12.57 PH	n. asked licensed plactical resisting in asked licensed plactical reposition and reposition that morning. LPN-A verification that morning. LPN-A verification that morning.	ed le		recommendations by		1
1	l cinca H12 99	or up telectioned	vet		Committee. Results	vill be	
1	เองรากลก กษ	DOULD . I DAL A chale	n. 1		reviewed at QAA mor	nthly x 3	
1	since H12 9	of oh mar	ito lay i		reviewed at QAA mo	an fo	
\	"[H12] nad )	" O40 went for four hours and 1	5		months with follow-	ib ro	
1	[R12] down	hout being repositioned.  NA G wheeled R12 to bedro	om		Committee recommo	endations	·- \
- 1	_ Δt 1:10 p.	hout being repositioned. m. NA-G wheeled R12 to bedro	0,11				1
1	land	P19 boonder u. A. A.	in E4 1		Corrections to deficie	nt practio	ce
}	- At 1:16 P.	m. NA-G and NA-H placed R12 echanical standing lift) and stoo	d R12		will be made by Marc	h 8, 2016	<b>5.</b> \
1	listand (a M	ecijanica oza. Josep and sal	id the is	1	will be made by Mark	, -	1
	Luo, NA-H F	Julieu Tite o Porti Front " Redues	ted				1
1	dry in back	c and he is dry in from: Trouble ove R12's incontinence brief. R over intest, specyx was red but	12.8	1			\
l	ekin intact	was intact, coccyx was red but	stool.				1
ļ	blanchabl	was intact, coccyx was ted bar e. R12 had been incontinent of the laweshed R12's bottom ar	nd				
1	NA-G and	e. R12 had been incomment I NA-H washed R12's bottom ar	=			If continua	ation sheet Page
1	applied a	MAKE INITIALITY OF THE STATE OF	on ID:KOXE	a11	Facility ID: 00198		

							FORM /	02/17/2016 APPROVED	
		ENGLIT OF HEALTH	AND HUMAN SERVICES				OMB NO.	0938-0391	
Į	)EPAH	DO FOR MEDICARE	& IVICEDIONIS SERVICE	OVOLAGIET	TIPLE C	CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		くひち ひたたじにENCIEが	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULL A PUNDI	NG				
S Al	ND PLAN	OF CORRECTION	IDENTIFICATION NOMES.	, Boiles			01/	28/2016	
			245544	B, WING		710 0005		2012	
				1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		}	
_	NAME OF	PROVIDER OR SUPPLIER		,	512	2 49TH AVENUE NORTH			
		EN CARE CENTER		ļ	M	NNEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION	
l	CAMDI		OF DEFICIENCIES	Δį		PROVIDER'S PLAN OF CORNE (EACH CORRECTIVE ACTION SH	OULD BE	COWNE	
	(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)			
	F 26	32 Continued From t	page 27	F	282				
		During continuou 7:30 a.m. to 10:4 and 16 minutes v - At 7:15 a.m. R1 - At 7:30 a.m. up - At 7:45 a.m. R1 - At 8:52 a.m. N. breakfast, - At 9:15 a.m. R - At 10:30 a.m At 10:40 a.m. NA-A to be reported to the continence of the continence of R12's right gluth that R12 had nup. LPN-A che was blanchable R12's Minimum R12 was sever assistance with incontinent of development  The Pressure 11/3/15, indicated the continence of	s observation on 1/28/16, from 6 a.m. R12 went for three hours without being repositioned. It was lying in bed, In Broda chair in the hallway, It in dining room, A-A assisting R12 to eat 12 sitting in TV room, R12 remained in TV room, R12 taken to shower room by seitioned and checked and, R12 stood up in standing lift. Incontinence brief was wet. It is a pulled pants down and remove rief. Incontinence brief was wet. It is a pulled was red. LPN-A verified to been repositioned since R12 cked R12's skin and indicated it e.  In Data Set dated 11/3/15, indicated and activities of daily living, was bowel and bladder and at risk for pressure ulcers. It is all activities of daily living, was bowel and bladder and at risk for pressure ulcers were trigged required extensive assistance frequent urinary and bowel and identified risk for pressure to the pressure ulcers were trigged required extensive assistance frequent urinary and bowel and identified risk for pressure to the pressure ulcers were trigged to the pressure ulcers were trigged required extensive assistance frequent urinary and bowel and identified risk for pressure to the pressure ulcers were trigged to the press	got got ated ed s or lated ered with					
		to history of	pressure dicer, interpretation of the properties	use.		Facility ID: 00168	if continuat	ion sheet Page 2	 28 of 79

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

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	•	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		245544	B, WING		01/2	B/2016
,	PROVIDER OR SUPPLIER		512	REET AODRESS, CITY, STATE. ZIP CODE 149TH AVENUE NORTH NNEAPOLIS, MN 55430		
(X4) ID PREFIX TAG	/FACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE (	(X5) COMPLETION DATE
F 28	schedule per nurs and perform peri-change and as ne check and change and on rounds through the Physician Ordinstructed staff to every two hours a over right buttock.  The Treatment Active dated Jan 16, indi "REPOSITION IN HOURS (Started shift was left bland 1/28/16.  The undated Growinstructed staff of breakfast after lunthrough night as a nand changes.  During interview stated, "[R12] has repositioned yet a stated, "[R12] unitact. NA-A state repositioned today get people up or During interview director of nursimoften the resider look at tissue tole	ing, provide moisture barrier care during each check and eded, wound care as ordered, before breakfast after lunch ough night and as needed.  ders signed by doctor on 1/6/16, reposition R12 in wheelchair and house barrier cream to skin				

DEPARTMENT OF HEALTH A	AND HUMAN SERVICES		DI E CONS		INTED: 02 FORM AP MB NO. 09 (X3) DATE S COMPL	938-0391 SUBVEY
DEPARTMENT OF HEALTH A CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG		01/20	8/2016
	245544	B. WING	-40 40°	ADDRESS, CITY, STATE, ZIP CODE TH AVENUE NORTH		
NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER		ID	MINN	EAPOLIS, MN 55430	DN BE	(X5) COMPLETION DATE
(X4) ID SUMMARY ST PREFIX (EACH DEFICIENCE PREFIX DEGULATORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)		
F 282 Continued From part two hours minimulated. If the wound only be up for me turning/reposition assignment sheet. The facility's Redated July 2012 "3. Residents' was sheets." R12 was the plan of care reposition ever 483.25 PROVINGHEST WE Each resident provide the new or maintain the mental, and part of care and plan of care and plan of care and september of the plan of care and september of the plan development of the plan developm	page 29  Jam. If there is a wound every 1 dis nasty, the resident should eals. The individualized hing schedule should be on the eas and care plans."  positioning of resident's policy instructed staff:  your liber repositioned every 2 hours a decumented on care plan and assistant registered assignments as not repositioned according to which instructed staff to turn a system hours per the TAR.  DE CARE/SERVICES FOR TAR.  THE BEING  The must receive and the facility made highest practicable physical, asychosocial well-being, in with the comprehensive assessment. The services including assessment, of the facility failed to provide appropriate including assessment, or the facility failed to provide appropriate including assessment, or the facility failed to provide appropriate including assessment, or the facility failed to provide appropriate including assessment, or the facility failed skin issues.	sed to and triate tare the had	F 309	F309 (D) —R34's attending physician was contacted 1/27/16 and wound treat orders obtained for R 34 comprehensive skin assessment, completion Braden risk assessment tissue tolerance test with completed for R34. Riscare plan and NAR care were reviewed and reaccording to M.D. orders assessment findings, wound care monitor implemented for R34. All residents requiring assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders assistance are at riscare and reaccording to M.D. orders are at riscare at riscare and reaccording to M.D. orders are at riscare at riscare and reaccording to M.D. orders are at riscare and reaccording to M.D. orders are at riscare at riscare and reaccording to M.D. orders are at riscare at riscare and reaccording to M.D. orders are at riscare at	atment  4. A  n of a t and ere 34's TAR, re guide evised ders and Weekly ing was  4.  ng k for skin	
	Ev Obradela	ent ID: KOXf	A11	Facility ID: 00166		

		AN SERVICES				INTED: 02 FORM AP MB NO. 09	938-0391	
DEPARTM	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			VETOLICTION	(X3) DATE S COMPL	ETED	
CENTERS	3 FOR MEDIODINE	THE PROLITICAL LEGISLAND	(X2) MULTI	PLE CO	NSTAUCTION			•
	IC DEFICIENCES 1	(X1) PROVIDENSON CLIMBER:	A. BUILDIN	G		01/25	8/2016	
AND PLAN OF	CORRECTION		B. WING_			01/20	1,4-21-	
		245544	J. W.	STRE	ET ADDRESS, CITY, STATE. ZIP CODE		1	
	OF BURGUER		1	-AD A	INTH AVENUE NUMIN			
	ROVIDER OR SUPPLIER		\	NIM	NEAPOLIS, MN 55430	ON	(X5) COMPLETION	
CAMPEN	CARE CENTER		7 10	-T-	BOOVIDER'S FLAN OF CORNEY	LD BE	DATE	
L	DUMMARY ST	TATEMENT OF DEFICIENCIES	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	)rtiinit	\	
(X4) ID PREFIX	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TO MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG		DE1.01=-			
TAG	REGULATORY OF		<del></del>		breakdown due to lack of		1	ı
	<del> </del>		F	309	ropriate assessment,		1	l
F 000	Continued From	page 30			interventions, communicat	jon,	1	4
F 309	l zws a m. until 83	42 g.m. aic tours	1	1	litter version ,		1	1
	l sheerved:	A A A A A A B A B A B A A A A A A A A A	bd∫	1	and monitoring.			
1	At 7:27 a.m. nur	sing assistant (NA)-A and entero obtained permission to observe moduring morning care there	•	1	Staff were educated on			
	ししゅんき もりりほうかいか	OPION INDIC	•	1	reporting skin issues		1	
1	I Mae a DIUK GIGS	and open or viv visewoved n	he	ļ	immediately and follow-u	ıp	1	1
1	Lauter cide of the	PAD IO	l i		immediately and be put if	nto	1	1
1	resident's incom	"hirls." N	<b>1-</b> /1		interventions to be put in	at as		1
1	resident's incontinence brief and was led united the resident's incontinence brief and was led united." NA R34's abdominal fold. R34 said that "hurts." NA told R34 there was a tear under left abdomen told R34 there was a tear under left abdomen fold, and verified there was no gauze dressing fold, and verified there was no gauze dressing fold, and verified there was no gauze dressing.				place and followed to tre	log skin	1	1
1	I fold and VOEIIIS	the file of the Arthur At B	:09 1		well as to prevent declin	RIE AWAY	1	1
1	LANGED HOTE	abusines a second to notici	П1 1		condition, stressing the	•	\	- 1
}	a.m. registered	be measurements and descript	ions		importance of timely			1
	Molitide Care: 1	re as followed:			insortinence care and		1	1
1	14) Left breast	A CIOSCOIN STOREM 3 5	•		repositioning per the ca	re plan.	1	
1	l tooked like a i	There Was	110		1		ł	
l	LooptimAIBIS II	VIII-/ ^ ' Timead and an	Jiod		DON/Designee will mo	nitor all	1	1
l l	drainage   110	e wound was cleansed, this applied or compress applied or promote healing) was applied.	, ilea		skin sheets, wound she	ets,	1	1
1	i in a wound u	Promoti in the last aroun fold 9.	2 (11)		TARs and care plans of	F	1	
l l	l ol Abdomini	al sins, a) by the right of the let	it (		residents with wound	s weekly?	x \	1
<b>\</b>	long. b) 0.5 (	om long slit to the light of the long slit in right groin fold 2.8 cm long	].		residents with woon	_	Ì	\
	groin sill c)	sing the second of River and River a	34 was		· ·		1	
1	R34's care	plan printed 6/3/15, indicated Ri	history		12 weeks. Findings v	vill be	1	1
1	at risk for in	Than of whore related to			reported monthly to	QAPI		Ì
1	D9VIO291 to 1	Diagonio attention poin			Committee x 3 mont	hs with		1
\	incontinent	e, immobility diabetes, pair, chronic issues of open areas conservates related to scar tissue fr	O II IO		Committee x 5	tee		1
	Jacral Cocc	Cyx area in thinle tice	rs on		follow-up to commit			1
	Previousiy	nealed dioti	ne i		recommendations.			}
.	Latomach (	BIBIOU IV IV I FT	1 WITH		Corrections to defic	ient praci	tice	
l	Tolfienns I	IND AS HELLOS La Fraguer	n <b>t</b>		Corrections to dend	rch a 70	16.	
1	i zhanne. E	HICOURAGO ~ whis will	en III viie	1	will be made by Ma	1011 0, 20.		
1	) nosition (	Dariges with the terms to phys	sician as	1			u shoot Perre	31 ol 75
1	chair or it	Theu, reports per facility pro	otocol		Facility ID: 00168	II continus	ation sheet Page	***
1	they arise	9 and skin Obsolete	ent 10:KOXF	711	Lacind week			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES INTERMENT OF DEPOISONES IND PLAN OF CORRECTIONS (IND 0, 998)-0931  A BUILDING  Z46544  NAME OF PROVIDER OR SUPPLIER CAMDEN CARE CENTER  STREET ADDRESS, DITY, STATE, 2P CODE STATEMENT OF DEPOISONES (IND PLAN OF CORRECTION) (IND 0, 998)-0931 (IND 0, 99	_ == . DT\	ATAIT OF USALTH	AND HUMAN SERVICES				FORM OMB NO.	02/17/2016 APPROVED 0938-0391
NAME OF PROVIDER OR SUPPLIER  24544  24544  CAMDEN CARE CENTER  STREET ADDRESS, CITY, STATE, ZP CODE 512 48TH AVENUE NORTH MINNEAPOLIS, MN 55430  PROVIDER OR SUPPLIER  CAMDEN CARE CENTER  STREET ADDRESS, CITY, STATE, ZP CODE 512 48TH AVENUE NORTH MINNEAPOLIS, MN 55430  PROVIDERS PLAN OF CORRECTION PREFIX TAG  COntinued From page 31  with bath and as needed. The care plan indicated R24 was incontinent of bowol and bladder and required extensive assistance to total assistance with tolleting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after furch and during the night on rounds or as needed. In addition, the care plan provided by facility with print date of 11/30/15, indicated R34 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.  R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily ining (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for daynoses included diabetes mellitus. Avenual related to the continence of the continen	DEPARIN	S FOR MEDICARE	F MEDICAID OFFITAIOSS	NAN ER BTI	DI E CON	ISTRUCTION	(V3) DATE	SURVEY
NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER    STREET ADDRESS, CITY, STATE, ZIP CODE	TATCHIENT (	or DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A, BUILDIN	IG		00	
NAME OF PROVIDER OR SUPPLIER  CAMDIEN CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY SULL FACH BY	ND PLAN OF	CORRECTION		میسید			01/	28/2016
CAMDEN CARE CENTER  SUMMAY STATEMENT OF DEPICIENCES PAGE D SUMMAY STATEMENT OF DEPICIENCES PAGE DEPICE PAGE DEPICE PAGE DEPICIENCY MUST BE PRECEDED BY DILL REGULATORY OR US DENTETYING INFORMATION) TAG  F 309  Continued From page 31 with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with tolleting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after funch and during the night on rounds or as needed, in addition, the care plan provided by facility with print date of 11/30/15, did not address skin or incontinence issues.  Pressure Ulcer Care Area Assessment dated 8/5/15, indicated R34 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.  R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of towel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension.  Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY ADDOMINAL FOLDS AND GROIN, APPLY DRY ABDOMINAL FOLDS AND GROIN APPLY DRY ABDOMINAL FOLD			245544	B. WING _	QTRE6	T ADDRESS, CITY, STATE, ZIP CO	ODE	
MINNEAPOLIS, MN 55430   MINN	NAME OF P	ROVIDER OR SUPPLIER			512 49	ITH AVENUE NORTH		
PRESIDENT OF SECURIORS (EACH DEPRICEMENTS) (EACH DEPRICEMENT What is enreaced by the temperature of the property of the proper				1	MINN	EAPOLIS, MN 55430		NSI.
F 309  Continued From page 31 with bath and as needed. The care plan indicated R34 was incomtinent of bowel and bladder and required extensive assistance to total assistance with tolleting, and instructed staff to manage incomtinence issues by checking and changing R34 before breakfast, after funch and during the night on rounds or as needed, in addition, the care plan provided by facility with print date of 11/30/15, indicated R34 was at risk for skin breakfowr related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.  R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS indicated R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension.  Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff that (R34) required total assist of two to check and change before breakfast after lunch and during the night on rounds or as needed, and encourage repositioning.  The Treatment Administration Record dated January 2016, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY was a power of the property of	CANIDEN		A CHENT OF DEFICIENCIES					COMPLETION
with bath and as needed. The care plan indicated R34 was incontinent of bowel and bladder and required extensive assistance to total assistance with toileting, and instructed staff to manage incontinence issues by checking and changing R34 before breakfast, after lunch and during the night on rounds or as needed. In addition, the care plan provided by facility with print date of 11/30/15, did not address skin or incontinence Issues.  Pressure Ulcer Care Area Assessment dated 8/5/15, indicated R341 was at risk for skin breakdown related to incontinence, immobility, decreased sensation related to past stroke, and reliance upon staff for repositioning.  R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension.  Nursing Assistant Assignment Sheet dated 11/10/15, instructed staff to R44 required total asslet of two to check and change before breakfasts after lunch and during the night on rounds or as needed, and encourage repositioning.  The Treatment Administration Record dated January 2016, instructed staff to "WASH AND DRY ABDOMINAL FOLDS AND GROIN, APPLY ABDOMINAL FOLDS AND	PREFIX				<u> </u>		APPROPRIATE	
treatment was set up for every shift. The	F 309	with bath and as in R34 was incontine required extensive with toileting, and incontinence issue R34 before breakinght on rounds of care plan provided 11/30/15, did not issues.  Pressure Ulcer (8/5/15, indicated breakdown related decreased sensively importance upon site of the cognitively important and activities of always inconting quarterly MDS developing prediagnoses including diseases.  Nursing Assist 11/10/15, instrusted or as including or an including o	ent of bowel and bladder and e assistance to total assistance. Instructed staff to manage less by checking and changing dast, after lunch and during the or as needed. In addition, the ed by facility with print date of address skin or incontinence.  Care Area Assessment dated address skin or incontinence.  Minimum Data Set (MDS) dated attended R34 was moderately alred and required assistance with daily living (ADLs). R34 was lent of bowel and bladder. R34's indicated R34 was at risk for insure ulcers. R34's quarterly Minimum and during the night on the check and change before in lunch and during the night on meeded, and encourage  Int Administration Record dated in the colors and hypertension.  Administration Record dated in the colors and encourage.  Int Administration Record dated in the colors and encourage.  Int Administration Record dated in the colors and encourage.  Internal RS Istarted 01/20/15]." Tile EOLDS IStarted 01/20/15]." Tile EOLDS IStarted 01/20/15]."	ith OS OPLY	309			

シーでん ヴェル	IENT OF HFALTH	AND HUMAN SERVICES				FORM OMB NO.	02/17/2016 APPROVED 0938-0391
DEPARTM	EOR MEDICARE	K VICUIONIO GENERALI	0401 14111	ribi E CC	NSTAUCTION	(X3) DATE	SURVEY PLETED
CENTER	S PETICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	ING ING		00	
TATEMENT C	F DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	11403			200000
(1401 - 211 - 1			B. WING				28/2016
		245544	[ B. VVIII ]	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		į
	ROVIDER OR SUPPLIER		i	512.4	BTH AVENUE NORTH		ł
			'	MIN	NFAPOLIS, MN 55430		<del></del>
CAMDEN	CARE CENTER			<del></del>		CTION	(X5) COMPLETION
		FATEMENT OF DEFICIENCIES	PAEF	=ix	PROVIDER'S PLAN OF CONTE (EACH CORRECTIVE ACTION SE CROSS-REFERENCED TO THE API	PROPRIATE	DATE
(X4) ID PREFIX	(EACH DEFICIENCE BEGULATORY OR	FATEMENT OF DEFICIED BY FULL CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAC		CROSS-REFERENCED DEFICIENCY)		
ŢAĞ (	1104		+	_		•	1
<del>                                     </del>				309			
F309	Continued From t	page 32	1	303			\ <b>\</b>
1 000	Lakewartion Was I	not on care plan or nuising	Ì	1			1 1
}	assistant assign	nent sheet.		}			
		Walte at Dinn am BN-A		1			
	During interview	on 1/27/16, at 9:00 a.m. RN-A		}			1
1	stated, "I was no	aware of the cheets because	1	1			
1	abdomen, There	eloped in December while I was		1			
l <sub>i</sub>	the wounds deve	aloped in December the wounds a nurse who found the wounds a local doctor). I al	1				1
1	On vacauore rail	led the MD (medical doctor). I al	m	1			1
ł			e.	ļ			
į	I don't know if th	rse the director is a the weekly ne information is on the weekly	, l	l l			
	l ckin sheets, it 5	Mould be. The name of its	e				. [
1	updated the car	re plan."					
}	1 4 4	DAN D was interviewel	d		i i		
1	On 1/27/16 at 1	11:00 a.m. RN-B was interviewed	_				
1	and stated, "i (	don't care plan turing a	1				}
	repositioning s	chedules because it is a sue, you cannot get the staff to					
1	compliance iss	dule"	1				}
	follow the sche		{				ļ
1	On 1/27/15 at	11:09 am RN-A was asked how	V .		1		
	troquently & re	sident should be repositioned a	ino				1
l l							
	When asked	how frequently a resident with a	Δ				1
1	그 그 사람이 사이 되었다.	AZ'E GNAING DO TOPODIS	^		Ì		
	stated, "at lea	ast every two hours."	1				
ļ		4 in the at 9:31 n.m. the			<b>\</b>		1
1	During intervi	iew on 1/27/16, at 2:31 p.m. the irses stated, "[NA-A] told me abo	out				
1	director of nu	rses stated, introduced No.	one		1		
l	the slit on H3	It the other wounds or that there	was		1		l
							1
1	not a treatme	ent for [1134], My expectation and the nurse right away who had tell the nurse needs to	en		1		
1	the aides wo	open area, The nurse needs to	chart		1		1
•			<b>4]</b> .		\		
							1
1		s for the open area in place and					
			care		_		
	plan. The n	urse needs to get a troatmone			Facility ID: 00166	II continuati	on sheet Page 33 o
1	( high 1112 ii		ID-KOXB11	1	PACHRY ID. 00100		

							NINTED: 02 FORM AP MB NO. 09	PHOVED	
<del>_</del> =	es ac a im	OF HEALTH A	AND HUMAN SERVICES 8. MEDICAID SERVICES				WAYE &	HRVEY	1
DEPART	DC EU	R MEDICARE	& MEDICAID SERVICES  (X1) PROVIDENSUPPLIENCLIA	(X2) MULTI	PLE CONS	TRUCTION	COMPL	ETED	
	イクスクス	-ICH-NUES I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	1G		_		
STATEMEN AND PLAN	OF COR	RECTION	(25				01/28	3/2016	
			245544	B. WING	STREET	ADDRESS, CITY, STATE, ZIP CODE		<b>\</b>	
	5 550VIE	ER OR SUPPLIER		1	FAC ADT	H AVENUE NOH IT			
				ł	MINNE	PAOVIDER'S PLAN OF CORRECTION SHOUL	NC	(X5) COMPLETION	
CAMDI	EN CAF	RE CENTER	CIQIENCIES	ID I		PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION THE APPRIOR	DBE PRIATE	DATE	
(X4) ID PREFIX TAG	×	SUMMARY ST. (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	×	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)			
				F	309				
F 3	09   Co	ntinued From F	page 33	1	1				
	im	mediately from	page 33 the doctor. The nurse would and as needed until resolved. I congrehensive skin assessment	. \					
	to	low up weeks	and as needed unit reservent omprehensive skin assessment There should be a tissue	` \	1				
	to	pe combieren:	L La wookly skin checks		\				
1	l to	lerance, i nere	should be how often the	1					
	l re	<sub>esident</sub> s need t	O De leposition Desidents		1				
1	1 11	esue tolerance	and comments the hours		\				
1	10	APPLICATION NAMED IN	TU CAL DOUBLE I	(מונ	1			\	
1	11	he wound is no	isty, the in Learning/reposition	ing i	1				
-	l li	for meals. The	usty, the resident should only be individualized turning/reposition d be on the assignment sheets	1	1			1	
į	1	schedule shoul and care plans	u po ou an	l l	1			1 1	
1			- 1 - Lroviead 6/28/	05,	1			1 1	
1		The facility's S	kin Care Protocol Tevised 6,25, n assessments will be complete	ed	l	F314 (D) A current			
		on a weekly be	asis."	Ì	F 314	F314 (D) A curron			
}	E 314	483.25(c) TRE	EATMENT/SVCS TO EAL PRESSURE SORES			comprehensive skin	k	1	
1	SS≓D	1 6460614 111 12				assessment, Braden ris	1		
1		Dosed on the	comprehensive assessment of	ent		assessment, nutritiona	•	;	1
1		resident, the	RUMY ITTO	5		assessment and tissue	moleted		\
		who enters tr	19 lacility with the unless the	1		tolerance test were co	ilibicia-		
		does not dev	elop pressure sores uniced an linical condition demonstrates the project and a resident having	nai		for R10. R10's TAR wa			
}		I they ware Uf	lavoluable, c	ntana I		reviewed for accuracy	/ 	'c	
1		pressure sol	es received ind. prevent infection	on and		according to M.D. ord	-1- f612' KTO	3	
		Services to t	sores from developing.	1		care plan and NAR ca	re guide		
1		Ļ				were reviewed and re	evised to		1
		THE DECIL	IREMENT is not met as evider	ıcəd		include interventions	s <b>to</b>		1
1		l bv:	Joob and dock	iment		promote healing of s	skin		
:		Based on	observation, interview and docu facility failed to comprehensive	ly		hreakdown and prev	vent furti	ier	1
1		l review, the	Haumy was and corvices to	)		hroakdown, Weekly	y wound		_
ļ		promote h	and provide care and services no ealing for a lacility acquired pre	gaulv			Il continuati	ion sheet Page 34 of	(79
	l	\		o In KOXB		Facility ID: 00168			

						FORM A	2/17/2016 PPROVED
	. د فیسو د	AND HIMAN SERVICES			0	MB NO. C	1938-0381
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES  (XI) PROVIDERSUPPLIENCLIA			NSTAUCTION	(X3) DATE	EETEO
CENTERS	FOH MEDICADE	THE THE PROPERTY OF THE PROPER	(X2) MULT A. BUILDIN	ILTE CO		1	
STATEMENT OF C	S DEFRIBENCIES I	(X1) PROVIDENSOFI CIEMBER:	HOTEON			01/2	8/2016
AND PLAN OF	001111111111111111111111111111111111111		B. WING_		719 CODE	1 0 11 =	
	1	245544		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
TOUR DE PR	ROVIDER OR SUPPLIER	· <del></del>	ì	512 4	19TH AVENUE NORTH		
			1	MIN	NEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRECT	ION	(X5) COMPLETION
CAMDEN	CARE CENTER	- SEIGIENCIES	ID		PROVIDER'S PLAN OF CURRED IN CORRECTIVE ACTION SHOLE (EACH CORRECTIVE ACTION SHOLE) TO THE APPRIL	JLD BE OPRIATE	DATE
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD CHOSS-REFERENCED TO THE APPRIDEFICIENCY)		
PREFIX	(EACH DEFICIENCE REGULATORY OR	LSC IDENTIFYING INFORMATION)				ed	ì
TAG					assessments were complet	d has	
h		-4	F	314	for R10; R10's sacral woun	M 1140	
F 314	Continued From	page 34	1	1	healed since survey. Weel	KIY	
	luicer for 1 of 3 re	Siderita (1179) spailing failed to			wound assessments were		
	pressure ulcers,	in addition, of 2 residents (FI34,	1	1	initiated for R34. A curren	t,	
	provide reposition	risk for pressure ulcers.	1	-	comprehensive skin		1
1	1			1	assessment, Braden risk		
1	Findings include	:		Ì	assessment, broading		
1	not col	mprehensively reassessed to			assessment and tissue	nleted	1
	H10 was not ool	mprehensively reasessor ors in order to prevent potential eldown, and to promote healing	,		tolerance test were com	do to	
1	Lurther skin brei	arcounti and the chaff of	1		for R34 with updates ma	Josel	
1	after a pressure	akdown, and to promote the action and to promote the staff on a ulcer was identified by staff on on 11/24/15 (33 days after nurs	sing \		care plan, TAR (per M.D.	(orders)	
1	H10's buttocks home admission	Off then in A			and NAR care guide. RL	7 Ma2	1
1	home admission	- Leaguetinn the	,		rossessed for skin brea	Kdown	1
1	On 1/26/16, du	uring continuous observation the			through a new skin che	ck and	1
	following was	the was transferred into the whe	el		Braden risk assessment	; R12's	1
1	Λι R·07 B.M. H	(10 Was thanson	440		Braden risk assessment	L care	1
}	chair, and bio	ught to the dining room; 310 was observed still sitting in 34 0.22 a.m. R10 was wheeled to	the		TAR, care plan and NAR	, <b>u</b>	
}	wheel chair. A	R10 was observed still stilling in At 9:22 a.m. R10 was wheeled to At 10:18 a.m. R10 was brough	nt		guide were reviewed	and	\
1	activity (00M.	At 10,10 million accietant	1		guide were reviewed	ude	
	hack to not re	Dun stated she w	vas i		revisions made to incl	Louer	\ ·
1	(NA)-J put for	er coat on her. HTO states only lunch to a 50's Style Grill with of Language staff. At approximately	office		repositioning every 2	((Ours.	1
ļ	residents and	funch to a 50's Style Callindon d activity staff. At approximately			a a securitina	nt .	
1	10;23 a.m. F	(10 9 Skill Walls of the murse	{		All residents requiring	5 	
	l renistered III	files (Lily)			assistance with cares	and	
1	consultanvi	RN (NC)-A was present during t along with licensed practical no han interviewed R10 stated, "m	urse		mobility are at risk fo	r skin	Ì
	I (I PNI-U. W	Heli lillo i i o i i i i bilite Wh	nen i sii i		breakdown and requ	iire	
	l le falling 80	are allo allo allo	nm ine i		appropriate interver	tions are	
1	i in the WN69	Ullan	m, ine i		taken to prevent ski	n	1
\	wheel chair	to the bed with a medical to a mattress on it. There was a mattress on it.	i thick	}	1		1
	vollic atidu. l	n air mattress on it. There was by on the top of the cushion in the NAL removed R10's pad, the	are was	1	breakdown		l
	l chair, Wn€	Bli MA-6 101119 11-P4 and Plond Off	the	1			
	a moderat	e amount or bright have hee	n a				
1	pad. LPN-	D stated thore and stated she ha	ad not	1	Facility ID: 00166	If continua	tion sheet Page 35 o
	dressing c	Obcolete Eve	nt JD:KOXA	111	Lamina in		

						RINTED: 02/1 FORM APPE MB NO. 0938	(O 4 CD
	CNT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				TWO DATE SUR	vey l :
DEPARTM	EOD MEDICARE	& MEDICAID SERVICES  (X1) PROVIDENSUPPLIENCLIA	(X2) MULT	IPLE CO	NSTRUCTION	COMPLETE	י טיב
	・ルロトルバトルグルクラー・ド	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. OUILDIN	VG		\	
AND PLAN OF	CORRECTION	DERTH				01/28/2	016
	·	245544	B. WING	0705	ET ADDRESS, CITY, STATE, ZIP CODE		\
				-140 A	INTH AVENUE NORTH		1
NAME OF PR	OVIDER OR SUPPLIER			MIN	NEADOLIC MN 55430	1001	(X5)
CAMDEN	CARE CENTER		l		PROVIDER'S PLAN OF CORRECT	RINKE I	(X5) DMPLETION DATE
L	CLIMMARY ST	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	OPRIATE	
(X4) ID PREFIX	(EACH DEFICIENC	LSC (DENTIFYING INFORMATION)	1			e for	
TAG	HEGODATOM				Staff were educated on risk	3 101	
			F	314	skin breakdown, the standa	aru	{
F 314	Continued From	page 35	اه		for accessing residents for	Stries	
' ' ' '	boon informed b	y stati triat trio pro-		1	breakdown, implementing	and	
1	I had come un. II	יישיי סו Lay πeasule.	d	1	following care planned	•	1
	I localized On the	SULI NO o cm Wide.	.	1	following care planning (	or	
	it to be 4 certain	eter (cm) long and 2 cit thou nd 100 % bleeding in the wound no touched R10's wound to clea	an	Ì	interventions for healing (	- lown-	l
\	Thed When Lriv	TO TOWN A GLOSAN THE WOUNG	i l		prevention of skin breakd	,000	<b>\</b>
	1 if D10 retracted	hit was			libre litro-	skin	
	I would have bed	II CHOOL	li li		DON/Designee will audit	ets.	\
	Land chearing P	PAYOU I TO right theis	e.		assessments, wound she		1
	of the wound s	layed a big role in the development ince the brief line was right there as a pressure ulcer." R10 went 16 minutes without being	for		TARs, care plans, NAR ca	,re €	1
,	didn't think it w	as a pressure dicor.  16 minutes without being			-uides and visual monito	יט אווואטי	
1	Than hours and	16 (tilliates and	1		***tonientions for all resi	dema	l l
1	repositioned.	Adja/15 Indicate	ed \		with wounds weekly x 1	.2 week.	\
}	The Admission	n Record dated 12/8/15, indicate litted to the facility on 10/21/15, indicate lighting unspecified kidney failure	with				
1	H10 was adm	hiter to the select kidney failuit	е,		Findings will be reported	∌d	\
	diagnoses inc	cluding unspective thattey, peripheral vascular disease,	1		monthly to QAPI comm	iittee x 3	\
	hypertension	potiposa	ł		months with follow-up	•	
1	diabotos		1		months with termitte	-6	1
	The Admissi	on Nursing Assessment dated licated R10's left side was			according to committee	, –	1
	10/21/15, inc	dicated R10's left side was at skin risk included incontinent ability chair fast. The body diagr	ce,		recommendations		Ì
	"paralyzed"	at skin risk included incommon bility, chair fast. The body diagr bles an coccyx, and bilateral	am		Corrections to deficie	nt practice	
\	had three Cl	LCIA2 OIL COAST.	and I		Corrections to defice	- ห. ย. 2016.	<b>\</b>
	buttocks, ar	rcles on coccyx, and black of the condition noted for left of the condition noted for left of the condition old pressure of the condition of t	ore."		will be made by Marc	) 10 LOV-	1
1	Light parroc	140/06/15	l				1
. \	The Tempo	orary Care Plan dated 10/26/15,					
	Lindinated E	(In transfer to the transfer t					1
	(mechanic	al III used to detailed plan to pr	event		1		<b>\</b>
		IICHI IICAOISE			l l		1
, \	rennsitiON	ING Schedare.					
	<b>!</b>	~ L- Cat (MDS)	dated				
	The admi	ssion Minimum Data Set (MDS) indicated R10 was dependent of the desistance with bed mobile	owl no				sheet Page 36 of 79
· .	10/27/15,	indicated R10 was dependent ober's assistance with bed mobi	uty,		Facility ID: 00188	Il continuation	Faucori -a-
·	Stait met	EV.	OX:OX:	HII	• ••		

	SENT OF HEALTH	I AND HUMAN SERVICES				OMB NO. C	938-0391	\$- 1
CENTER	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	MEDICAID SERVICES     MEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	10		01/2	ETED 26/2016	
		245544	B. WING_	STREE	T ADDRESS, CITY, STATE, ZIP COD	Æ	1	1
NAME OF	PROVIDER OR SUPPLIE	A	1	512 4	ETH AVENUE NORTH DEAPOLIS, MN 55430		1 (96)	
	N CARE CENTER		T 10		OF CORP	IECTION HOULD BE	COMPLETION DATE	
(X4) ID PREFIX	SUBMANDY S	BTATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI	iX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	PPHUPHIAI =		
TAG		26	F	314				
F 31	Continued From transfers, and to unhealed press	oilet use, reto did risk for						
	tunctional limite	alion of range of motion one side; and used wheel chair f	or e					
	care plan deve	eloped after the MDS had been						
	pressure uice	cale (tool used to determine r risk) dated 11/13/15, had score mild risk for developing pressure					1	
	ulcer, Howev questionable	due to staff indicating no sensor due to staff indicating R10 had npairment even though R10 had	left la				The second secon	\
	friction and seven though	sis, and sing only potential probler shear being only potential probler i A10 required maximum assistal i Additional Braden assessment	nce					
	found in the	medical residence completed	on					
;	11/3/15, the assessmen	onal Assessment was completed and record lacked evidence of a net a record lacked evidence of a net after buttocks wound develope	don					
;	11/24/15. The Care	Area Assessment (CAA) worksho 0/15, indicated "PLACE NELONS THAT ASSIST IN	eet					
;	INTERVE	SING THE POTENTIAL FOR RE AREA AND FOR OTHER SK	IN					
	The Prog	gress Note dated 11/24/15, indica n noted on LF [left] buttocks, sm	note					
	amount also ind	or blood estigent was laid down allo icated resident was laid down allo ositioned/offloaded every two hot ositioned/ostroaded. All progr	er meas, <sub>115</sub> . The		Facility ID: 00168	If continu	ation sheet Per	<sub>38</sub> 37 of 79
}		L - Verrious Obsoleie	GUI ID: KOV					

DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICEST	will f	CONSTRUCTION	OMB NO. C	938-0391	
CENTERS	POR MEDIOAITE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		01/2	8/2016	1
STATEMENT OF	CORRECTION		B. WING	OFFICE TIP CO		· · ·	
		245544	S	TREET ADDRESS, CITY, STATE, ZIP CO		ļ	\
NAME OF PR	OVIDER OR SUPPLIER		1 5	WEADALIS MN 50400	- orioni	(X6)	1
	CARE CENTER		10	OBOVIDER'S FLAN OF COL	SHORED BE	COMPLETION DATE	
(X4) ID PREFIX TAG	71 V0100V ST	(ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CAOSS-REFERENCED TO THE DEFICIENCY)	АРРИОГЕНЕН В		1
124			F 31	4			
F 314	I reviewed, no our	er entries found related R10's	re \				
	buttocks wound.	44/04/15 indicated					
	treatment order	reat wounds] to Lt [left] buttocks	<b>~</b> 1				
	am (sic- morring	hrs [every two hours]." The	ply				
	dressing and c	change q 3 days + PRN."	455   254				
	The Physician Notes dated 1	n/Nurse Practitioner (NP) Progre 12/9/15, 12/15/15, 12/23/15, 1/1 SKIN: normal, no rash."	2/15.				
	The Physical	Therapy Daily Notes dated ted R10 complained of right but	tocks form				
	pain, and nu nosition chai	nge every hour to decrease pair	n and				
	recommend	duction cushion for wheel chair	use).				
	The Hospita 12/29/15, in ulcers: "Wo	al Discharge Orders dated print ndicated R10 had a history of pr ound buttocks pressure ulcer 9/	ea ressure 17/13."				
	The Janua Record (To	try 2016 Treatment Administration (1975) AR) indicated the Physician Ord	ler from:				
	11/24/15. hours) and	d 12/16/16, (for dressing change	e). rional				
	\ therapy/s	T/ST (physical therapy/occupal peech therapy) Resident Refer rendations dated 1/8/16, indicate the of top of ROHO cushion in	ed Do		ll continu	vation sheet Pa	ge 38 of 79
	not put p	endations dated 176710, including in including in top of ROHO cushion in including in the cushion in t	VBNt ID:KOXA11	Facility ID: 00186	ŗ, <b>~</b> =····		

	A. Tid	AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO. (	938-0391 SUBVEY	:
DEPARTM	ENT OF HEALINA	8 MEDICAID SERVICES  (XI) PROVIDERISUPPLIERICLIA	(Y2) MULTI	PLE CONSTP	RUCTION	COMP	LETED	;
STATEMENT OF	- VEE11:11-NOTES 1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG			28/2016	i
		245544	B, WING_	CTOEET A	DORESS, CITY, STATE, ZIP	CODE	1	
	PER DO SUPPLIER		1	E40 /0TH	WENUE NOHTH		_	1
	ROVIDER OR SUPPLIER		1	MINNEA	POLIS, MN 55430	DRRECTION	(X5) COMPLETION	<b>\</b>
CAMDEN	CARE CENTER	CEICIGNOS	ID		PROVIDER'S PLAN OF COMPACTIVE ACTION (EACH CONRECTIVE ACTION FOR THE PROPERTY OF THE PROPERTY	N SHOULD BE E APPROPRIATE	DATE	
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL USC IDENTIFYING INFORMATION)	PREF	'^ \ ^!	HOSS-REFERENCED TO THE	)		1
F 214	Continued From	page 38	F	314				
F 314	wheelchair."	•					İ	
	The undated NA 1/22/16, indicate top of ROHO cudid not indicate presence of but.  The medical reassessments, buttocks wound evidence of codetermine cauchanges in R1 development.  On 1/26/16, a nurse (LPN)-right buttocks since 11/24/1 progress not R10 had one left side verse top of the progress of the	cord lacked evidence of weekly or any measurements of the difference of the medical record also lack imprehensive reassessment to eative factor, evaluate risk and 0's condition that caused the of the buttocks wound.  It 9:30 a.m. the licensed practical stated R10 had a wound on the more than likely pressure related to the more than likely pressure related to the difference of the pressure ulcer only, document the right side must have been a	ed lal la					
	On 1/26/16 nursing (DC) R10 did not or her butto not aware the right but On 1/26/16 about the have been	3 10:29 a.m., the DON was info observation, and stated R10 sh o repositioned at least every two o going out to outings.	wore nd on rmed ould hours,					
	On 1/26/2 and could	26 at 10:32 a.m., NA-J was inteled not remember when she had I	ast ent ID:KOXF	911	Facility ID; 00166	If continu	etion sheet Pag	18 38 01 ta

						FORM -OMB NO	02/17/2016 APPROVED 0938-0391 E SURVEY	;
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		PLE CONSTR	LICTION	(X3) DAI	PLETED	
CENTERS STATEMENT OF AND PLAN OF	FOR MEDICATE	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	iG			/28/2016	;
1	ļ	245544	B. WING	EYBSET AL	DRESS, CITY, STATE, ZIP	CODE	ļ	
	A VODI JEG		1	CAO ADTH	VAENUE MORTIL			\
NAME OF PR	OVIDER OR SUPPLIER		1	MINNEA	notic MN 5543V	CONION	(X5) COMPLETION	1
CAMDEN	CARE CENTER		<u></u>		DROVIDER'S PLAN OF U	ON SHOULD BE	COMPLETION	1
(X4) ID PREFIX TAG	DUMANAQY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	^	EACH CORRECTIVE ACTIVE ACOSS-REFERENCED TO THE DEFICIENCY	HE APPROPHIATE		1
F 314	Continued From repositioned R10 not repositioned transferred into his that morning. Not repositioned at life DON (director of supposed to be when they device causative factors scale, tissue per to see a comple contributing fare expect dietary updated, and started to more RN-A was resput in place, any assessment developed not there was not which the MI At 9:55 a.m., the converse comprehens after she transfer she transf	page 39  NA-J acknowledged R10 was or offloaded since she was her wheel chair before breakfas A-J stated R10 should have bee east every two hours.  on 1/28/16, at 9:46 a.m. the following was replan with the record with crors included. She would expect staff to do Braceriusion test, and she would expertusion test, and she would also staff to be informed, care plan weekly wound measurements into the aling process. DON states from 11/24/16, when R10 expensible making sure all these from 11/24/16, when R10 expensible making sure plan writted and stated "didn't believe" at comprehensive care plan writted at the care plan was written for R10 expension, and stated "didn't believe" at the state of the other facility. The served continuously on 1/27/16 expension of the other facility. The served continuously on 1/27/16 expension of the other facility. The served continuously on 1/27/16 expension of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast. NA-A remain and obtained permission to old the served in place on of R34's left breast.	e ine iden pect hall ed were ind serve here the top oved the under ts." NA-A				valing sheet Par	ge 40 of 79
	R34's abo	iominal fold. The under left abdo	men		- 771110-00185	li conlic	nuation sheet Pag	ge 40 01 79
1	told R34	there was a teal uncontrol	ent ID:KOXF	111	Facility ID: 00166			

		SERVICES				OMB NO.	)938-0391	;
DEPARTA	MENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES		PLE CONSTRU	CTION	(X3) DATE	SURVEY LETED	
CENTER	S FOR MEDICAHE OF DEFICIENCIES CORRECTION		(X2) MULTII A. BUILDINI B. WING _	G			28/2016	•
		245544	B. Milag	STREET ADD	RESS, CITY, STATE, ZIP	CODE		
TANG OF F	POVIDER OR SUPPLIER		1	CAN ADTH A	NENUE NOR IN			
1				MINNEAP	OLIS, MN 55430	ORRECTION	COMPLETION (X5)	1
CAMDE	CARE CENTER	ATEMENT OF DEFICIENCIES	ID PAEFI)	k (E	ACH CORNECTO TO TH	IE APPROPRIATE	DATE	\
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENT REQULATORY OR	ATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CRO	DEFICIENCY	()		
\			\ F∶	314				
5 314	Continued From	page 40	1					}
	I fold and verified	thete was to an aroun At 8:09	,		•			1
	I halween Ho45 9	Daving a meridin						1
	a.m. registered i	nurse (RN)-A arrived to perform e measurements and description ro were as followed:	19	1				1
1	of pressure ulco	15 WOID TO A DESCRIPTION	er	Ì				
1	14) Right ischiai	imperogny, and winning bed						1
1	measuring roll	. x 0.8 cm. x 0 cm. wound (%) granulation tissue and 50% (and was observed. RN-A state	d.					1
1	I plough, No urai	ingo Jeacsing until I can						1
	I "I WILL COVEL IT W	itti or a see alleet dectori."		1				}
	obtain orders	om the MD (medical doctor) It between buttocks measuring (	3					1
1	cm. in length.		1			•		
.	1	ow with NA-A at 9:16 a.m. on stated "The sore on [R34's] rig		-				1
<b>\</b>	During intervie	w with NA-A at 9:10 a.m. on stated, "The sore on [R34's] rig share since I started here, about	mt	l l				- 1
	led has been	stated, "The sole of the sole there since I started here, about They pormally put cream on it b	ut it					1
1	three weeks.	THEY TOTAL THE Slit on (R34's)					l L	1
}	l is detting wor	So, I move and Monday	1					1
1	bottom and a	n [R34's] abdomer Markey d the nurse Monday. I think LPN etical purse)-B was the nurse					Ì	1
	i /licensed Die	Clical Harvey - Land barri	er i					1
l l	Monday mor	ning. LPN-8 told me to put barr nd watch it. It looks worse that is	why !				ļ	1
1	asked for th	e nurse."	1					1
}	l		4 was	1			}	1
1	R34's care	plan printed 6/3/15, indicated to npaired skin integrity and had a property ulcers related to	history					. 1
1	at risk for it	pressure ulcers related to	1	1				1
. 1	lincontinend	enginoully all and areas t	o the	1				1
·: \	neuropath)	CULOTIO 1990 The coor tiestie (C	om	1			ļ	ļ.
•	hacral coc	Cyx area roller a multiple ulcer	15 ON	1				1
3.1	l stomach f	BIRTON IN LIGHT TO A TOTAL	.wm.	Ì				1
	l interventio	olls illian dotot and with each ch	e¢k and i	'			Ì	1
	l renosition	IIII do mode - 1- frontino	t '				\ 	
	change, e	ncourage R34 to make nequestions in the hanges when R34 was able who had report skin issues to physical report skin issues t	ician as			ម ក្ខុការប្រជ	ation sheet Pag	<sub>je</sub> 41 ol 79
l	chair or it	Ded' (short own	AXOX:CI Inc	11 Fi	acility ID; 00166	H COLLEGE		
,****		- Chenlete						

					OMB NO. 1	0938-0391	
DEPARTMENT OF HEALT	H AND HUMAN SERVICES				WAY DATE	SURVEY	;
CENTERS FOR MEDICAL	THE CHICAGO SERVICIA	(X2) MULT	IPLE CONSTRU	CTION	COWI	12,20	•
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDENSOR LIGHT	A. BUILDIN	VO		01/3	28/2016	
AND PERIOD TO THE	245544	B. WING		RESS, CITY, STATE, ZIP			
			STREET ADD	YENUE NORTH		-	
NAME OF PROVIDER OR SUPPL	E <b>H</b>	1	SANSINITE ADI	NIS MN 55430		(X5)	
CAMDEN CARE CENTER				OBOVIDER'S PLAN OF C	DARECTION	COMPLETION	
SUMMARIA	PATATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREF	"" \ COC	ACH CORRECTIVE ACTION OF ACTION OF THE ACTIO	)		
F 314 Continued From they arise and with bath and R34 was incontinence with tolleting, incontinence R34 before by night on round print date of incontinence.  A Pressure R3/5/15, indicated are as a continence of the continence of	skin checks per tackey has needed. The care plan indicate at needed. The care plan indicate at timent of bowel and bladder and assive assistance to total assistance and instructed staff to manage issues by checking and changing reakfast, after lunch and during the description of the care plan with 1/30/15, did not address skin or issues.  Licer Care Area Assessment date ated R34 was at risk for skin related to incontinence, immobility in the care plan with the care plan in the plant of the care plan with the care plan with the care plan in the plant pl	ed dee dee dee dee dee dee dee dee dee	314				
indicate	of "Hesiderit had a reason of the state of the state of the state of the harrier cream appropriate the state of the state of the harrier cream appropriate of the state of the	n. 5%	in Fa	cillly ID: 00166	II continu	ation sheet Page	42 of 79

DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM OMB NO.	02/17/2016 APPROVED . 0938-0391 E SURVEY
マペルエエトをごわげ 介	F DEFICIENCIES CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CON	IPLETED
		245544	B. WING	OTATE 780		/28/2016
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 512 49TH AVENUE NORTH	COBL	
			1	MINNEAPOLIS, MN 55430		
CAMDEN	CARE CENTER		10	THE STATE OF CO	ORRECTION	(X5) COMPLETION
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PAECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	X (EACH CORRECTIVE ACTION ACCIONALLY ACCIONA	IE APPROPRIATE	DATE
F 314	care plan.	ation was not updated on the	F:	314		
	stated, "There at the wounds develon vacation. The should have calle not a wound nurse I don't know if the skin sheets. It sit the wound on Rithickness skin kneerosis of subcidown to, but not ulcer presents of without underm stated, "The nuplan."  RN-B was inter RN-B stated, "I repositioning scompliance issifullow the schelling in the schell		od d			
	frequently a restated, "I would When asked I wound like R3 stated, "at least During intervidirector of nuthe slit on R3 right ischial to	11:09 am RN-A was asked how sident should be repositioned a d need to check the care plan." how frequently a resident with a 34's should be repositioned RN-st every two hours."  The won 1/27/16, at 2:31 p.m. the reses stated, "I did not know about 4's coccyx or the wound on R34 aborosity. [NA-A] told me about right groin this morning. No one other wounds or that there was	ut l's the			on sheet Page 43

	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				OMB NO.	0938-0391	
CENTERS	FOR MEDIOPILE	EN/CLIA	(X2) MULTI	PLE CONSTI	RUCTION	COW	VELED	•
STATEMENT OF	- DEFICIENCIES I	(X1) PROVIDENSOFT TO NUMBER:	A. BUILUIN	NG		01/3	28/2016	
7,12	!	245544	B. WING	QTAFET A	DDRESS, CITY, STATE, ZIP C	ODE		
777 05 00	OVIDER OR SUPPLIER			619 49TH	AVENUE NORTH			
				MINNE	PROVIDER'S PLAN OF CO	PRECTION	(X5) COMPLETION	
(X4) ID PREFIX	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	ix c	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO ROSS-REFERENCED TO TH DEFICIENCY)	EAPPROPRIATE	DATE	
F 314	Continued From I a treatment for R aides would tell the find an open are and tell the wour nurses need to provide the open are nurse needs to get at doctor. The nur needed until recomprehensive completed. The there should be turned at be turned at be turned at be there is a winasty, the resemble the open and the needs to be a winasty, the resemble the should be on plans."  R12 was observed as the sitting in a Best a.m. to sitting in a Best a.m. Not a sitting in a Best a.m. R12 was a sitting	page 43 34. My expectation is that the me nurse right away when they at The nurse needs to chart on a dinurse about it [RN-A]. The put the appropriate interventions a in place and document. The update the care plan. The nurse reatment immediately from the se would follow up weekly and a skin assessment to be ere should be a tissue tolerance e weekly skin checks for all etermine how often the resident ositioned we look at tissue comorbidities. Residents need to aseline, every two hours minimus and every one hour. It the would ent should only be up for meatized turning/repositioning scheditied turning/repositioning scheditied turning to the assignment sheets and carried to the dining room. At Grand chair in the dining room. At Grand Cook R12 to his room to put res in the resident's mouth. Navid R12 to the dining room. At Grand R12 to the dining room as taken to the television (TV) room. R12 remained sitting in the Turpeared to have fallen asleep. To the TV room until 11:2 urveyor left the area. At 12:45 to TV room and	ts to to um, nd is dule e from as At -G -G -C	314				
	12:57 p.m   whether R	12 had been toileted or reposition 12 had been toileted or reposition 12 had been laid down or	onea I-A 		5. JEN IO 00168	If continu	ation sheet Page	e 44 of 79
	verified R	12 had not begin to	ent ID:KOXA	311	Facility ID: 00168			

					PRINTED: ( FORM A OMB NO. (	02/17/2016 NPPROVED 0938-0391	,
DEPARTMENT OF HEALTH	AND HUMAN SERVICES				ALON DATE	SURVEY	
DEPARTMENT OF HEALTH CENTERS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULTI	PLE CONST	AUCTION	COMP	LETED	
AD DEFICIENCIES	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	A. BUILDIN	1G				
AND PLAN OF CORRECTION		- 411546				28/2016	
	245544	e. WING	STREETA	ODRESS, CITY, STATE, ZIP CODE	:		
OO FURRI IEA		1	449 /OTH	I AVENUE NORTH			
NAME OF PROVIDER OR SUPPLIER		1	MINNE	NDOLIS, MN 65430		(M5) COMPLETION	<b>l</b>
CAMDEN CARE CENTER		T 10		PROVIDER'S PLAN OF CORRE	IOULD BE	COMPLETION	1
OUMMARY ST	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSG IDENTIFYING INFORMATION)	PREFI	X C	(EACH CORRECTIVE ACTION SP CROSS-REFERENCED TO THE AP DEFICIENCY)	PROPRIATE		
morning. (Four in being repositions has just eaten for him down." At 1 the bedroom an transferred R12 standing lift) an R12's pants down dry in front." R1 intact, his coccus was noted R12 NA-G and NA-applied a new  During continut 7:30 a.m. to 1 and 16 minute At 7:30 a.m.	ours and 15 minutes without od). LPN-A then stated, "[R12] inch and staff were going to lay inch the EZ stand (a mechanical stood R12 up. NA-H pulled with the EZ stand (a mechanical inch inch inch inch inch inch inch inch	al It Urs Chair	314				
the dining for R12 was take During interv said I got (R) intact. NA-A repositioned get people L At 10:30 a.m the Broada the bathroo standing lift down and repusing the lating t	on to the TV room.  Jew on 1/28/16, at 10:21 a.m. Notes on 1/28/16, at 10:46 a.m. R12 was taken where he was stood using a second of the two distributions of two distributions of the two distri	A-A is not ated in ken to pants which t fold ent t been	11	Facility ID: 00166	{ continue	ation sheet Page	e 45 of 79

NAME OF FROWDER OR SUPPLER  CAMDEN CARE CENTER  CAMDEN CARE CENTER  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES  SUMMARY STATEMENT OF DEFICIENCES OF FILL  (PACE OF TROVIDERS PLAN OF CORRECTION  RESOLUTION OR LSC DENTIFYING THE OF MAINTAIN)  F 314  CONTINUED FROM TOT PAGE 45  H12°s MOS dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily hirty, was incontinent of bowel and bladder and at risk for development of pressure ulcers.  The Pressure Ulcer CAA dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcers, and incinitied risk for pressure ulcers, incontinence impaired mobility by psychotropic drug use and durrefic use. Interventions included for staff to follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change before breakfast after funch and on rounds through night as needed, wound care as ordered, check and change before breakfast after funch before bed and on rounds through night as needed.  The NA Assignment Sheet instructed staff check and change before breakfast after funch before bed and on rounds through night as needed.  Reposition during check and changes.  The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition of the presence of	CENTER	S FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	TIPLE		Form <u>No</u> .	02/17/2016 APPROVED 0938-0391 © SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER  SUMMARY STATEMENT OF DEPCISIONES.  PHERY (EACH BERGLENCY MUST are PRECESSED BY FULL, FREE MUST AND	AND PLAN OF	COHHECTION		- WIND			01/	/28/2016
CAMBEN CARE CENTER  CAMBON CARE CENTER  (XA) D  SUMMAY STATEMENT OF DESICIENCIES (EACH DERICIENCY MUST BE PRECEDED BY FULL PRECED TO THE APPROPRIATE  (RA) D  REQULATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE DENTIFYING INFORMATION)  FROM CORRECTION SHOULD BE RECOLATORY OR USE APPROPRIATE  F 314  F 314  F 314  F 314  F 314  F 314  The Pressure Ulcer CAA dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, froquent urinary and bowel incontinence, and identified risk for pressure ulcer development.  R12's care plan printed 1/28/16, instructed staff that R12 continued to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility, beycholropic drug use and diuretic use. Interventions included for staff to follow repositioning schedule per rursing, provide moisture barrier and perform peri-care during each check and change before breakfast after lunch barrier and sendedd, wound care as ordered, check and change before breakfast after lunch barrier and as needed.  The NA Assignment Sheet instructed staff check and change before breakfast after lunch before bed and on rounds through night as needed.  Reposition during check and changes.  The Physician Orders signed by doctor on 18/16, instructed staff to reposition R12 in whreelchair every two hours and house barrier cream to skin over right buttock twice a day.  The Treatment Administration Record for January 2016, indicated for R12 "REPOSITION IN WHEELECHAIR EVERY 2 HOURS (Started 10/13/14/15.")			245544	B. WING	ST	REET ADDRESS, CITY, STATE, ZIP CODE		1
SUMMARY STATEMENT OF DEFICIENCIES   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY EUL.)   PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY EUL.)   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY EUL.)   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY EUL.)   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY)   PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE PLAN OF CAPITON SHOULD BE PLAN OF C	NAME OF PI	ROVIDER OR SUPPLIER			612	2 49TH AVENUE NORTH		1
SUMMARY STATEMENT OF DEFICIENCES   PROPERTY   TAO   PRO	CAMDEN	CARE CENTER			MI	NNEAPOLIS, MN 55430	TION	(X5)
F 314 Continued From page 45  R12's MDS dated 11/3/15, indicated R12 was severely cognitively impaired, required assistance with all activities of daily living, was incontinent of bowel and bladder and at risk for development of pressure ulcers.  The Pressure Ulcer CAA dated 11/3/15, indicated pressure ulcers were triggered because R12 required extensive assistance with bed mobility, frequent urinary and bowel incontinence, and identified risk for pressure ulcer development.  R12's care plan printed 1/28/16, instructed staff that R12 continued to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions included for staff to follow repositioning schedule per nursing, provide molisture barrier and perform peri-care during each oheck and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed.  The NAAssignment Sheet instructed staff check and change before breakfast after lunch and on rounds through night as needed. Reposition during check and changes.  The Physician Orders signed by doctor on 1/6/16, instructed staff to reposition R12 in wheelchair every two hours and house barrier cream to skin over right buttock twice a day.  The Treatment Administration Record for January 2016, indicated for R12 "REPOSITION IN WHEELCHAIR EVERY 2 HOURS (Started 10/13/14)."	(X4) ID PREFIX	SUMMARY ST		PREP		(EACH CORRECTIVE ACTION SHO		
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CAMDEN CA	RE CENTER			MINN	PROVIDER'S PLAN OF CORRECTION	ON	(X6) COMPLETION
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F 315 Continued From page 47 F 315 (AB) 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 that catheterization was necessary; and a resident who is inconfinent of bladder receives appropriate transmit 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 provide appropriate indwelling Foley catheter care to 1 of 2 residents (Rt5) in the sample reviewed with indwelling Foley catheter.  Findings include:  R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in the morning and peri care. R15 had an indwelling Foley catheter with a 2000 milliliter (mi) bag attached to 1. R15 stated she used to have urinary tract linections (UTI) in the past, and did not know when staff supposed to care for the receives and indwelling catheter or require assistance with elimination and grooming (peri-care) based on resident's identified needs.  DON/Designee will audit. 5 residents weekly who have an indwelling catheter or require assistance with elimination and grooming catcording to residents' care plan. Findings will be reported	CAMDEN		TENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECT	LD BE CPRIATE	COMPLETION
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attached to it. A 13 stated with elimination and grooming urinary tract infections (UTI) in the past, and did urinary trac	1	1 Faley cault	field with have	P		assistance with permitted as	sistance	
not know when state she preferred to use the catheter. R15 also stated she preferred to use the catheter. R15 also stated she preferred to use the according to residents' care bedpan when she had bed pan available to plan. Findings will be reported	1	l attached to	II. NIJ stated in the past at	ndidioi i		proper delivery of do	groomin	<b>E</b> \
catheter. R15 also shad bowel movements, but bedpan when she had bowel movements, but bedpan when she had bed pan available to plan. Findings will be reported	-	urinary trac	when staff supposed to care for	ner ( Luse the		with elimination and	ts' care	
bedpan when she had bed pan available to plan. Findings will be the plan bed bed pan available to	•	l cathéter. t	115 distriction of movements.	. bul		according to residen	a ranarte	ed b
etaff have not diversy that the state of the		bedpan w	nen sile had bed pan availat	ole to		plan. Findings will b	e reporte	- In a Book 4A of
use. On 1/27/16, at 1:35 p.m. H15 was Event ID:KOXR11 Facility ID: 00166		staff have	not always flat b.m. R15 was		<u> </u>		ii couținuai	MOU 2⊔681 ∟ Ծոնգ 45 0.

							FORM A	02/17/2016 APPROVED	,
		4m a 1 75 1 1	NID HIJMAN SERVICES				OMB NO.	0938-0391	
DEF	MTAA	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDENSUPPLIENCIA		IN E CON	ISTRUCTION	(X3) DATE COM	LETED	
CEN	VTERS	FOH MEDICALE	(X1) PROVIDER/SUPPLIER/CLIA	A. BUILDIN	NG _		1		
STATE	MENT OF	DEFICIENCIES CORRECTION	(X1) PROVIDENSOP LIZE (X1) IDENTIFICATION NUMBER:	K. Balco			01/	28/2016	
KIND I	<b>H</b>		245544	B, WING_		DTATE ZIP CODE			
			245544		STREE	T ADDRESS, CITY, STATE, ZIP CODE			
NAN	AE OF PR	OVIDER OR SUPPLIER		1	512 49	OTH AVENUE NORTH HEAPOLIS, MN 55430			l
		CARE CENTER			MINN		TION	COMPLETION	}
CA	MDEW		ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CONFICE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFIDIENCY)	HOPAIATE	DATE	1
10	(4) ID	BUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION)	TAG		CHOSS-REFERENCED TO THE			4
P	REFIX TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	\-				1
1					_	monthly to QAPI committe	5C Y 3		1
			200 48	F	315	months with follow-up to			1
1	F 315	Continued From F	, stated she have not received			committee recommendat	ions.		1
1		interviewed again	pericare or catheter care yet	1					l
1		grooming career	ecked in with her yet today	1		Corrections to deficient p	Lactice		1
l		I related to her gru	time and saw the	э \		will be made by March 8	, 2016.		1
1		she had the cath	eter for a long time, and saw the trouble with kidney failure.	}	1	Will Do			1
- {		urologist when in	Hodbie						\
1		The Admission	dursing assessment dated						
1		1 12/1/15, indicate	od Cautetor abov 32404 19/1/15						\\
- }		I LITE The temp	orally care plant the ca	ıre					- 1
- 1		I noted toileting a	SSIST OF OTTO - F Enlay cathete	۲,					1
1		plan old not ind	icate presence of Poley data- ons related to urinary tract, and	aio			•		l
1		not indicate car	es related to catheter.						1
l		1	· · · · · · · · · · · · · · · · · · ·	-					1
1		The Admission	Nursing assessment (mot dated 12/9/15, also indicated us to with no additional informatio	ie		1			1
1		re-admission	dated 12/9/15, also indicated the date of	111-					1
1		1	hetch trans.	1					l
	 	The Admission	n Nursing Assessment dated ond re-admission), indicated his way the form was left incomplet	tory					<b>\</b>
	}	12/23/15 (500)	ond re-admission), indicates ever the form was left incomplet ever the form was left incomplet ever the form was left incomplet ever the following the follo	e,					1
	\	of UTTS, now	ever the form was left incompa- te presence of the Foley cathete eleted medical conditions or	ðī,					1
	1	urinary fract r	elated mountain date	di l		\			1
	1	interventions.	The remporary accept of two sta	ff,		1			1
	1	12/23/15, ind	licated tolleting and include	l					1
	1	and pad use	. The care plan did not included Foley catheter, medical condition report and did not indicate to	ODE					1
	1	l rolated to uti	Hary had a	)					1
	1	CO OI Delete: I	Mildioi.	- 1		1			•
			ssion Minimum Data Set (MDS)	dated					1
	1	H15'5 adms   42/40/15, in	esion Minimum Data Set (MSS) dicated R15 had indwelling cath the incontinent of bowel; and we	ieiei,					1
		was frequer	ntly incommon sistence with be	ed i				\	1
	1	l denendent	Of IMO State of the VIDS	also i					1
		l mobility, tre	Insiers and tollor and intact ar	id able					
	1	Do bave CIG	al comprone	able .	1		**	ation sheet Page	9 49 of 79
		to clearly s	19114 (16600)	n in KOXB.	11	Facility ID: 00166	II cominu	2HD11 4110011 -9	

	a com at Tit	AND HIIMAN SERVICES				OMB NO.	0938-0391	
DEPARTI	MENT OF HEALTH	AND HUMAN SERVICES  8 MEDICAID SERVICES  WY PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE	SURVEY PLETED	
CENTER	S FOR MEDICANC	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	LIBLE C	CONSTRUCTION	COM	C#164	
STATEMENT ! AND PLAN OF	OF DEFICIENCIES FOORRECTION	(X1) PHOVIDERSON NUMBER:	A. HUILUI			046	28/2016	
, ((40 t - 1	!	- 45544	B. WING				2012010	
		245544	١ - ٦	STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	}	
NAME OF F	PROVIDER OR SUPPLIER		ļ	512	2 49TH AVENUE NORTH			
CAMDEN	N CARE CENTER			MII	NNEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRE	CTION	(X5) COMPLETION	
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CONNE (EACH CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULO BE PROPRIATE	DATE	
F 315	The Urinary Incor Care Area Assess the facility would catheter care and outcomes associ The comprehens and bladder nee and catheter use there any interversity indicated assist toileting, and transity indicated assist toileting, and transity indicated R15 chronic indwelly years due to in The note also recently of blasses	page 49  Intinence and Indwelling Cathete sment dated 1/4/16, indicated proceed to care plan for Foley of monitoring of adverse lated with the Foley catheter used as activities of daily living need to was not developed nor was entions identified to assist R15.  Instant (NA) care sheet (undated as of two with grooming, dressing ansfer with Hoyer to commode, heet did not indicate presence by catheter, or related cares.  In Progress Notes dated 1/14/16 had chronic kidney disease and ling Foley catheter for the past of t	el s six	315				
	had urine and one organism ordered a thr (antibiotic). A diabetes, ost	ilysis with thixed the culture), an isolated from urine culture), an ee day course of Levaquin diagnoses included eoarthritis, and depression.	d					
	care of R15 nurse mana	the NA who was assigned to take nor registered nurse (RN)-A (als ger) were not available for intenational at 2:09 p.m. the licensed practicles was interviewed and stated to complete the process were expected to complete the complete to complete the com	riew. cal					
	nursing ass twice daily	pericare, "wipe the catheter ever	y ID:KOXR1	1	Facility ID: 00166	If continuati	ion sheet Page 5	io of 79

							PRINTED: 0 FORM AF OMB NO. 0	PHOVES	!
AD	TMENT (	OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				(X3) DATE S	atiraVEY l	
DELAU	RS FOR	MEDICARE	STICLION IERICLIA	(XZ) MULTI	PLE CONSTRU	JCTION	COMPL	TE LED	;
		SHACIES	(X1) PROVIDENSUPPOLITY  IDENTIFICATION NUMBER:	A, BUILDIN	G		04/2	8/2016	1
STATEMEN AND PLAN	OF COARE	GHOM 1		B. WING_		#12 AODE		0/2010	1
			245544	<u> </u>	STREET AD	DRESS, CITY, STATE, ZIP CODE			1
110145 0	PROVIDE	R OR SUPPLIER	<del></del>	į.	512 49TH A	VENUE NORTH	_		4
				_1	MINNEAP	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	MOITC	COMPLETION	1
CAMD		CENTER	ATEMENT OF DEFICIENCIES	ID PREFI	x (1	EACH CONHECTIVE ACT THE APP	ROPRIATE	DATE	1
(X4) IC PREFI TAG	^ \ a	SUMMARY ST EACH DEFICIENC EGULATORY OR	ATEMENT OF DEPICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	TAG	CR	OSS-HEFEREINCY)			_
F3	mor	tinued From	Ident cleaned ob	1	315				
	and "ev sta	orything is do ted she was r t morning.	ne" (meaning cares). LPN-B not told R15 did not receive care	s					
	(D m re	orning cares, sident had Fo	1:22 p.m. the director of nursing ne would expect staff to complet such as partial baths, and if a pley catheter to complete cathet who pericars. The DON was no	er					
	ce a	are along whith ware R15 did torning.	not receive those cares that						
		lay 21 or adm <sub>compre</sub> hensiv	10:11 a.m. the DON also stated dission she would expect to see de care plan written by the MDS DN reviewed R15's record and and expect R15 to have care play						
	1	stated she wo developed for (include groo care.	r activities of daily living care ne ming, toileting) and Foley cathe	ter					
		policy indica 24 hours fro	undated Resident Care Plannir ted "The care plan is initiated wi m the time of admission and ful vithin 21 days following the resid e facility. All disciplines are	iy lent's					
	۳ <i>۵</i> ۵	responsible care plan a	nd the permanent care plan."	4 11001	F 323	F323 (D) Assist bar o	and repaire	d	
1	F 323 8S∍[	) ( HAだみひひつ	1001 21-	Ì	İ	by maintenance on	1/27/16.	All	1
}	G0-1	·	table of the total dent	nzorde	i '	assist bars/side rail	s were		1
1		anvironme	ent receives	iacarus		checked by mainte	nance on		
		as is poss	ent remains as free of de- ible; and each resident receives supervision and assistance dev	ices to		Checken by maintan	ance		
		adequate prevent a	SUDGLAISION STUD 4-1			1/28/16. Mainten	I coolinus	tion sheet Pa	ge 51 of 79
	1	blesein o		LID.YOYB	13 F	acility 10: 00165	H COMMOS	19-41: :	

						RINTED: 0	SHOAED
DEBARTM	ENT OF HEALTH	AND HUMAN SERVICES				MB NO. 0	938-0391 BUBVEY
CENTERS	FOR MEDICARE		(X2) MULT	IPLE C	ONSTRUCTION	COMPI	ETED
OTACENCHIC OF	noficiENCIES I	(X1) PAOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI	NG		1	
AND PLAN OF	COMMECTION		o wilding			01/2	8/2016
		245544	B. WING	eTRI	EET ADDRESS, CITY, STATE, ZIP CODE	-	1
MANG OF PR	OVIDER OR SUPPLIER		ļ	512	49TH AVENUE NORTH		1
				MIN	NEAPOLIS, MN 55430	(40)	(X6) COMPLETION
CAMDEN	CARE CENTER	OF SECUENCIES	ID	<u> </u>	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLL)	JLD BE	COMPLÉTION OATE
(X4) ID PREFIX	SUMMARY BY (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		CROSS-REFERENCED TO THE		
TAG			<del>                                     </del>		maintains a weekly record	of	
		51	F	323	checks of all assist bars and	side	
F 323	Continued From	page 51	ļ		rails in facility.		
					All residents using assist ba	ers of	
	This REQUIREM	MENT is not met as evidenced			side rails are at risk for inju		
	by:	unting interview and document	}	1	due to improperly maintai	ned	
1	Based on obser	alled to ensure assist bar for	ro		equipment.		
1	positioning and	transfers was properly secured transfers was properly secured transfers was properly secured transfer to the secure of the secure transfer	ent			ad on	
}	resident bed to (R12) who utilize	assule saw noo iv.	1		Maintenance was educate	-i	1
}	(R12) WIO GUIZ		1		performing and documen	ting .	\ \ <b>\</b>
	Findings include	e:			weekly checks of assist ba	ars and	
		Ligardia at Aina n m. the			side rails, and to perform	any	
	right assist (a)	which was attached to bow outward. F	112		necessary repairs immed	iatelγ.	
	was in the day	100th sitting in a mi-	\		Maintenance will audit t	he	
		Town Dispersed ly	ing		security of assist bars an	d side	
	li haad with he	an illined to the form	-		rails weekly x 12 weeks	with	
	assist rail was	DOMING OUTWARE			findings reported month	ily to	
1	Diote Minimu	ım Data Set dated 11/3/15, ident	tified		the QAPI committee x 3	months	
	diagnosis of r	im Data Set dated The ight sided hemiplegia, stroke an	iu		with follow-up to comm	ittee	1
	dementia.				recommendations,		
	Dane Fall Ca	are Area Assessment dated 11/3	/15,		<u></u>		
l					Corrections to deficient	t practice	
	transfers bet	Ween bed and whostons.			will be completed by N	tarch 8,	1
ł	The care pla	an printed 1/28/16, indicated R12	2 was		2016.		
1			ia,				
1	impaired mo	bility and unitary and red cell ligh	nt l				1
	incontinence	e. Interventions trace on hed to	reduce				
1	within react	n, perimeter mattiess of boars of falls, extensive to total assis	tance				
\	with transfe	of falls, extensive to decrease or and bed mobility to decrease	ne r bars	l			n sheel Page 52 of
1	potential fo	r falls, and resident doos on	ID-KOX81	<del></del>	Facility ID: 00166	If continuation	II Sheet Land on or

DEPARTME	ENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPULIBA/CLIA	(X2) MULT	IPLE CON	O	FORM AF MB NO. 09 (X3) DATE S COMPL	938-0391
ニー・・・・・・ へだ	: NEEK JENGIED !	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	49		01/2	8/2016
STATEMENT OF C	COHHECTION		B. WING		PTATE ZIP CODE	1 01/2	
		245544	1 7	STREE	ADDRESS, CITY, STATE, ZIP CODE TH AVENUE NORTH		Ì
NAME OF PR	OVIDER OR SUPPLIER		1	512 49	CAROLIS MN 55430		
	CARE CENTER			181141A	PROVIDER'S PLAN OF CORRECT	ION   ILO BE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG	S VOAMANIA	TATEMENT OF DEFICIENCIES OY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOU CROSS-HEFERENCED TO THE APPRI DEFICIENCY)	DPRIATE -	
	Continued From	page 52	F	323			
F 323	when in bed.	r <b>v</b>					
	On 1/27/16, at 9 verified the enate manager stated off, ensure the hightened and the manager stated to audit all assischeck every bareport indicated rails was done for the week of 12/31/15.  On 1/27/16, and an an an an an an an an an an an an an	ONS  nust develop policies and proceduat — fering the influenza immunization, or the resident's legal live receives education regarding depotential side effects of the consident is offered an influenza on October 1 through March 31 unless the immunization is medicated or the resident has already during this time period; esident or the resident's legal ative has the opportunity to refusion; and esident's medical record include station that indicates, at a minimum.	ist sist sed lip to CAL dures in, g the cally y been se um, the	F 334	policy was reviewed. The offered and declined be influenza and pneumo vaccines as well declined by vaccine information S (VIS). Review of recoived administering RN indicated R46 and R9 received vaccine in 2015 and pneumococcal vaccine previously. All resid were reviewed for immunization statu	oth the coccal sed the sheet rds for R ew of icate that the flu the ne ent records and thoses and thoses and thoses and thoses	ds
	(iv) The re	esident's medicates, at a minimate tation that indicates, at a minimate tation that indicates, at a minimate tation that indicates at a minimate tation to the tation to t	um, the	R11	immunization statu	If continue	tion sheet Page 53 of

						FORM A	02/17/2016 PPROVED
	a= 1:= 81*T11	AND HUMAN SERVICES				MB NO <u>. (</u>	)93B-0391
DEPART	MENT OF HEALTH	& MEDICAID SERVICES			PONOTRUCTION	(X3) DATE	SURVEY LETED
CENTER	35 FOR MEDICARL	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	ILTE C	CONSTRUCTION	55	-
STATEMENT	OF DEFICIENCIES OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDIN	W		01/2	28/2016
AMBIBUT		- 45EAA	B. WING_		TIP ZIP COOF	01/2	.0/15
		245544	L T	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIER		1	512	49TH AVENUE NORTH NNEAPOLIS, MN 55430		
1	N CARE CENTER		1	WI		ION	(X6) COMPLETION
CAMBE		ATEMENT OF DEFICIENCIES	ID PREFI	v	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOUND OF TO THE APPR  CROSS-REFERENCED TO THE APPR  CROSS-REFERENCED TO THE APPR	JLD BE OPRIATE	DATE
(X4) IO	SUMMARY ST	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  L SC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED DEFICIENCY)		
PRÉFIX	REGULATORY OR	LSC IDENTIFYING INFORMATION)		}	residents who did not have	an	1
			_		annual flu shot or did not ha	ıvė	
Γ	I o would Erom t	запе 53	F:	334	annual flu shot of discordal		
F33	Continued From F		1		a previous pneumococcal	ıe.	1
1	following:  (A) That the res	ident or resident's legal	.		vaccination were offered th	al	
	representative wi	ident or resident's logar as provided education regarding perceptial side effects of influenz	a		influenza and pneumococc	a1	1
}	the benefits and	Poleting of a control	1		( a side what If	fuse	1
l l	immunization; ar	ident either received the	}		vaccines. Residents that re	15	
1					immunizations are given V	i.b.u	
1	the standard in militia	MZAIION QUE LO MOSTO			education sheets provided	i nA	1
- }	contraindication	g Of Teroson	}		the CDC and re-offered th	e	
١	The facility mus	t develop policies and procedur	es		vaccinations.		
Ì	that ensure that		1			A	
	(i) Before offering	ng the pneumococcal each resident, or the resident's eating receives education regard	.		All residents are at a grea	tei	
1	Immunization, V	each resident, of the resident ative receives education regard departmental side effects of the	ing		risk for contracting	_	1
1	the benefits an	d potential side effects of the	1		communicable infections	of	1
1	immunization;	. : fored a pneumococcal			influenza and pneumonia	due due	
l l	(ii) Each reside	unless the immunization is	İ		to lack of immunizations		} }
1	Lmodically CDDI	Latiforcared of many	\				
1	already been	mmunized,			<b>Education of Infection C</b>	ontrol	
l	(iii) The reside	mmunized; ent or the resident's legal has the opportunity to refuse	1		Nurse and nursing staff	done	
1	immunization	and			regarding the policy of		
1	(iv) The resid	; and ent's medical record includes that indicated, at a minimum,	the		identifying immunization	n status	
	documentation	on triat molocious	1		upon admission to facil	ity,	
1	following:	resident or resident's legal	rdingt		offering influenza and	•	1
ł			rung		offering initiatiza and	tions as	
Ì	the benefits	and bottomer and			pneumococcal vaccina	5	
\	pneumococo	cal immunization, care			indicated and providin	β SecieΩ	1
1	DOSOMOSOCI	e resident entier received the call immunization or did not rece	dical		education using the Va		ļ.
1	the pneumo	COCOSI HIMITATIZZA	ì		Information Sheet (VIS	) upon	
1	contraindica	allon of refusor.	ent		request or refusal and		\
1	(v) As an ai	oner recommendation, a second	after 5		vaccinations and to re	-offer	
	pnetmocot	oner recommendation, a second ocal immunization may be given	alrei 2			16 04:10:	on sheel Page 54 of 7
1	15				Exemple to to 188	It COMMINST	Un direct to

CENTERS	FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES  [X1] PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE C	ONSTRUCTION	FORM A	02/17/2016 PPROVED 1938-0391 SURVEY LETED
······································	F DEFICIENCIES COARECTION	IDENTIFICATION NUMBER:				01/2	8/2016
		245544	8. WING	STR	EET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PE	ROVIDER OR SUPPLIER		Ì	612	49TH AVENUE NORTH		
l	CARE CENTER			MIN	PROVIDERS PLAN OF CORRECT	ION	(X5) COMPLETION
(X4) ID PREFIX TAG	SLIMMARY ST	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PAEF TAG		(FACH CORRECTIVE ACTION CAOSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE	DAYE
1/10				924	vaccinations following resid	ent	
F 334	Continued From p	page 54	F	334	education.		
	vears following th	e tirst priediffoodda.	)T	l	DNS/Designee will audit all		
		less medically confidence e resident's legal representative nd immunization.	' <b>\</b>		newly admitted residents'		
	refuses the seco	HO Militarii			immunization records for consents and completion of	f flu	
1					and pneumococcal		
	CAUDEN	MENT is not met as evidenced			immunizations per resider	nt	
					consent including the use	of	
	Based on interv	view and document review, the ensure 3 of 5 residents (R63, Residents (R63, Residents (R63), Residents (R63), Residents (R63), Residents (R63), Residents (R64), R64, R64, R64, R64, R64, R64, R64, R64	9,		Vaccine Information Shee	ts	
	R46) were offer	An alianol rooms as	\ \		(VIS) upon refusals of	10	
	and pneumoco	by Centers for Disease Control			vaccine(s). Findings will be reported monthly to the	QAPI	
	(CDC).				committee x 3 months w	 jth	
	Findings includ				follow-up to committee		
	R63 was admi	itted to the facility on 11/12/15,			recommendations.		
	according to the	ne admission too one no indicati	on				
	R63 had been	's records, there was the influence of t	128				
	had contraind	ceal vaccinations.			Corrections to deficient	oractice	\
		the tocility on 11/5/15,			will be completed by Ma	irch 8,	
	according to	the admission face sheet. After	on		2016.		
	review of H9	s records, mero tracelyed an			2010.		
	influenza vai	CCIUSIIOU Oning are part					
1	influenza se						
1	R46 was ad	mitted to the facility on 8/24/15, or the admission face sheet. After	it				
	review of R	46's recolus, front received ar	nd/or				
	R46 had be	en offered, religiously of the influ	ienza				
	or pneumo	coccai yaccinadona.	LID:KOXFI	1	Facility ID: 00166	If continuati	on sheet Page 55 of

	-uz oz USALTH	AND HUMAN SERVICES & MEDICAID SERVICES				FORM A OMB NO.	02/17/2016 APPROVED 0938-0391	
DEPARTM	ENT OF HEALTH	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	CHIM (CV)	PLE CONSTI	RUCTION	COM	PLETED	•
STATEMENT OF	- UEDICINIDIEG	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	1G			28/2016	
		245544	B. WING		DDRESS, CITY, STATE, ZIP	CODE	1	
	- SUPOLUGE			Feb AGTH	WENDE NOH I I			
NAME OF PR	OVIDER OR SUPPLIER		\	MINNEA	DOLIS, MN 55430		(X6)	
CAMDEN	CARE CENTER		<u></u>		PROVIDER'S PLAN OF CO	DARECTION ON SHOULD BE	COMPLETION	
(X4) ID PREFIX TAG	CUMMAARY ST	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFI	ix c	(EACH CORRECTIVE ACTIV ROSS-REFERENCED TO TH DEFICIENCY			
F 334	Continued From	page 55	F	334				
	nurse (CN)-A an were missing im stated they would not found any dimmunizations.  An undated face Residents direct that annually, in immunization with CDC (cent state department of this facility responsible purchased in vaccination of vaccination of vaccination of vaccination of vaccination of vaccination of vaccination resident at the CDON) stated have an impunization of vaccination of vaccination of vaccination of vaccination of vaccination resident at the CDON) stated have an impunization of vaccination of vaccination of vaccination resident at the control of vaccination of vaccination of vaccination of vaccination resident at the control of vaccination of	cility policy, Pneumococcal for Residents directed, "It is the post that each resident or their party will be asked on admission eviously had the pneumococcal and their age at the time of The records that accompany the will be used to determine a status. If there is no prior evident, the vaccine will be offered to that time."  The residents were supposed munication sheet in their individed documentation of Pneumovax and all residents. The DON further dents who did not have proof and if resident had not received and if resident had not received to the resident was supposed the resident was supposed to the resident was supposed to the resident was supposed t	of by of of of of of of of of of of of of of					
	immuniza'	tion then tesident was a cons	ent to			# anglish	ation sheet Page	e 56 of 79
	sign before	re receiving it or if they refused to	ONOUIG DE	111	Facility ID: 00186	H COURT	<b>V</b>	

						INTED: 02 FORM API VIB NO. 09	PHOΛ⊏Ω
o com a style at	INT OF HEALTH	AND HUMAN SERVICES				WAY DATE SI	JAVEY L
DEPARTME	FOR MEDICARE	& MEDICAID SERVICES	(Y2) MULT	IPLE CON	NSTRUCTION	COMPLE	TED
THE WORLD	- VERICIENCIES	(X1) PHOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDI	NG		1	}
IND PLAN OF C	CORRECTION	IDEMILIONISMA				01/28	/2016
		245544	B. WING		CITY STATE ZIP GODE		_
			<del>'                                    </del>	STREE	ET ADDRESS, CITY, STATE, ZIP CODE		ł
NAME OF PA	OVIDER OR SUPPLIER			512 4	9TH AVENUE NORTH NEAPOLIS, MN 55430	=	
				WIN	THE PROPERTY OF COURSE	NC	(X5) COMPLETION
CAMDEN	CARE CENTER	OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF COMMENT (EACH CORRECTIVE ACTION SHOUL (EACH CORRECTIVE ACTION THE APPRO	D BE PRIATE	DATE
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENT REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPRO DEFICIENCY)		
				334		ļ	i
	Continued From	page 5 <del>0</del>	1	30-1			
F 334	Continued Loss	page oo tatement that risks and benefits	}				
ļ	had been review	ed.	F   F	353	F353 (F)		\
C 052	Laga antal SUFFI	ICIENT 24-FILLING TOTAL	'   '		·		
555 <del> </del>	I HEH ONDE I PL	11 12	1	}	Staffing numbers are revie	wed	
ا=ی		restant nursing staff to		1	daily for adequate staffing		
	The facility must	t have sufficient national details of and related services to attain or wheet practicable physical, mental to the services of		\	levels. PRN staff as well as	,	
\	provide nursing	and related services to shest practicable physical, mental followed by the services of each resident, a	±1,	1	scheduled staff are utilize	i to	
1	and psychosoci	thest practicable physical, that, a lial well-being of each resident, a seessments and	.5	1	scheduled starr are utilized	nts to	
1	L datamined DV I	(8210cm moson		}	fill absences, Readjustme	(1L3 LV	
1	individual plans	on care.			staff assignments are made	10 111	
	The toolike mit	st provide services by sufficient	}		accordance with resident		Ì
}	I he facility inc	ch of the following types of	na		needs.		
1	personnel on a	ch of the tollowing types of 24-hour basis to provide nursir doute in accordance with reside	nt l				
	care to all resi	a 24-hour basis to provide mana dents in accordance with reside	1		All residents are at risk d	ue to	
1	care plans:		1		deficient staff numbers.		
	l l	waived under paragraph (c) of the	ain		deficient stail notificers		}
1	Except when	sed nurses and other nursing			Staff were educated on	policy	ļ
}	nersonnel.				and procedure for suffic	ient	
1	1	waived under paragraph (c) of i	this		· · · · · · · · · · · · · · · · · · ·		
	Except when	racility must designate a licensed active on each to	<b>d</b>		staffing.		Ì
1	section, the i	acility must designate a licontent ve as a charge nurse on each to	uror		Staffing numbers are re	viewed	
	duty.	· · · · · · · · · · · · · · · · · · ·	1		Staffing numbers are to		
1	1		1		daily for adequacy and	tennant	
		IREMENT is not met as evident	bec		appropriateness of ass	iBullistir.	
	This REQU	BUCKIE 141 12 1104			Corporate HR represer	<b>Utative</b>	1
ţ	by:	observation, interview and docur	nent )			5/25/10	
•	review, the	bservation, interview and incent facility failed to ensure sufficent resided to meet the individual	<b>,</b> \		and 2/26/16 and cond	lucted an	
1	staffing was	S Provided to more pan R15.	R12, 1		and 2/26/16 and com	ddress	
\	needs of 5	of 6 residerns (116 mith repositi	onina. '		open staff forum to a	duioss disse war	ا م
1	1 R211 who i	required assistance the ter care Ti	nis had		staffing concerns; fin	aruRz Mer.	
{	skin care,	pressure ulcer, catheter care ial to affect all 52 residents who	resided		reported to facility		
1	I the botern	Mar to allow and		1	Teporte-		

in the facility.

n	rda ATME	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES		LE CONSTRUC	TION	PRINTED: 07 FORM AF OMB NO. 0 (X3) DATE S	938-0391 SUBVEY	:
_	CNITERS	HON MEDIO!	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	i			n/2016	:
STAN	ATEMENT OF ID FLAN OF C	DEFICIENCIES CORRECTION	IDENTIFICATION	B.WING_				B/2016	•
		'	245544	B. WING	STREET ADDR	ESS, CITY, STATE, ZIP CO	DE.	1	
		OVIDER OR SUPPLIER		}	456	ENUE NORTH LIS, MN 55430			
		CARE CENTER				COMPER'S PLAN UP CON	RECTION SHOULD BE	COMPLETION DATE	
-	(X4) ID		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CHOS	DEFICIENCY)			
1	PREFIX	REGULATORY OF	LISC IDENTIFY THE	_	adı	ministration. A fam	ily council		
1				FS	953 me	eting continues to	be held		
1	F 353	Continued From	page 5/	1	an	nually.			1
		   Findings include	:		Fi	ndings will be repor	rted	1	
	}	1	and to provide	Ì	\ m	anthly to QAPI com	ıWıtter		
	<b>\</b>	I ANDEDDISTO CHI	Calle Jament and		W	ith follow-up to cor	mmittee		}
	1			\	r	ecommendations.			1
	1	residents (no-	of interventions, for 1 of 2 who had non pressure related			Corrections to defici	ient practice	1	1
	1	skin issues.	The socility tailed to	. \		will be made by Ma	rch 8, 2016.		\
	1		The facility failed to ely reassess and provide care a prote healing for a facility acqui	red			•		1
	1	services to pro	ely reassess and provide care of the provide care of the provided and	wed					
	1	with pressure	ulcers.			•			1
	1	0.40r E915'	The facility failed to provide	1 0					\
		appropriate i	The facility falled to provide ndwelling Foley catheter care to R15) in the sample reviewed will heav catheter.	th					
	1		oley catheter.	1				1	1
	\ \	i i		from	l I				1
	\	D40 was 01	Selven commun.	tu ba	1				
		8:54 a.m. 10	m R12 was sitting in a Broda Ci	in it				\ \ \	1
:	1	l w. – dining l	(8000) . (XIAX (2.100)	)% (lli— i	1				1
	1	to room ar	m. nursing assistant (NA)-critical and put upper dentures in R12's not hesive. NA-G returned R12 to the size of th	ne					\
	1	1 660 0 1 1 540	1100100	1	1				1
	\	- At 9:15	a.m. 1412 Suure	ים דע					
	1	100M	z a.m. R12 remained sitting in th	IG IV					1
		room asi	eep, 3 a.m. R12 sitting in the TV room	M SWake	,				}
		and,	2 a.m. R12 still sitting in TV roof	ΠI.				uation sheet Pa	ge 58 of 79
		sleeping	recurred on 1/2//	16, at	1 F	acility ID: 00166	If continu	usion sucer i e	·u-
	1	i Le ons	Sel various	vent ID:KOX	311				

						PRINTED: FORM ! OMB NO.	/ PEROVED	
	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES				ATAC (eva)	SURVEY	
DEPAR	RS FOR MEDICARE	& MEDICAID SERVICES	(X2) MULT	IPLE CO	NSTRUCTION	COM	PLETED	
	<u> </u>	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	VG				
AND PLAN	OF CORRECTION	155,000					28/2016	
		245544	B. WING.	STREE	T ADDRESS, CITY, STATE, ZIP CO	DE	}	
	F PROVIDER OR SUPPLIER		1	E19 A	ATH AVENUE NORTH			
1			Ì	MINI	IEAPOLIS, MN 55430	OFECTION!	(X5) COMPLETION	l
CAMDI	en care center 	TO STATE OF THE ST			PAOVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION)	SHOULD BE	OATE	\
(X4) IC PREFI TAG	X (EACH DEFICIENT	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPHOPHIA =		
\			F	353				
F3	53 Continued From )	page 58	1.					
\ ' '	12:45 p.m. R12 s	litting in TV room sleeping						1
1	- At 12:57 p.m. a	Bred hootiest prod		\				\
1	(LPN)-AITHIZII	Dig Lub that morning.	1					1
1	I PN-A verified P	ice H12 got up that mount or 112 had not been laid down or since H12 got up that morning.		1				1
1	repositioned yet	Since it is a sales lunch staff		\				1
-	I PN-A stated, i	TIZE THE BAD WANT FOR TOL	J[ ]L					
1	hours and 15 m	y [R12] down. "R12 works inutes without being repositions IA G wheeled R12 to bedroom	;u.	ļ				1
1	At 1;10 p.m. N	MACI MILOSIA	1	į				}
}	l and.	LALA LI placed B12 in B	EZ					1
1	- At 1:16 p.m.	VA-G and NA-H placed Hamber of Renical standing lift) and stood Research and said "h	ne is		1		1	- }
Ì	I up. NA-H pulle	unizapana Requested	١					1
1	dry in back and	the is dry incontinence brief. R12's						1
1	NA-H remove	e intact, coccyx was red but	. I					1
1	blanchable. R	e intact, coccyx was found 12 had been incontinent of stoo 11 washed B12's bottom and	"					1
		12 had been incortained. -H washed R12's bottom and rincontinence brief.					1	l
1	applied a new	A IODITAL TO	om					Ì
{	During contin	uous observation on 1/28/16, fr	ours					1
- 1	7:30 a.m. to	being repositioned.						- 1
1	and 16 minut	, R12 was lying in bed,						1
1			±y,					1
Ţ	- At 7:45 а.п	n. R12 in dining room, n. RA-A assisting R12 to eat						1
ţ	- At 8:52 a.n	J. NA-A gasiamia	1					1
1	breakfast,	n. R12 sitting in TV room,						1
1	- At 10:30 a	Im, h 12 to the to chower room	by					1
1	- At 10:40 a	I.m. HIZ land charked and,	ļ					Ì
1	NA-A to De	repositioned and choose a repositioned and choose a.m. R12 stood up in standing li	wayed	I				Ì
1	NA-C and	NA-F pulled parks and briof was	wet.					
1	Lincontinent	CO Diser, recommend 1 DVI VA	rified	<u> </u>			1	
. }	R12's right	t gluteal fold was red. LF 1940 tot been repositioned since R12 tod R12's skin and indicated	got up.				ation sheet Page	59 of 79
ļ	LPN-A che		nt ID:KOXA		Facility ID: 00168	if continu	AUDII BIICGET - BE	
		Eve	ינול וח: ערטעני	••				

						FORM A	02/17/2016 APPROVED	
		AND HUMAN SERVICES				<u>. ON BMC</u>	0938-0391	
DEPARTM				10) E CC	DNSTRUCTION	(X3) DATE	PLETED	
CENTERS	FOH MEDIOAI IE	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULI	NG		1	1	
STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDENSOFT ELEMENT IDENTIFICATION NUMBER:	A. BUILUI	.,,		01/	28/2016	
AND I Day o.	,		B, WING		- TO A CORE		20,2010	
		245544	1———	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		l	
NAME OF PE	NOVIDER OR SUPPLIER		ţ	512	49TH AVENUE NORTH			i
1				MIM	NEAPOLIS, MN 55430	TION	(X5) COMPLETION	
CAMDEN	CARE CENTER	TOTAL CICIENCIES	lD ID	-	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO	ULD BE	DATE	l
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)			
			F	353				
F 353	Continued From p	page 59	1	1				1
l l	blanchable.		1	1				1
1	- and Adi-imputed [	Data Set (MDS) dated 11/3/15,	}	1			1	1
	Indicated R12 W	Data Set (MDS) dated Triblings of taily and activities of daily	<b>\</b>	1				l
	required assistar	as severally cognitively make the series of daily and bladder and						1
	living, was incon	nce with all activities of day tinent of bowel and bladder and opment of pressure ulcers.	}					1
	at risk for develo	philent of prooper	, )					1
	The Pressure U	lcer Care Area Assessment date	ea   .d.					1
1	11/3/15, indicate	lcer Care Area Assessment ed pressure ulcers were triggere envired extensive assistance wit	h					l
1	I hecause H1216	lawed bearing	}				Ì	l
1	bed mobility, tre	equent urinary and bower nd identified risk for pressure ul	cer					\
	development.							1
	1	us to about ad staff R12			\			- 1
	Care plan print	ed 1/28/16, instructed staff R12 e at risk for skin breakdown rela	ted					1
	continues to be	at tisk to skill shappinence impa	ired					- 1
	to Distoly of his	essure ulcer, incommone in us otropic drug use and diuretic us ottopic drug taff follow repositioni	e.				}	1
\ \	Interventions	otropic drug use and didicioning the staff follow repositioning provide moisture barrie	r l					l l
1	schedule per	nursing, provide mach check and					Į.	1
1	and perform F	orreside doming owner as order	ed,				1	}
\	change and a	s needed, would care as ange before breakfast after lund and as needed.	ch			٠	l L	}
	and on round	ange pelore broakt and as needed.	1		, I		1	<b>\</b>
1	and on	themment (	Sheet		{			1
	The undated	Nursing Assistant Assignment ( aff check and change before	Ì		1		\	1
1	instructed sta	aff check and change botone or lunch before bed and on rour the appendix Reposition during	nds					į.
1	breaklast at	er lunch before bed and different t as needed. Reposition during	cneck				}	1
l l	and changes	3.	1				}	\ \
		and by doctor on 1	/6/16,					
1	The Physici	an Orders signed by doctor taff to reposition R12 in wheelch	ıair					1
\	1 hace b	ALIFE AND HOUSE PORTS.	skin		\			1
	every two ii	uttock twice a day.	Ì		}			ļ
1	040, 119.112	Docord date	d Jan					
1	The Treatm	nent Administration Record date ed R12 was to be "REPOSITION	I IN			If continual	tion sheet Page	60 of 79
	16, indicate	ed R (2 Was to bo (12	I ID:KOXR	11	Facility ID: 00188			

	-VIT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			FORM A OMB NO.	02/17/2016 APPROVED 0938-0391 SURVEY	:
DEPARTM	ENT OF HEALTH	& MEDICAID SERVICES  (XI) PROVIDER/SUPPLIER/CLIA	O'COL MILITIP	LE CONSTRUCTION	COM	PLETED	!
STATEMENT OF AND PLAN OF	CUEEKALNOIDO I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			28/2016	
		245544	B. WING	STREET ADDRESS, CITY, STATE,	ZIP CODE		I
	numu IEG		1	FAR ANTH AVENUE NORTH			
N .	OVIDER OR SUPPLIER		1		- OPEOTION	(X5) COMPLETION	1
CAMDEN	CARE CENTER		1 10	PROVIDER'S PLAN	OF COMMECTION	COMPLETION	1
(X4) ID PREFIX TAG	SUMMARY SY (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE			1
F 353	10/13/14)." The con 1/27/16, and son 1/2	oox for the AM shift was left blandsigned 1/28/16.  Sesue tolerance requested but not as not been laid down or the since he got up this morning."  Non 1/28/16, at 10:21 a.m. NA-2] up at 7:30 a.m. [R12]'s skin is urther stated, "[R12] has not been day. We are so short we cannot toileted or repositioned."	A S S D T				
	cognition was physical assistation, the addition, the wheelchair for the common of the common of the light of	intact and R21 required extensistance of two staff with dressing sters and personal hygiene. In MDS indicated R21 used a personal material or mobility.  at 4:48 p.m. during interview whitely there was enough staff available there was enough staff available there was enough staff available there was enough staff available there was enough staff available there was enough staff available there was enough staff available there was enough staff available the responsible to the residual to the find the light on at around sone had come into the room turing at 10:25 p.m. and had told here would take care of it. The night would take care of it. The night pack until about 11:30 p.m. Reside had reported the concern to inursing.	nen able ce you ident vious 10:00 med the staff did	Facility ID: 00166	If continu	Jation sheel Pag	je 61 ol 79

PRINTED: 02/17/2016 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES
STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

AND HUMAN SERVICES

& MEDICAID SERVICES

(X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY | COMPLETED

(X1) PROVIDER/SUPPLIER/CLIA | A. BUILDING | A. BUILDING | COMPLETED

4516			B. WING			01/28/2	2016
		245544	EL. VERVO	STA	EET ADDRESS, CITY, STATE, ZIP CODE		ļ
NAME OF PE	OVIDER OR SUPPLIER	<del>_</del> -		512	49TH AVENUE NORTH		1
				MII	NNEAPOLIS, MN 55430		
(X4) ID	CARE CENTER SUMMARY STA	ATEMENT OF DEFICIENCIES	ID PREF	<del>'                                    </del>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIES.)		(XS) OMPLETION OATE
PREFIX	(EACH DEFICIENC REGULATORY OR I	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAC	3	DEFICIENCY)		
F 353	Continued From p	age 61	F	353			
	R13's admission N cognition was sev extensive physica	MDS dated 11/9/15, Indicated erely impaired and required I assistance of one to two staff december tolleting and personal					
	a wheelchair for r						
	asked if he felt in to make sure you	31 p.m. during interview when ere was enough staff available get the care and assistance young to wait a long time resident for when they are ready for	u				
	resident had inta extensive physic dressing, toiletin hygiene. In addi a wheelchair for						
	asked if he felt to make sure you need without he stated, the faci	9:11 a.m. during interview when there was enough staff avallable ou get the care and assistance yaving to wait a long time residently was understaffed and at time or resident hollering for help as were not being answered.	you l				
	oognition was physical assis dressing, toile	y MDS dated 11/26/15, indicated intact and required extensive tance of two staff with bed mobiting and personal hygiene. In MDS indicated R46 used both and walker for mobility.	lity,				

wheelchair and walker for mobility.

						EO¤M A	02/17/2016 \PPROVED	
	ENT OF HEATTH	AND HUMAN SERVICES  8 MEDICAID SERVICES				OMB MO.	0938-0391 SUBVEY	
DEPARTM	ENT OF REALTH	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONST	RUCTION	COM	PLETED	
	c nEEICIENCIEO - I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IG			1	
AND PLAN OF	CORRECTION	DEMINION	_				28/2016	
		245544	B. WING	OTOECT !	ADDRESS, CITY, STATE, ZIP CODE			
	OF CHOPLIES		l l	K12 49Th	I AVENUE NORTH			
	ROVIDER OR SUPPLIER			MINNE	ADOLIS, MN 55430		(X6)	
CAMDEN	CARE CENTER		7 10		PROVIDER'S PLAN OF CORRE	ONFO BE	COMPLETION	l
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEPICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI	×	(EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPHIATE		
			_	353				1
F 353	Continued From F	page 62	,	333				\
F 333	asked if he felt th	ore was enough staff available and the care and assistance yo	u l	1				
	to make sure you	get the ctar and time resident						1
	I need Without Hev	IN AVAILABLE THE	i i					1
	myself because	es have to wait. Thave well I had to wait. Weekends are th		}				
1	worse."		1					1
		u = 1 - E-olod	l	1				
1	R34's quarterly	MDS dated 10/30/15, indicated	ed (	}				
	F(34 had moder	ately impariod on a	1	1				Ì
\ \	lotal dependent	octivities of	l					1
1	l sur Primer in G	annon, no mee		Ì				
ļ	used a wheelch	ISH IOI HIGHWAY	1	į				}
	On 1/26/16, at	2:50 p.m. during interview when	n   Ne				1	- }
	asked if he rem	Illere was one and aggistance	you	l				- 1
\ \	to make sure	you get the long time reside	ent					}
	ctated Without I	for 1 hour to get out of bed."		1				Ì
	}			ļ.			l	*.
1	المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم المعالم	led 14 day MDS dated 1/6/16,	l					1
l	R15's soneuu	nition was intact and resident	,	Ì				}
	required exte	insive privators and	·					\
	staff with dre	ssing, tollow the MDS indic	ated					1
	personal ny9	piene. In addition, the Mac wheelchair for mobility and had it stan in range of motion on bo	a h the					1
\ \	ta a mail operat little	nitalilli ili lange vi	יווכ					\
.	l Hoper and IC	MRL AVII CHILIPAGE	1					
1	On 1/28/18	at 4:49 p.m. during interview w	hen				1	Ì
	asked if ne	tell more the save and assistar	nce you					ļ
	to make su	re you get the out of the time res	ident l					
	UBBQ MITUO	ut liaving to muld loove the ITA	/ in the					
	∤ room. Whe	INA had book a line ineed	to help i					
	tray would	en NA had been asked to tener state, "I don't have time. I need ble." Resident also stated some	of the			( continua	alion sheet Page	63 of 79
·· }	other peop	Ne. Mesident dies state	ot ID:KOXR1	11	Facility ID: 00166	• • • •		

DEPARTMENT OF HE	ALTH :	AND HUMAN SERVICES				FORM. OMB NO.	02/17/2016 APPROVED 0938-0391 E SURVEY
CENTERS FOR MED) TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	<u> JAHE</u>	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CI	ONSTRUCTION	COM	Prejen
ND PEAN OF COUNTRY (1911)			e, WING				28/2016
	•	245544	B, WINC	STRI	EET ADDRESS, CITY, STATE, ZIP CODE		1
NAME OF PROVIDER OR SU	PPLIER			512	49TH AVENUE NORTH		ļ
				MIN	INEAPOLIS, MN 55430		
CAMDEN CARE CENTI	EH		T ID	┸-┯-		OTION OULD BE	(X5) COMPLETION
(X4) ID SUMN PREFIX (EACH DE TAG REGULATO	IARY ST FICIENC ORY OR	ATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	IX	PROVIDER'S PLAN OF COMME (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	ROPRIATE	DATE
a couple he	facilit Id bee	y were quite mean and thought n fired.		353			
had severe extensive transters functional wheelchall on 1/26/1 family me enough set the care having to never set afternoon it. They be switching to extensive the care afternoon it.	ual MU ely imp physic rom be r for m 6, at 1 mber, taff av and as wait a e staff n. The nave g g aides	os dated 11/3/15, indicated R12 paired cognitive skills, required all assistance of two staff with ed to wheelchair and used a pobility.  1:20 a.m. during interview with a when asked if they felt there we allable to make sure resident gesistance he needed without allong time family member states at shift change. I am here every y need to re-think the way they could aides. They have started a every month. This causes him when they approach him wrong what is going to happen."	a assist				
was wo stated, once in because planning -At 10 called	7/16, a rking t "Hope a while e I hav g on t 30 a.m in to c	t 7:19 am registered nurse (RN) to 7:19 am registered nurse (RN) he North medication cart, and fully not for long, I have to fill in le, but, it takes me a long time ve to read everything, and I was his today."  1. LPN-C, verified she had been over short staff.  at 8:29 a.m. LPN-D stated "Usu hort staff here but today we are	n't				

		AND HUMAN SERVICES				OMB NO.	0938-0391	
DEPARTME	NT OF HEALIH	* AFDICAID SERVICES			- ALIATION I	(X3) DATE	SURVEY	
CENTERS	O <u>R MEDICAHE</u>		(X2) MULT	INTE COI	NSTAUCTION	COMP	100	
IT OF	noticiENCIES 1	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	NG		1	i i	
STATEMENT OF C	OARECTION	IDERTIN IOTA				01/3	2B/2016	
		*******	a, WING		719 CO			
		245544	<u> </u>	STRFE	T ADDRESS, CITY, STATE, ZIP CO	DL		
	VIDER OR SUPPLIER		į.	E 19 4	ATH AVENUE NORTH			
NAME OF PHO	MIDEM OLL GOL L EVEN			AFIRA	IEADOLIS, MN 55430			}
CAMDENC	ARE CENTER					RECTION	(X5) COMPLETION	1
CAMBER		TO DESICIENCIES	ID		PROVIDER'S PLAN OF CON- (EACH CORRECTIVE ACTION !	SHOULD BE SPROPRIATE	DATE	1
(X4) ID PREFIX YAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ACTION DEFICIENCY)			1
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	_	- 1	F	353			\ \	1
F 353	Continued From p	page 64	1	l				1
			į	1				l
			1	ļ				1
\ \	are short of one	nurse and I am passing	1	1			ł	1
1	medications and	the nurses are doing the		1				į.
l l	treatments." Who	en asked if staffing was a	Ì	1			1	1
	problem SC state	en asked it stating was a ed "Usually on PM's we have a see shifts but we are able to cov	er	1			· ·	1
	problem with nu	ed "Usually on Fixe we have eed "Usually on Fixe are able to covered to be suited t		1			ļ	1
- 1	them as the other	ree shing but we kilo an or nurses would either work or me are diving bonuses so	.	1			1	ì
l l	Leophles of DICK	ND St Me or a sum a	}	ļ				
1	it's always cover	red."	n l	1			1	1
1	At 8:50 a.m. L	red." PN-A stated he had worked both decad it was big mess, becau	se	1				1
į į	i hallways yesteri	day and it was big		- 1			<b>\</b>	<b>\</b>
1	they were short	'	1				1	1
1	-At 9:00 p,m, N	A-C stated the today she was the	uet					1
1	assigned to the	West Hallway towny	ds				l	l
į	floating around	and neight over alled in sick.	1				1	1
į	help, because	those two aides called in sick.  NA-A stated, "[R34] has not be	en		1		1	1
1	- At 10:21 a.m.	NA-A stated, friend we cannot	ot (					1
1	repositioned to	day, we allow a still aned to	d I				1	}
1	get people up	or tolleted of topodhore It is ba	d."				1	1
l l	you yesterday	If was not too bear an hard wor	rking				l	1
ļ	At 10:36 a.m	1. 194-1 States and get everything	a 1				1	1
1	with just four	people we barrier get	1em				1	1
ŀ	done, We car	JUOL Lehosing in book an log in 1 st	T)		Ì		ļ	\ \
1	as we should	. An entire halfvay	try to		1			1
1	tired of every	but it makes the residents life	1					1
	do what i car	Dut it thates an	1				1	1
١	miserable wi	Jeu we site affort.	ort.		Ì		1	1
l l	- At 10:40 a.i	m. NA-O stated, We normally ha	ve six		\ 		i i	- 1
1	We are dow	n three people. The other than the other	ner		1		1	1
l	to seven aid	95. I am make sure	1				ļ	1
<b>\</b>	hallways and	turned and toileted. It is not wor	king.		}		1	1
·	everyone is	TULUO SIIG TOTOGO "	1		1		1	ļ
1	We are late	on just about every fust taking	a		1		1	ļ
1	- At 1:00 p.i	n. NA-A stated, the are here	ə, il's		<b>\</b>		ļ	
1	break As yo	OU KNOW WHEN YOU SET THIS WAY S	365." I		1		1	
1	crazy, it'd b	e dillerent in you to facility was	always		\			
1	- Al 2:30 p.	m. NA-C stated the facility fraction make and it was even hard to make	sure	L		If continual	tion sheet Page	65 of 79
1	short staffe	ed and it was even that	t ID:KOXA	11	Facility ID: 00165	1, 40,		
		CANILL CHANGE						

			- 4D/10EP				PRINTED: FORM A OMB NO.	/bhK∩∧⊏n	
,	SCOARTN	MENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				NA DATE	SURVEY	
1	DEFANTS			(X2) MULT	IPLE CONST	FAUCTION	COM	LETEO	
	Commence of the last of	AE AEEKCIENCIES I	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILON	NG		1	ŀ	
o A	ND PLAN OF	CORRECTION	IDEIALII IOMI IOM				01/3	28/2016	ı
			245544	B. WING		OTATE 7/P CO			
					STREET	ADDRESS, CITY, STATE, ZIP CO			
_	NAME OF P	PROVIDER OR SUPPLIER		İ	512 49T!	AVENUE NORTH			]
				]	MINNE	APOLIS, MN 55430	DECTION	(X5) COMPLETION	1
١	CAMDEN	CARE CENTER	10/50	T ID		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION	1
ŀ	(X4) ID PRÉFIX	SUMMARY ST (EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	EX.	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPHOPHIATE		-
١	TAG	HEGODYION ON						1	1
١		<del> </del>		, r.	353			l	}
١		Continued From F	nade 65		303				1
	F 353			1	ļ			1	1
	l l	all resident cares	, tolleting and allowering NA-C stated at times it is even and lights answered because it	. }	}			}	1
		lights was ushed	NA-C stated at times it is call lights answered because it to of resident's had a lot of	. ]				}	1
		was heavy and a	lot of resident's had a lot of		}			· ·	1
	1	needs yet there	was not enough staff in the	d l	1			}	}
	}	facility to meet re	for bad had modelless	_ }	Ì			1	1
	1	even taking brea	esident needs. We had had not ak was a problem and had not eak for the shift and that was no	t \				1	
		even taken a bre	Bak tot the start the		{			}	1
	\	good.	ther-D, stated the facility no long	jer	\			ļ	Ì
	1	At 2:30 p.m. of	her-D, stated the tacking the here, because they do not have the stated they were talking about		\			1	1
	1	nad residiative	here, because they do the about at stated they were talking about	<b>'</b>				l I	1
	}	bringing it back		nt \	Ì			Ì	1
	1	- At 3:06 a.m. N	JA-D stated she did not work a l	i ni E	1				1
	1	at the facility bu	IA-D stated she bid not work a like times when someone called the staff and a	1				Ì	l
		the staffing wo	uld if y to replace the group.	1	į.				1
	1	times, would ju	ist end up spirate and were shie	to !	1			1	1
	1	When asked !!	resident care needs were do NA-D stated "sometimes we do	the	1			}	- 1
	1	be completed best we can."	IV-D state	ł	\				\ \
	1	Dest we carr	NA-E stated since the new	ama	1			ł	1
	- 1	administrator	NA-E stated since the flow and director of nursing (DON) can be a some with staff from the staff	10   10	1			1	<u> </u>
	1	to the facility,	and director of hursing (borry they had come with staff from the that staff were always report	ina	1			(	1
	1	other facility	they had come with star report and that staff were always report I staff who had been at the facili	ty to	1			1	- 1
	\	the aides and	stall with had decided to quit					1	1
	1	managemen	and stail had been why the	ļ				l I	1
	}	because of u	ne issues and that was why he ratting issues. NA-E stated most facility was under staffed and	tot					1
	1	tacility riad s	facility was under staffed and	. aara				ļ	1
		ING fillie file	facility was under station and it did not care about the resident and the some resident's requ	CSI O				<b>\</b>	1
	1	needs like fo	or example some resident's requestance and needed two to three	ee l					1
		extensive as	or example some readow to three sistance and needed two to three sistances. NA	Ē				\	1
	1	staff for care	es yet was cutting into the mas st	ill !				-	1
		gave an exa	ample of whether to leave at a	round 🚶				-	}
	1	l noing on an	IG SIZIT WELL HOUSE WALL WALL	. 1					}
	}	9:00 p.m. a	nu at that this are to had and to	vo stati					Ì
	1	residents s	till up waiting to go to cook and to leave for the night yet one s	tatt in					66 of 70
	1	Mete gaver	nni aine to mor			Facility 10: 00168	If continua	tion sheet Page	, 00 0110
	<u> </u>	tile wing to	- Vanione Obsolele Even	LID:KOXF1	1	I DOWN I I			

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES  & MEDICAID SERVICES				(VO) DATE	= SURVEY	
CENTER	S FOR MEDICADE	THE PUBLICATION OF THE PUBLICATI	(X2) MULTI	IPLE CONSTAL	JCTION	COM	PLETED	
	<b>マロレモとじけいいだり しょり</b>	(X1) PROVIDENSOFT CAMBER:	A. BUILDIN	1G		1	28/2016	
AND PLAN O	F CORRECTION		B. WING_				20/2010	
		245544	L	STREET AD	DRESS, CITY, STATE, ZIP C	,QUE	į	
NAME OF I	PROVIDER OR SUPPLIER		1	512 49TH	VENUE NORTH			
1	N CARE CENTER		1		PROVIDER'S PLAN OF CO	RHECTION	(X5) COMPLETION	l
CAMDE		ATEMENT OF DEFICIENCIES	ID PREFI	, (I	PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION EACH CORRECTIVE ACTION OSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	DATE	1
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			F	353				1
F 353	3 Continued From F	page 66	1					1
, 55	When asked if st	aff was able to thou time and	\					1
	needs timely, NA	is feet a while for staff to come	,					1
\	residents flad to	d at times residents were not	1	1			}	1
}	toileted or reposi	Moried on a famous conversation	n \					1
	directed by the p	har of care						1
	NA-E appeared	tant than the money yet						
}	manadement di	a nut sec it all beenice RN		l l			}	}
1	At 3:22 p.m. a	n outside agone, burn over and	I II					1
-	LIL EAVA TO BROW	WIID to 90 .	10					1
1	ensure continu	ity of care."	1	1				1
1	1							\
1	Document revi	nae noide dutina a	,					
	actual staffing	and stalf postings.	up." }					1
	On 1/25/16, da	and staff postings. ay shift, group 1 was a "split gro waning shift, group 1 was a "spli	t	l		•		l
\	1 On 1/26/16, e	Actually stands	1					\ \
	group" as the	re was one INA call III. lay shift, RN/MDS nurse and hei lay shift, RN pulled to medical	alth				i i	1
1	unit coordinat	lay shift, RN/MDS hurse and he for (HUC)/LPN pulled to medical trop call in Evening shift - two N	1As					1
1	cart due to nu	tor (HUC)/LPN pulled to filed by the call in, Evening shift - two has evening shift split group 1.	1				Ì	1
}	( called in so u	De Cyoling -					\	1
	Receptionist	day HUC/LPN call in, /TMA pulled to medication cart of the Most pulled to medication car	rt	ļ				1
	West, LPN o	Olf AA car banga This Mye caller	din I				1	1
-	North/East,	split group ", and seed), working the	hree				1	1
l	Non vvesi	everyone sharing everyone in	ļ				\	1
1	building."		actual					\
}	The facility	failed to provide the requested a ets for 11/11 through 11/15/15	\	Ì				\
1	statting sne	on 1/29/16, at 3:02 p.m.	orded					1
	On 11/10/1	5, indicated a transport hours) the	at are		1			\
	in RN ma⊓	ager of Living the	eet. )					1
1	not reflecte	d in the actual asset the BN col	verage				boo! Dene	67 of 79
	listed on th			1 Fa	cility ID: 00166	li continu	ation sheet Page	
I _	10.00	Ever	nt IO:KOXFI		•			

PRINTED: 02/17/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES YAVAUR ATAG (EX) (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING\_ 01/28/2016 B. WING. 245544 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 CAMDEN CARE CENTER (X6) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY TAG F 353 Continued From page 67 F 353 i On 11/125/15, no RN coverage. On Saturday 11/28/15, no RN coverage. On Sunday 11/29/15, no RN coverage. On Sunday 12/27/15, no RN coverage and LPN double shift. On Sunday 1/17/16, planned split group 1 on both a.m. and p.m. shifts. On Sunday 1/24/16, MDS RN planned as South hallway nurse. The staffing pattern could not be reviewed as the staffing sheets for 11/16 through 11/24/15, were missing as well as the staff postings. In addition, the staffing schedule and postings were missing for 11/25 through 11/28/15. On 1/28/16, at 2:57 p.m. the staffing coordinator, human resources person and the DON were interviewed for staffing. The staffing coordinator explained the usual staffing: South - Day shift: one nurse and three NAs, South/East Evening shift: one nurse and three NAs. West - Day shift; one nurse and two NAs, North/West Evening shift: one nurse and two to three NAs (+ pick up residents on EAST), North/East - Days; one nurse and two NAs, Evenings: one TMA and two NAs and, Night shift: one to two nurses and two to three NAs for the building. Further explanation of a split group, indicated when there was not enough staff to fill the staffing plan, so staff assigned to other groups would split group 1 (residents in addition to their assignment). On 1/28/16, at 1:20 p.m. the HR director was interviewed and indicated the facility had a turnover rate of 4% last month and that they are

actively advertising.

CENTERS FOR MICEUTON (XI) PROVIDERS (XI) PROVIDERS (XI) PROVIDERS (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDER CARRON NAMES (XI) PROVIDERS (XII) PROVIDERS (XII) PROVIDERS (XIII) PROVIDERS	>~no¤TM <b>E</b> NT	OF HEALTH /	AND HUMAN SERVICES			ON	FORM AP FORM AP MB NO. 09 (X3) DATES	938-0391 UBVEY	
CAMDEN CARE CENTER  SUMMANY STATEMENT OF DEFICIENCIES  PALE ID  (CAMDEN CARE CENTER  SUMMANY STATEMENT OF DEFICIENCIES  SUMMANY STATEMENT OF DEFICIENCIES  (CAMDEN CARE CENTER  SUMMANY STATEMENT OF DEFICIENCIES  SUMMANY STATEMENT OF DEFICIENCIES  (CAMDEN CARD DEFICIENCY MUST BE PRECEDED BY FULL (CACH DEFICENCY MUST BE ACCH BY FULL	CENTERS FOR	CIENCIES	COLUMN TERMINATION OF THE PROPERTY OF THE PROP	A, BUILDING			01/28/2016		
This REQUIREMENT is not mel as evidenced and active to ensure a dejat or on ursing on a full time basis.  This REQUIREMENT is not mel as evidenced by:  Tack and the director of nursing may serve as a charge nurse only when the tacility has an average daily occupancy of 60 or fewer residents.  This REQUIREMENT is not mel as evidenced by:  Tack and the director of nursing may serve as every dight consocitive hours a elight consocitive hours per day, seven days a week, and did not have an RN waiver.			245544					Ì	
AMDEN CARE CENTER    SUMMARY STITEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH DEFICIENCY) OF LSC IDENTIFYING INFORMATION)    F 353	oc poovi0	e oa suppliea		\	649 4	ATH AVENUE NORTH			
DOWN TO SUMMARY STATEMENT OF DEPICIENCES BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY MUST BE PRECEDED BY STULL (EACH DEPICIENCY)  F 353  Continued From page 68  On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, revealed they currently are thiring, as a lot of nurses have called and asked if the facility pays less than other facilities. F 354 (F) RN coverage 8 hours daily 7 days a week is provided  All residents are at risk due to lack of professional nurse coverage.  F 354 (F) RN coverage 8 hours daily 7 days a week is provided  All residents are at risk due to lack of professional nurse coverage.  RN managerial staff and staffing coordinators were educated on the regulation requiring RN coverage at least 8 hours daily 7 days per week  This RECUIREMENT is not met as evidenced by: Based on interview and document review, the lacility failed to provide a registered nurse (RN) eight consecutive hours per day, seven days a week, and did not have an RN waiver.							RECTION (X5)		
Continued From page 68  On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, revealed they currently are hiring, as a lot of nurses have called and asked if the facility was hiring but they did not show for the facility was hiring but they did not show for the interview process. Per the DON the facilities.  F 3544 483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, SS=F FULL-TIME DON  Except when waived under paragraph (e) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.  Except when waived under paragraph (e) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility lailed to provide a registered nurse (RN) eight consecutive hours per day, seven days a week, and did not have an RN waiver.  F 354 (F) RN coverage 8 hours daily 7 days a week is provided  All residents are at risk due to lack of professional nurse coverage.  RN managerial staff and staffing coordinators were educated on the regulation requiring RN coverage at least 8 hours daily 7 days per week  Staffing schedules are reviewed daily to ensure adequate RN coverage is maintained within facility. Findings will be reported monthly to QAPI committee x 3 months with follow-up to committee recommendations.	(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORNECTIVE ACTION APPRO	D BE	DATE	
the director of nurses have called and asked if hiring, as a lot of nurses have called and asked if the facility was hiring but they did not show for the interview process. Per the DON the facility currently pays less than other facilities.  F 354  SS=F  F 354  F 354  SS=F  F 354  F 354  F 354  F 354  F 354  F 354  A83,30(b) WAIVER-RN B HRS 7 DAYS/WK, FULL-TIME DON  Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a day, 7 days a week.  Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis.  The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to provide a registered nurse (RN) eight consecutive hours per day, seven days a week, and did not have an RN waiver.	F 353 Cor	ntinued From F	age 68		353				
On 1/28/16, at 2:30 p.m. a staffing interview with the director of nursing, staffing coordinator and the director of nursing, staffing coordinator and human resources person revealed the scheduler and human resources coordinator were not aware and human resources are not aware and hum	On the hiri the introverse see the second se	1/28/16, at 2:3 director of numerical director of numerical director of numerical director of a director of numerical director of nu	as partial interview with raing, revealed they currently are nurses have called and asked in ing but they did not show for the services. Per the DON the facility is than other facilities.  ER-RN B HRS 7 DAYS/WK, is already under paragraph (c) or (d) tacility must use the services of the facility must use the services of the facility must designate a set to serve as the director of all time basis.  If nursing may serve as a charging the facility has an average of the facility has an average o	of a lars  d) of a lars d) of lars d) of lars w with r and reduler		All residents are at risk du lack of professional nurse coverage.  RN managerial staff and coordinators were educated the regulation requiring coverage at least 8 hours days per week  Staffing schedules are redaily to ensure adequate coverage is maintained facility. Findings will be reported monthly to Que committee x 3 months follow-up to committee recommendations.  Corrections to deficient will be completed by the complete completed by the complete completed by the complete completed by the complete complete complete completed by the complete	staffing staffing ated on RN s daily 7 eviewed ae RN within e API with ae API with		

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391 DEPARTMENT OF HEALTH AND HUMAN SERVICES (X3) DATE SURVEY CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION COMPLETED (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_\_\_ AND PLAN OF CORRECTION 01/28/2016 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 245544 NAME OF PROVIDER OR SUPPLIER 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION CAMDEN CARE CENTER (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (X4) ID TAG DEFICIENCY) PRÉFIX TAG F 354 Continued From page 69 that RN coverage was required at least eight hours a day. The facility did not have a staffing waiver. Review of the actual staffing and the staff postings revealed: -Staff posting dated Saturday 11/10/15, indicated eight RN hours (not recorded in RN manager or LPN manager hours) that are not reflected in the actual daily staffing sheet, - On Sunday 11/15/15, there was no RN coverage listed on the 24 hours actual staffing sheet, - On Saturday 11/28/15, no RN coverage, - On Sunday 11/29/15, no RN coverage and, - On Sunday 12/27/15, no RN coverage. All three facility staff verified no RN coverage was provided on those days. F356 (C) Facility maintains F 356 F 356 483.30(e) POSTED NURSE STAFFING records of daily posted staffing INFORMATION SS=C The facility must post the following information on All residents, families and visitors have the potential to be a daily basis: o Facility name. affected by missing posted o The current date. o The total number and the actual hours worked by the following categories of licensed and staffing data. unlicensed nursing staff directly responsible for Schedulers were educated on resident care per shift: the requirement for daily Registered nurses. - Licensed practical nurses or licensed staffing posting within facility vocational nurses (as defined under State law). and the retention of schedules - Certified nurse aides. for a minimum of 18 months. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:

ADTA	AGNIT OF HFALTH	AND HUMAN SERVICES				PRINTED: FORM A OMB NO. (x3) DATE	0938-0391	
DEPART	EOR MEDICARE	& IVIEUTO/10 July 1	OVOLANDA T	IPLE CONS	STRUCTION	COME	PLETED	
	SE NECICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) WOLL A BUILDE	NG			1	
AND PLAN OF	CORRECTION	IDENTIFICATION NOMES	A. Boics. 			01/	28/2016	
		205524	B, WING		TIP CORE		50,20	
		245544	<del>'                                    </del>	STREET	ADDRESS, CITY, STATE, ZIP CODE		1	
NAME OF P	ROVIDER OR SUPPLIER		1	512 49	TH AVENUE NORTH		1	
				MINN	EAPOLIS, MN 55430	TION	(X6)	
CAMDEN	CARE CENTER	TO THE PART OF THE	10		PAOVIDER'S PLAN OF CORRECTIVE ACTION SHO	OULD BE	COMPLETION	į
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PHEF		(EACH CORRECTIVE ACTION OF CROSS-REPERENCED TO THE APP DEFICIENCY)	ROPRIALE		
	Continued From 1	page 70	F	356	Staffing data will be review	ras		
Ì		able format. place readily accessible to			maintained for 18 month	5.		1
1	o in a prominent residents and vis	place readily areas.	}	}	rindings will be reported			
			1		monthly to QAPI commit	tee x 3	1	1
1	The facility must	, upon oral or written request,	ļ		months with follow-up to	0	}	1
	make nurse star for review at a c	, upon oral of Whiten republic fing data available to the public ost not to exceed the community	y		committee recommenda	ațions.		
	standard.		_ \	1	Corrections to deficient	practice	Ì	1
Ì	The facility MUS	t maintain the posted daily nurse	€	1	Corrections to deficient	arch 8	1	
l	staffing data for	t maintain the posted daily his a minimum of 18 months, or as	'	1	will be completed by M	alcii o,		
1	required by Sta	te law, whichever is greater.	1		2016.		ļ	
1	ļ			1				{
		MENT is not met as evidenced						
	tacility failed to	rview and document review, the retain records of staffing for the required. This had the potential ( 52 residents, familles and visit	to \					
	Findings inclu	de:	41-0				<b>\</b>	
	director of nu human resou	at 2:30 p.m. a staff interview with rsing, staffing coordinator and irces person was completed.	i iiio					
	postings rev	he actual statfing and the staff ealed: I sheets were missing from 11/1 24/15, In addition, the staff postir g for 11/25 through 11/28/15.	6/15 ngs					
	The above to posting she	three facility staff verified the states were missing on those days did not maintain the full 18 month (d), (e) DRUG RECORDS,	and hs.	F 43	31			
\	F 431   483.60(b),				- III - ID - 00186	II continuat	ion sheet Page	71 0179
. \ _		Eyenl	ID:KOXR1	1	Facility ID: 00166			

PRINTED: 02/17/2016 FORM APPROVED

DEDABTM	MENT OF HEALTH	AND HUMAN SERVICES			0	MB NO.	938-039 <u>1</u>
CENTERS	NTERS FOR MEDICARE & MEDICARD SCHOOLS		(X2) MUI	TIPLE CON	STRUCTION	(X3) DATE SURVEY COMPLETED	
TATEMENT O	IF DEFICIENCIES	(X1) PAOVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING		<b>J</b>	
ND PLAN OF	CORRECTION				_	01/2	B/2016
		245544	B. WING	OTRECT	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PI	ROVIDEA OR SUPPLIER			512 49	TH AVENUE NORTH		
	CARE CENTER			MINNE	EAPOLIS, MN 55430		///
CAMDEN		ACTIOICNOIES	10		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU		(X6) COMPLETION DATE
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL. LBC IDENTIFYING INFORMATION)	PRE		(EACH CORRECTIVE ACTION SHOOL CROSS-REFERENCED TO THE APPAC DEFICIENCY)	PAIATE	DAIL
			1		F431 (E) Temperature stora	ge	
<b>□ 491</b>	Continued From p	page 71	F	431	guidelines for medications		
F 431	I ARFI/STORE D	RUGS & BIOLOGICALS		-	housed in medication room	1	
Ģ3=L					refrigerator were verified w	vith	
	a licensed pharmacist wild es	employ or obtain the services of acist who establishes a system		\	suppliers and pharmacists	on	
				1	1/27/16. Medications stor	ed in	
			<b>a</b> \	Ì	1/27/16. Medications 200	ere	
	controlled drugs in sufficient dotain to accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically			{	refrigerator on 1/27/16 we	ites	
				1	relabeled for expiration da	tor	
}	reconciled.			}	or removed from refrigera		1
1	Drugg and biolog	gicals used in the facility must b	e	1	according to manufacture	13	1
		Mance Willi Culleling Good		1	guidelines and destroyed.	r	
1	l randani Mrit	ncinies and literacy inv			Refrigerator located in		
	appropriate acc	essory and cautionary d the expiration date when			medication room was rep	placed	1
	applicable.	u (		1	on 1/27/16 and new		
		with State and Federal laws, the	,	l l	refrigerator temp is mon	itored	
					to maintain the acceptat	ole	
			re   Ito	1	temperature range betw	reen 36	
	controls, and p	CAUMIL OLITA STREET, SECTION STATES			and 46 degrees F. R62's	s sen-	
- {	1				administered insulin wit	hout an	
	The facility mu	st provide separately locked,	e of	}	'opened/expiration' dat	e was	}
		flixed compartments for storage gs listed in Schedule II of the			removed and destroyed	l and	
	)	UNIN ANICE FIGVENIOUS ASS	_		insulin was replaced in		
\	Control Act of 1976 and other drugs subjections abuse, except when the facility uses single abuse, except when the facility uses single abuse, except when the facility uses single abuse.	1976 and other drugs subject			resident's room with a	n	
1		distribution systems in which the	10		expiration date label at	ffixed.	
	l muantity store	package drug distribution systems in package drug drug distribution systems in package drug drug drug drug drug drug drug drug			R62 was educated on r	need to	
	be readily detected.				keep all medications in	n room	
					securely locked when	not in	
			ed		1	-	
1	This REQUIF	REMENT is not met as evidenc			use.		Ì

by:

EPARTMENT OF HEALTH AND HUMAN SERVICES				FORM A	02/17/2016 \PPROVED 0938-0391
EPARTMENT OF HEALTH AND SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	(X2) MULI A. BUILDI	riple co	ONSTRUCTION	COME	26/2016
245544	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF PROVIDER OR SUPPLIER		STRE 612	49TH AVENUE NORTH		1
		MIN	INEAPOLIS, MN 55430		T 055
CAMDEN CARE CENTER	T ID		PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	ITO BE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREF	1X	CHOSS-REFERENCED TO (TILL ATT)	opriate 	
Ind			All residents receiving		
F 431 Continued From page 72	1	431	medications requiring		
to the tile to the tile tile tile tile tile tile tile til	on		refrigeration are at risk due	to	
review, the facility falled to shape within refrigerator temperature was kept within	e	1	inadequate daily monitorin	g of	
manufacturer's recommendation ratingerator			medication refrigerator		
facility failed to ensure the roman had the temperature was monitored. This had the			temperature. All residents	are	
potential to affect 12 of 52 loads B10 B21, R6	9, \		at risk if medications are n	pt	
R15, R62, R14, H34, R70, R50, H10, R53) currently resided in the facility. In addition	n		labeled with opened/expir	ation	
R53) currently resided in the room were not R62's medications kept in the room were not			dates as well as unsecure		
locked and secured, and made view	1		medications stored within		
dated when opened.	Ì		facility.		
Findings include:			,		
- shaperustion in the			Nursing staff were educat	ed of	\
	4)-D		the need for the mainten	ance	
presence of the licensed the medication on 1/28/16, at 9:08 a.m. the medication	). l		of 36 - 46 degrees F		
refrigerator was at 55 degrees 1 discretion suit	pply		temperature range for		
LPN-D stated residents extra medicate to such as insulin was stored in this refrigerator	r, and i		refrigerator containing	٠	. \
temperature was 100 mg/s. From July 2015 (f	rom 6		medications, the labeling	gof	\
above the retrigerator was from temperature			medications with		
months ago) and had only lost for the current results recorded. When asked for the current results recorded.	nt   nt find		'opened/expiration' dat	es and	1
temperature log, LPN-D stated and obtaining			the need for locking all		1
any for the past 6 months. The tollowing unopened medications were observed store	ed in		medications in facility in	cluding	
the refrigerator:	cine)		those in resident rooms	being	
the refrigerator:  - Affuria 5 milliliter (ml) (influenza virus vac  - Nine vials of Infuvite (multiple vitamins fo	or		self-administered by re	sident.	<u> </u>
			2611-adiminatores plans		
- One Novolog insulin peri (used to trous			A revised medication		
diabetes) for H45,			refrigerator temp log v	/as	
- Two Novolog insulin pens for R62, - Three Novolog insulin pens for R62,	roat		implemented immedia	tely and	
- One vial of Lantus Insulin (also dosa is	u eat		is monitored daily for		
diabetes) for H34,					
One Lantus insulin viai for floor	st ID:KOXR11		Facility ID: 00166	II continuati	on sheet Page 7

PRINTED: 02/17/2016

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING \_\_\_ AND PLAN OF CORRECTION 01/28/2016\_ B. WING. 245544 STREET ADDRESS, CITY, STATE, 2IP CODE NAME OF PROVIDER OR SUPPLIER 512 49TH AVENUE NOATH MINNEAPOLIS, MN 55430 CAMDEN CARE CENTER (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE SUMMARY STATEMENT OF DEFICIENCIES DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID TAG DEFICIENCY) PREFIX TAG completion and the F 431 appropriateness of Continued From page 73 F 431 temperatures. DNS/Designee - Two Lantus insulin pens for R10, - Three Lantus insulin pens for R21, will monitor resident rooms - One Humalog insulin (also used to treat weekly x 12 weeks where selfdiabetes) pen for R69, One bottle of Latanoprost 0.005 percent (%) administered medications are (eye drops) for R53, stored for inclusion of labeling - One vial of Lorazepam injection (with no of 'open/expiration' dates on resident name on) LPN-Z was not sure if the thermometer was medications, removal and accurate or not, suggested to recheck temperature with another thermometer. replacement of expired medications and to monitor On 1/28/16, at 9:12 a.m. the director of nursing that medications are securely (DON) verified the refrigerator temperature should have been between 36 and 46 degree F, locked when not in use by and stated night staff were responsible for checking the refrigerator temperature daily at resident. Findings will be night. The DON also verified the last temperature checks were done 6 months ago in July 2015. reported monthly to QAPI committee x 3 months with On 1/28/16, at 10:55 a.m. the medication refrigerator temperature was checked again by follow-up to committee LPN-A, and it was at 48 degrees (still too high). recommendations. On 1/28/16, the nurse consultant (NC)-C was Corrections to deficient practice interviewed and stated the refrigerator temperature should have been kept between 36 will be completed by March 8, and 46 degrees F, and the refrigerator 2016. temperature monitored daily. The undated manufacturer's recommendation for unopened Latanoprost eye drops, Lantus, Novolog, Infuvite, Humalog, and Lorazepam storage was to be stored at 36 F- 46 F. The pharmacy consultant (PC) was interview via phone call on 1/28/16, at 3:10 p.m., and stated the medication refrigerator temperature should have been kept between 36 and 46 degrees F,

						EOBM (	02/17/2016 \PPHOVED 0938-0391	
DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES				CV9) DATE	SURVEY	
CENTERS	FOR MEDICAHE	A VILDIONIO SERICLIA	(X2) MULTI	bre co	NSTRUCTION	COM	PLEYED	
	e negiciENCIES	IDENTIFICATION NUMBER:	A. BUILDIN	IG		1	1	
AND PLAN OF	CORRECTION						28/2016	
		245544	B. WING_		ET ADDRESS, CITY, STATE, ZIP CODE		ţ	
				STRE	9TH AVENUE NORTH			
NAME OF PE	OVIDER OR SUPPLIER		1	512.4	NEAPOLIS, MN 55430			
CAMDEN	CARE CENTER			MINI		CTION	(X5)	
CAMOLIV		ATEMENT OF DEFICIENCIES	ID.	.	PROVIDER'S PLAN OF COMMEN	DULD BE BORRIATE	DATE	ļ
(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFIDITION  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFI) TAG		(EACH CORRECTIVE ACTION OF THE APP CROSS-REFERENCED TO THE APP DEFICIENCY)			
<b></b>			E /	431				
T 421	Continued From (	page 74	, ,	+31				1
F 401								1
l l				1				1
1	ranges, PC also	stated refrigerator monitoring		Ì				1
	should include da	ally temperature checks. PC		1			\ \	1
	further stated ne	nau many control temperature		1			1	1
1	past with staff at	vas not aware the refrigerator	Ì	\			ļ	1
1	monitoring, but v	running so hìgh.		ļ			1	1
	temberature was							1
}	The undated Me	edication Storage in the Facility		Ì			ļ	1
1	nolicy indicated	"Medications requiring  "Kept at temperatures ranging	, \					1
1	"refrigeration" a	re kept at tomporation left to	'				. 1	}
1	from 2/36 degre	re kept at temporation ses C/F (Celsius/Fahrenheit) to refrigerator not accessib	le		•		1	Ì
1	8/46 degrees C	/FIN a remgerator	1		1			1
1	to patients".		1					1
	The facility's M	onitoring of Refrigerator	1		1		1	}
1			1				1	
1	Charge Nurse	will check refrigerator temp	eet					1
	(sic-temperatu	rejano record on colley did not					1	l
Ì	on the front of	rel and record of the fridge". The policy did not a frequency of temperature che	cks.				Ì	- 1
į į	clearly indicat	S (teductic) of territ	1				1	
l					Ì			1
1	Dez		and				}	\ \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\
1	On 1/25/16, 6	at 1:47 p.m. R62 was observed to	anu		\ 		l	- 1
ļ	interviewed in	his room. There was plastic	nd				1	\
1	container wit	h blood sugar check supplies ar	_ \				\	1
ł	insulin obser	ved on the top of the high his own	1 l		1		<b>\</b>	1
	When intervi	ewed Hoz stated the completered t	he \				1	}
	blood sugar	showed the content of the box.	There				1	1
	INSUIN, AND	og pen dated opened on 1/17/1	6,					1
	another No.	og pen dated opened on 1/24  volog pen dated opened on 1/24	10,					1
1	and an ope	rolog pen dated operied on the med Lantus vial not dated when the language delivery dated 1/11	(16)		1		l	ŀ
	opened (wit	ned Lantus viai not dated 1/11/ h pharmacy delivery dated 1/11/ h pharmacy delivery dated 1/11/ h pharmacy delivery dated 1/11/			[		1	1
	R62 also st	lowed two medication tablets. I	362					
ļ	Metformin	nowed two medication of tablets. If 1000 mg, each with 30 tablets. If ept his medication supply usual	ly on			II continual	ion sheet Page	75 of 79
į	stated he k	Epi Ilia Ilicapation Ser .	HD:KOXR11		Facility ID: 00166	.,		

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

CENTERS FOR MEDICA TATEMENT OF DEFICIENCIES AD PLAN OF CORRECTION	(X1) PROVIDENSUPPLIENCLIA IDENTIFICATION NUMBER:	A. BUILDING _	CONSTRUCTION	01/	28/2016
		51	PREET ADDRESS, CITY, STATE, ZIP (12 49TH AVENUE NORTH INNEAPOLIS, MN 55430  PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THI DEFICIENCY)	DRAECTION N SHOULD BE E APPROPRIATE	COMPLETION DATE
if he went to the facility and we facility and we on 1/28/16, at eating breakfathe plastic corrobserved aga room on the bound on 1/28/16, a medication be bedside table residents room the top draws the Lantus in the date when on 01/28/16 R62's medication be to policy did not storage required to the top of th	ble, did not lock them in the drawer of dining room, only if he left the ent out.  8:23 a.m. R62 was observed st in the dining room. At this time stainer with the insulin was in unattended/ unlocked in R62's edside table.  18:24 a.m. the DON verified the ex with insulin supply was on the and stated medications in ms supposed to be kept locked in of the dresser. DON also stated stilln should have been dated with an opened.  18:20 a.m. LPN-D also stated ations should have been locked in the top drawer of the dresser.  19:08 a.m. LPN-D also stated ations should have been locked in the top drawer of the dresser.  19:10 Medication Storage in the Facility of the instructions for medication in resident's rooms.	on F4	F465 (D) Wheelch chair for R 27 was Wheelchairs for R were examined, crepaired. R 21's pelectric wheelcha scheduled for repin resident rooms wheelchairs were cleanliness; a wh	cleaned. 12 and R41 deaned and personal hir has been pair. All chairs s and e checked for	

ENTERS	FOR MEDICAHE	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDERSTON NUMBER	(X2) MULT	IPLE C	ONSTRUCTION	OMB NO.	938-0391
- CMENT O	F DEFICIENCIES CORRECTION	(X1) PHOVIDENGEN LUMBER:	A. BUILDI	NG		01/2	8/2016
	•	245544	B. WING		EET ADDRESS, CITY, STATE, ZIP CODE		
	ROVIDER OR SUPPLIER			517	ARTH AVENUE NORTH		
		•		MIR	INEAPOLIS, MN 55430		NEI -
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)		(X5) COMPLETION DATE
TAG	REGULATORY ON		F	465	cleaning schedule has be established	en	
F 465	maintained in a clot of 1 resident (R27 of 3 residents (R1 wheelchairs main for environmenta Findings include:	ean and sanitary marmer for 1970. In addition failed to ensure 3 12, R41, R21) had their stained in good repair reviewed 1 concerns.			All residents with chairs froms and who use whe are at a safety risk due to unclean or equipment in repair.  Maintenance staff were	elchairs o 1 ill	
	1/26/16, at 8:5/ with spots on the secretions from On 1/28/16, at 1 the environmen (RM) verified the spots of perhaps a spot clethe chair when the tour resider chair and was and stated he gave surveyor indicated RM verified RM verified at 11:46 a.m. observed brold foam.  On 1/28/16, at 1:46 a.m. observed brold foam.	a.m. during room and sitting part perhaps trach and suctioning.  12:04 p.m. to 12:32 p.m. during tal tour with the regional manage lazy boy which was covered was secretions stated would have aner and use disinfectant to clearesident was not up on it. During the was observed seated on the able to acknowledge all the spowould not blame anyone for it at thumbs up when surveyor was going to clean it.  Wheelchair right armrest on 1/25 during room observation was ken and was missing front edge at 12:04 p.m. to 12:32 p.m. during roth the regional management at the regional management.	to an g		educated on need to che cleanliness and status of in rooms and resident wheelchairs.  Maintenance/Designed perform random auditains for cleanlinesed for repair daily x weeks. Findings will be reported monthly to Committee x 3 month follow-up to committee recommendations.  Corrections to deficie will be completed by	eck the of chairs  e will s by irs and 5 ness and 12 ee QAPI as with tee	
	(RM) verified appeared to	ninistrator and the regional I the wheelchair had simmers of be dry food on the side. In addi manager verified foam was mis armrest and was exposing gray	tion   sing		2016. Facility ID: 00168	_	n sheet Page

			SERVICES				OMB NO.	0938-0391	
DI	FPARTME	ENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			NICTION	TOTAL DATE	SURVEY PLETED	
C	FNTERS	FOR MEDICAGE	WHEN THE PROPERTY OF THE PARTY	(X2) MULT	IPLE CONSTR	IDCTION	COM		
	ニー・イニレイ へだ	INFFICIENCIES I	(X1) PROVIDENGOFFFILMBER:	A. BUILDI	۷G		1	ng/2016	
ANI	D PLAN OF C	ORRECTION		B, WING.				28/2016	
			245544	B, Whia.	STREET AL	DRESS, CITY, STATE, ZIP CO	DDE		1
	C DO	OVIDER OR SUPPLIER		1	612 A9TH	AVENUE NORTH			1
ı				}	MINNEA	POLIS, MN 55430	POERTION	(XE)	1
1	CAMDEN (	CARE CENTER				PROVIDER'S PLAN OF COL (EACH CORRECTIVE ACTION	SHOULD BE	COMPLETION	
	(X4) ID PREFIX TAG	SUMMARY ST (EACH DEFICIENC REGULATORY OR	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG	"` \ C	(EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	APPHOPHIATE		1
-			77	F	465				
	F 465	Continued From F	ng it not a cleanable surface.		1				
	l	underneath makii	ng it not a deathable output nt was due to staff probably blobair under the tables. RM was		\				\
1	Ì	HM stated the whee	nt was due to starr probably elchair under the tables. RM wait took to the administrator the	•					1
-									l
1		armrest was golf	d to be tobiassay	1					
١		Dagle enguel Mi	nimum Data Set (MDS) dated	Ì				1	1
1		11/3/15 Indicate	nimum Data Set (MD2) ad R12 had severely impaired		-				
		cognitive skills.	required extensive physical  required extensive physical  reacher with transfers from bed to	to	ļ				1
	1	assistance of tw	required extensive physical to staff with transfers from bed to used a wheelchair for mobility.	1					1
	ļ	wheelchair and	used a wildow	{	1				- 1
	1		L. La ia ili reni	air	\				1
	}	R41's wheelch	air was observed to be in ill repa						1
		1	during the environm	ient ∤					1
	1	On 1/28/16, at	12:25 p.m. during the seated on the wheelchair at the seated for lunch and the left arms						}
	1	dining table W	seated on the wheelchair at the alting for lunch and the left arms exacked and the vinyl was peel	ed				\	<b>\</b>
	\	was observed	Cidorco di la prodorce alli	h h					1
	ļ	off and was ex	cracked and the supposing the toam underneath uncleanable surface. HM verified	d it.	}				1
	1	i making it an t	IUCiegrapio ogu	544	1				1
	1	DAT'S SINUAL	MDS dated 11/13/15, indicated	H41				ĺ	<b>\</b>
	ŀ	had severely	MDS dated 17713/15, the impaired cognition skills, required to locate the impaired to locat	he h	}				1
	Ì	total depende	impaired cognition skills, require ence for locomotion on and off to d a wheelchair for locomotion.						1
	l l	unit and used	d a wheelchair for 1994		1				\
	1			opoir	\			į	1
	1	Roll's wheel	chair was observed to be in ill r	epan					1
	1	ŀ	- Dotte left arm(89	tof l					1
	1	On 1/26/16,	at 12:01 p.m. R21's left armres wheelchair was observed with v	rinyl	l			1	
-	}	the electric	wheelchair was observed with a peled off and was exposing the t recently making it an uncleanable	yellow		1			\
:	1	foam linder	peled off and was expected anable meath making it an uncleanable	• }					1
	1	surface.		l					}
,	1		- 42:44 nm during the						}
		On 1/28/16	3, at 12:44 p.m. during the intal tour the RM stated the elec	tric	\			. h:: al Bag	 28 of 79
	<b>\</b>	environine	LIND PORKING IL CHI PET		<u></u>	acility ID: 00166	Il continua	ntion sheet Pag	J 12 0
•	1	MITOCIOLIGI	Fye	ul ID:KOXR	11 '				

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STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		245544	B. WING			01/2	28/ <u>2016</u>	
	PAOVIDER OR SUPPLIER			512	EET ADDRESS, CITY, STATE, ZIP CODE 49TH AVENUE NORTH NNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CHOSS-REFERENCED TO DEFICIEN					TION SHOULD BE COM THE APPROPRIATE		
F 465	wheelchair. RM stanily member if the family would proving the wheelchair werified the wheelchair acknowledged standardseed to prevent acknowledged standardseed to prevent acknowledged standardseed to prevent acknowledged to prevent acknowledged to prevent acknowledged as wheelchair acknowledged a wheelchair acknowledged acknowle	ated staff were supposed to call hey noticed any concerns so de replacement parts. RM chair was with ill repair and iff should have reported the ely to his department to be ent causing skin Issues.  MDS dated 11/13/15, indicated gnition, required extensive se with transfers, had a en of both lower extremities and		465				

PRINTED: 02/17/2016

F5544026

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (XS) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDING O1 - MAIN BUILDING O1 AND PLAN OF CORRECTION 01/26/2016 245544 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **512 49TH AVENUE NORTH** CAMDEN CARE CENTER MINNEAPOLIS, MN 55430 PROVIDER'S PLAN OF CORRECTION (XE) **BUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX DATE CHOSS-HEFERENCED TO THE APPROPRIATE REGULATORY OR LSO IDENTIFYING INFORMATION) DAT TAG DEFICIENCY) K 000 K 000 I INITIAL COMMENTS APPROVED / hu. FIRE SAFETY By Tom Linhoff at 3:03 pm, Mar 15, 2016 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 Fire Marshal Division on January 26, 2016. At the time of this survey, Carndon 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 MAR - 7 2016 **DEFICIENCIES TO:** Healthcare Fire Inspections MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR Expentire Devitor LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 3-2-16 LNHA

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM OMB NO:	02/17/2016 APPROVED 0938-0391	
TAY	EMENT O	F DEFICIENCIES	I A 4 PROVIDER/SUPPLIENCUA	(X2) MUL	TIPLE C	CONSTRUCTION	(X3) DATE	E BURVEY PLETED
ON	PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING 01	- MAIN BUILDING 01	1	
			245644	B, WING			01/	26/2016
NA	ME OF PR	OVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		1
		CARE CENTER				48TH AVENUE NORTH NNEAPOLIS, MN 55430		
CF	MDEN (		The state of the s	T ID	1 1	PROVIDED'S PLAN OF CORRECT	TION	COMPLETION
P	X4) ID REFIX TAG	AT A OUR DESIGNATION OF THE PARTY OF THE PAR	AYEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
		Continued From p By email to: Marian.Whitney@	state.mn.us,	к	000			
		Angela.Kappenma	an@state.mn.us ORRECTION FOR EACH IST INCLUDE ALL OF THE				959	
		to correct the defi	f what has been, or will be, don iclency. proposed, completion date.	ė				
	٠	3. The name and	I/or title of the person orrection and monitoring to orrence of the deficiency.					
			enter is a 1-story building with a t. The 1 story building was 990 and was determined to be struction.					2
		the corridors and that is monitored	fully fire sprinklered. The facility system with smoke detection in d spaces open to the corridors of for automatic fire department a facility has a capacity of 73 be us of 52 at the time of the surve	ds				
	K 05: SS=	NOT MET as et NFPA 101 LIFE  A fire alarm system with NFPA 70 N	nt at 42 CFR, Subpart 483.70(a videnced by: E SAFETY CODE STANDARD stem required for life safety is d, and maintained in accordanc National Electrical Code and NF n has an approved maintenance ogram complying with applicable	e PA	K 05	K052F Testing of the dig communicator tester wa 16 by maintenance. Dig communicator tester is t logged monthly by main	is done or Ital alarm tested and	d

PRINTED: 02/17/2016 FORM APPROVED OMB NO. 0936-0391

	of deficiencies f correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245544	B. WING			01/26/2016	
	ROVIDER OR SUPPLIER	11		512	REET ADDRESS, CITY, STATE, ZIP CODE 2 48TH AVENUE NORTH NNEAPOLIS, MN 55430		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES I MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL OROGS-REFERENCED TO THE APPRO DEFICIENCY)	(Xd) COMPLETION DATE	
K 052	Continued From pa requirements of NF	•	Ko	52			
	Based upon a revistaff interview, test communicator transconducted during a year. This deficient accordance with the (2000) Chapter 9, (1999) and NFPA 7	s not met as evidenced by; ew of available records and ing of the digital alarm smitter (DACT) had not been each month of the previous it practice was not in e requirements at NFPA 101 Section 9.6.1.4, and NFPA 70 (2 (1999) and CMS policy.			ii.		
	on 01/26/2016, durecords no docume verifying the digital transmitter (DACT of Jan, Apr, Jul, Au	Neen 9:00 AM and 12:30 PM ring a review of available entation could be provided alarm communicator was tested during the months ug, Oot and Nov in 2015 in IFPA 70 and 72., 9.6.1.4			*		
K 062 SS=E	Maintenance Supe NFPA 101 LIFE SA Required automati	tice was verified by the printendent. AFETY CODE STANDARD or sprinkler systems are talned in reliable operating	к	062	K06ZE Corroded sprinkler head kitchen will be replaced along style plate by Tyco by March 8	with 401	)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		in etter en translation en en		E CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DAT( OOM	(X3) DATE SURVEY COMPLETED	
		245544	B. WING		01/2	26/2016	
	ROVIDER OR SUPPLIER		5	TREET ADDRESS, OITY, STATE, ZIP CODE 12 49TH AVENUE NORTH IINNEAPOLIS, MN 55430			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
K 062		nge 3 nspected and tested 7.6, 4.6.12, NFPA 13, NFPA 25,	K 062				
	Based on docume observation, the fa inspect and mainta system in accordance section 19.7.6, 4.6 does not ensure the functioning property.	is not met as evidenced by: ntation review and cility has falled to properly in the automatic sprinkler nce with NFPA 101 LSC (00) 1.12. This deficient practice at the fire sprinkler system is y and is fully operational in the could negatively affect 25					
	AM and 12:30 PM documentation rev sprinkler company corroded sprinkler	our between the hours of 9:00 on 1/26/2016, during flew it was revealed through the report that the kitchen has 3 heads and has a 401 style e replaced in accordance with NFPA 25(98).					
K 074 SS=F	Maintenance Super NFPA 101 LIFE Sand other loosely serving as furnishing are occupancies provisions of 10.3	etice was verified by the earlntendent. AFETY CODE STANDARD  s, including cubicle curtains, hanging fabrics and films ings or decorations in health are in accordance with 1 and NFPA 13, Standards for Sprinkler Systems. Shower	K 074	K074 Cubicle curtains in re and 148 were replaced on curtains meeting ½ inch di requirement to allow for a sprinkler coverage.	1-28-16 w agonal me	ith	

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\$TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	riple construction NG 01 - Main Building 01	(X3) DATE COMP	(X3) DATE BURVEY COMPLETED		
245544					01/2	01/26/2016	
NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL, REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	( EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
K 074	Curtains are in according and Newly introduced undealth care occupated specified when test methods alted in 10 NFPA 13  Newly introduced magnetified when test method alted in 10.  This STANDARD is Based on observatings and cubicle curtains requirements in according and NFPA 701 (99)	ge 4  produce with NFPA 701.  pholstered furniture within noies meets the criteria ed in accordance with the 0.3.2 (2) and 10.3.3. 19.7.5.1, nattresses meet the criteria ed in accordance with the 3.2 (3) , 10.3.4. 19.7.5.3  Is not met as evidenced by: tions and interview, the facility is that does not meet the cordance with NFPA 25 (98). This deficient practice could by hampering proper sprinkler	K 07	74		8	
	on 1/26/2016, it wa in patient rooms 16 the 1/2 inch diagon accordance with Ni	veen 9:00 AM and 12:30 PM s found that the cubicle curtain 9, 155, and 148 did not meet al mesh requirement in FPA 25 (98) and NFPA 701. ice was verified by the rintendent.					



Protecting, maintaining and improving the health of all Minnesotans

Certified Mail # 7013 3020 0001 8869 0732 February 16, 2016

Ms. Mary Hamer, Administrator Camden Care Center 512 49th Avenue North Minneapolis, MN 55430

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5544026

Dear Ms. Hamer:

The above facility was surveyed on January 25, 2016 through January 28, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm">http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</a>. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES

Camden Care Center February 16, 2016 Page 2

ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Ms. Gloria Derfus.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kamala Fiske Downing

**Health Regulation Division** 

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00166	8. WING		01/2	8/2016		
	NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  512 49TH AVENUE NORTH  MINNEAPOLIS, MN 55430							
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE		
2 000	NH LICENSING In accordance with 144A.10, this correpursuant to a surve found that the defic herein are not corrected shall with a schedule of the Minnesota Deputermination of weared requirements of the number and MN R When a rule contacomply with any of lack of compliance re-inspection with result in the assess that was violated of corrected.  You may request a that may result fro orders provided the Department with notice of assessminations.	thether a violation has been compliance with all e rule provided at the tag ule number indicated below. In several items, failure to the items will be considered a. Lack of compliance upon any item of multi-part rule will sment of a fine even if the item during the initial inspection was a hearing on any assessments on non-compliance with these at a written request is made to ithin 15 days of receipt of a ent for non-compliance.	Moter 3 Jets Degen	DEFICIENCY				
	surveyors of this D above provider an orders are issued, completed, please these orders and Minnesota Depart	ITS: o January 28th, 2016, Department's staff, visited the d the following correction When corrections are sign and date, make a copy of return the original to the ment of Health, Division of			,			
Minnesota I	turlens	IDER'SUPPLIER REPRESENTATIVE'S SI Jamer Eylyust	readu	TITLE Lefor OXR11	3-2-/6 If continue	(X6) DATE		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
00166		B. WING		01/28/2016		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•	
CAMDEN	I CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	Compliance Monitoring, Licensing and Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900					
2 555	MN Rule 4658.0405 Plan of Care; Devel	5 Subp. 1 Comprehensive opment	2 555			
	Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative.					
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide develop a plan of care for 1 of 2 residents (R15) in the sample reviewed with indwelling Foley catheter and oxygen /CPAP use.					
	Findings include:					
	Catheter care: R15 was observed on 1/27/16, at 8:23 a.m. laying in the bed. During interview R15 stated she felt staff did not always clean her properly in the morning, and she received cares only when she requested them, which included a partial bath in					

Minnesota Department of Health

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/28/201	
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	01/2	0/2010
	N CARE CENTER		AVENUE NO			
CAMBE			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 555	the morning and per Foley catheter, with attached to it. R15 surinary tract infection to know when staff catheter. R15 also shedpan when she hastaff have not alway use. On 1/27/16, at interviewed again, signooming cares, per today, no staff check related to her groom she had the catheter urologist when in track the had the catheter urologist when in track the kidney as a resist chronic kidney dise has had a Foley cather admission.  The Admission Nur 12/1/15, indicated of UTI's. The temporal noted toileting assist plan did not indicate medical conditions not indicate cares in the catheter [every] shift."	eri care. R15 had an indwelling a 2000 milliliter (ml) bag stated she used to have ons (UTI) in the past, and did f supposed to care for her stated she preferred to use the had bowel movements, but as had bed pan available to 1:35 p.m. R15 was stated she have not received ricare or catheter care yet exked in with her yet today ming needs. R15 also stated er for a long time, and saw the bouble with kidney failure.  That are Summary dated was hospitalized for UTI and action and a diagnoses of mmation of the substance of cult of bacterial infection) and ase. The note also reveal R15 theter in place prior to  sing assessment dated eatheter use, and history of ry care plan dated 12/1/15, at of one or two staff. The care appresence of Foley catheter, related to urinary tract, and did elated to catheter.  The provided read "Change of the provided read and the catheter cares question and administration and a did and a catheter cares question and and and a catheter cares question.	2 555			
	Record (MAR) and Treatment Administration Record (TAR) from 12/1/15 through 12/5/15,					

Minnesota Department of Health

STATE FORM 6899 KOXR11 If continuation sheet 3 of 78

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
00166		B. WING		01/2	/28/2016	
CAMDEN CARE CENTER 512 49TH			ORESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 555	identified catheter of catheter every mony was void of the size monitoring for adversive pyelonephritis and void R15 was hospitalized 12/23/15, per the Adassessment. The feather of the Temporary care indicated presence of tract related medicated toileting at the Temporary care indicated toileting at Review of R15's Marker (MAR) and Record (MAR) and Record (TAR) from lacked the identificated the identificated toileting at the catheter, balloor signs and symptom worsening kidney did R15's admission Mi 12/30/15, indicated was frequently incondependent of two signs and symptom worsening kidney did R15's admission Mi 12/30/15, indicated was frequently incondependent of two signs and symptom worsening kidney did requested R15 as be to have clear compitated R15 as be to have clear c	cares and to change the Foley th, however, the plan of care of the catheter, balloon size, ree signs and symptoms of worsening kidney disease.  The dand readmitted on dission Nursing form indicated history of UTI's, reas left incomplete, did not of the Foley catheter, urinary all conditions or interventions. The plan dated 12/23/15, assist of two staff, and pad use.  The dication Administration and the plan dated the size of the size of the size of the size, monitoring for adverse of UTIs, pyelonephritis and disease.  The monitoring for adverse of the size of the	2 555			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  2 555  Continued From page 4  The comprehensive plan of care dated 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter.  R15's care plan revised on 1/5/16, indicated R15 was a vulnerable adult and staff were to monitor and investigate any concerns. The care plan was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease.  The Physician's Progress notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
CAMDEN CARE CENTER  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430  (X4) ID  SUMMARY STATEMENT OF DEFICIENCIS, MN 55430  PROVIDER'S PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 555  Continued From page 4  The comprehensive plan of care dated 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not include presence of Foley catheter, medical conditions related to catheter.  R15's care plan revised on 1/5/16, indicated R15 was a vulnerable adult and staff were to monitor and investigate any concerns. The care plan was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease.  The Physician's Progress notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indiwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin			00166	B. WING		01/2	28/2016
SUMMARY STATEMENT OF DEFICIENCIES   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION   CACH ORRECTION   CACH OR	-	CAMPEN CARE CENTER 512 49TH			RTH		
The comprehensive plan of care dated 12/23/15, for bowel and bladder needs, activities of daily living needs and catheter use was not developed nor was there any interventions identified to assist R15 with cares. The care plan did not include presence of Foley catheter, medical conditions related to urinary tract, and did not indicate cares related to catheter.  R15's care plan revised on 1/5/16, indicated R15 was a vulnerable adult and staff were to monitor and investigate any concerns. The care plan was void of the size of the catheter, balloon size, monitoring for adverse signs and symptoms of UTIs, pyelonephritis and worsening kidney disease.  The Physician's Progress notes dated 1/14/16, indicated R15 had chronic kidney disease and chronic indwelling Foley catheter for the past six years due to immobility, and had history of UTI's. The note also indicated R15 had complaints recently of bladder spasm, started on oxybutynin, had urine analysis with mixed flora (more than one organism isolated from urine culture), and ordered a three day course of Levaquin	PRÉFIX	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
(antibiotic). The newly diagnosed bladder spasms was not added to the plan of care nor was there monitoring and interventions put into place on the plan of care other than the medication to relieve the spasms.  The nursing assistant (NA) care sheet (undated) indicated assist of two with grooming, dressing, toileting, and transfer with Hoyer to commode. However, the sheet did not indicate presence of indwelling Foley catheter, or related cares.  On 1/27/16, the NA who was assigned to take care of R15 or registered nurse (RN)-A (also	2 555	The comprehensive for bowel and bladd living needs and ca nor was there any in R15 with cares. The presence of Foley or related to urinary translated to catheter.  R15's care plan rev was a vulnerable as and investigate any void of the size of the monitoring for adve UTIs, pyelonephritis disease.  The Physician's Proindicated R15 had ochronic indwelling Fyears due to immost The note also indicated recently of bladder had urine analysis one organism isolation ordered a three day (antibiotic). The new was not added to the monitoring and interplan of care other the spasms.  The nursing assistatindicated assist of toileting, and transfer However, the sheet indwelling Foley cather 1/27/16, the NA	e plan of care dated 12/23/15, der needs, activities of daily theter use was not developed nterventions identified to assist e care plan did not include eatheter, medical conditions act, and did not indicate cares dised on 1/5/16, indicated R15 dult and staff were to monitor concerns. The care plan was ne catheter, balloon size, rse signs and symptoms of and worsening kidney  ogress notes dated 1/14/16, chronic kidney disease and foley catheter for the past six bility, and had history of UTI's. ated R15 had complaints spasm, started on oxybutynin, with mixed flora (more than ted from urine culture), and or course of Levaquin way diagnosed bladder spasms ne plan of care nor was there reventions put into place on the nan the medication to relieve ant (NA) care sheet (undated) wo with grooming, dressing, er with Hoyer to commode. It did not indicate presence of theter, or related cares.	2 555			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	28/2016
	NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER  512 49TI MINNEA					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 555	nurse manager wer On 1/27/16, at 2:09 nurse (LPN)-B was nursing assistants of twice daily pericare morning", get reside and nurses were re "everything is done stated she was not that morning. LPN-I dead", and preferred that morning cares, suc resident had Foley care along with the aware R15 did not a morning.  On 1/28/16, at 10:1 day 21 of admission comprehensive car nurse. The DON restated she would exact a she would exac	ge 5 e not available for interview.  p.m. the licensed practical interviewed and stated the were expected to complete , "wipe the catheter every ent cleaned up in the morning, sponsible to make sure ' (meaning cares). LPN-B told R15 did not receive cares B than stated "my brain is d to conclude interview.  p.m. the director of nursing yould expect staff to complete h as partial baths, and if a catheter to complete catheter pericare. The DON was not receive those cares this  1 a.m. the DON also stated by a she would expect to see a e plan written by the MDS viewed R15's record and expect R15 to have care plan ties of daily living care needs toileting) and Foley catheter  ecord indicate she had been lity on 12/1/15, with diagnoses and depression. The Admission at the catheter to tilized a airway pressure (CPAP) person who has obstructive breather more easily during	2 555			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING:			SURVEY LETED
		00166	B. WING	<del>-</del>	01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	0,2010
CAMDEN	CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 555	Continued From page 6		2 555			
	lacked evidence of	ddition, the assessment oxygen use and if the resident turation levels (O2 sats) due				
	On 12/1/15, the Physician Order read "Whatever she use [sic] at home for oxygen is fine and resident states she uses 2 L [liters] with CPAP at night."					
	The resident's Initial/Temporary Care Plan dated 12/1/15, indicated R15 needed one staff assist with dressing/grooming, needed assist of one-two staff with toileting, and two staff assist with transferring. The Temporary Care Plan did not include any information regarding O2 use or CPAP machine use. An undated nursing assistant assignment sheet did not include indwelling catheter use, O2 use or CPAP machine use.					
	physician ordered a to keep the oxygen keep the O2 Sats o	ysician Order noted the a chest xray, blood draws and levels between 2 to 4 L, and ver 90%. The information was an of care nor was the n the MAR/TARs.				
	Record (MAR) and Record (TAR) from	edication Administration Treatment Administration 12/1/15, through 12/15/15, the CPAP machine/O2 use, 5's breathing.				
	12/4/15, indicated F at the facility, had a failure, but did not in that she utilized an	mum Data Set (MDS) dated R15 received oxygen therapy diagnosis of respiratory ndicate R15 utilized CPAP, nor indwelling catheter. The MDS ndicated what the Admission				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
	PROVIDER OR SUPPLIER	512 49TH	ORESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 555	5 Continued From page 7		2 555			
	12/5/15, indicated the "ID/Sepsis/Severe Swith sepsis; cultures abx [antibiotic] start.  The Hospital Dischahad been sent to the readmitted to the nuprincipal diagnoses included: "acute hypolischarge Summar treatment with "intulantibiotics," had been and needed a low of than before. The Sum was observed to tal positive airway president.	arge Summary indicated R15 e hospital on 12/5/15, and ursing home 12/9/15. The listed for the hospitalization poxic respiratory arrest." The y indicated R15 had required bation, steroids, oxygen, en extubated after one day, lose of O2 which was different ummary also indicated, "[R15] are off her BIPAP [bilevel issure] at times when sleeping, her obesity could cause				
	dated 12/9/15, indic	sion Nursing Assessment cated R15's lungs were clear reathing easier however, there f CPAP use.				
	temporary care plar 12/9/15, and after n	lacked evidence of a from readmission on nultiple requests the facility document for review.				
	had been re-admitte septicemia (a bacte the entire vascular s use any oxygen in t	ated 12/14/15, indicated R15 ed with a diagnosis of erial infection spread through system of the body), did not he facility nor did R15 utilize a diagnosis of respiratory				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	0/2010
	I CARE CENTER		AVENUE NO			
CAMBLI			OLIS, MN 5		_	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 555	Continued From page 8		2 555			
	R15's MAR/TARs review dated 12/9/15, through 12/15/15, indicated no use of the CPAP machine/O2 use, or monitoring of R15's breathing.					
	The TAR dated 12/23/15 going forward to 12/13/15, identified the staff were monitoring the oxygen sats as they were to keep the sat level over 92% and monitoring the BiPAP usage.					
	R15's plan of care dated 12/23/15, was reviewed and noted the care plan did not identify any interventions that were put into place to monitor R15's recent diagnosis of pneumonia related sepsis with recent hospitalization dated 12/14/15, monitoring for lung sounds, changes in breathing, shortness of breath, and changes in vital signs.					
	and still the plan of hospitalizations or t there any interventi potential and/or pre readmissions regar	f care was revised on 1/5/16, care did not identify either he recent diagnoses, nor were ons identified to minimize event future hospital ding her breathing status, sepsis, CPAP machine use,				
	was interviewed on the plans of care fo plans lacked any in hospitalization, or th hospitalization, and to implement cares prevent future hosp commented the car written by day 21 af verified the compre	any new interventions for staff for R15 to minimize and or sitalizations for R15. He also re plans should have been fter resident admission, and hensive care plan for R15 completed by 1/14/16				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY LETED
AND I LAN	OF CONTLOTION	IDENTIFICATION NOWBER.	A. BUILDING:		COIVII	LLILD
	00166		B. WING		01/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	I CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE	(X5) COMPLETE DATE
2 555	Continued From pa	ge 9	2 555			
	1/28/16, at 10:11 a. the resident was reshe expected the stassessments, treat admission, monitor diagnosis(es) they comedical doctor (MD MD, and document hospitalization. The temporary care plar had "minimum infor include all relevant medical conditions, to address them. The of temporary care palso stated RN-B we residents' comprehense.	the residents as a new vital signs, note what came back with, note what the ordered, update the NP and circumstances of DON also verified the ordered from 12/1/15, and 12/23/15, mation", and should have information related to R15's and interventions put in place the DON also verified the lack blan from 12/9/15. The DON as responsible for developing ensive care plans by day 21, should have been completed				
	policy indicated "Th 24 hours from the ti developed within 21 arrival to the facility responsible for addicare plan and the p SUGGESTED MET The Director of Nurdevelop a system to	ing their portion to the 24 hour ermanent care plan."  HOD OF CORRECTION: sing (DON) or designee could be ensure a care plan is				
	needs. The DON or appropriate staff on ensure ongoing con	t each residents' current care designee could educate all the system, and monitor to appliance.  R CORRECTION: Twenty One				

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-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE	
			A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care I personnel involved in the	2 565			
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care (POC) for 1 of 3 residents (R12) who were observed for repositioning.  Findings include:					
	8:54 a.m. to 11:22 a - At 8:54 a.m. R12 n the dining room, - At 8:59 a.m. nursi to room and put up without adhesive. N dining room, - At 9:15 a.m. R12 n room, - At 10:37 a.m. R12 n room asleep, - At 10:53 a.m. R12 and, - At 11:22 a.m. R12 sleeping. The observation wa 12:45 p.m. R12 sitti - At 12:57 p.m. aske	continuously on 1/27/16, from a.m. was sitting in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in a Broda chair in R12 took R12 per dentures in R12's mouth IA-G returned R12 to the a Broda in a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda in TV and a Broda chair in TV and a Broda chair in TV and a Broda in TV and a Broda chair in TV and a Broda chair in TV and a Broda chair in Alberta in R12 in TV and a Broda chair in Alberta in R12 in TV and a Broda chair in Alberta in R12 i				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		00166	B. WING		01/2	8/2016
		00100			01/2	.0/2010
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMPE	LOADE OFNITED	512 49TH	AVENUE NO	PRTH		
CAMDE	N CARE CENTER	MINNEAP	OLIS, MN 5	5430		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				BEI IOIEIO I)		
2 565	Continued From pa	ge 11	2 565			
	since R12 got up that morning. LPN-A verified					
		aid down or repositioned yet				
		at morning. LPN-A stated,				
		en lunch staff were going to lay				
		vent for four hours and 15				
	minutes without bei					
		wheeled R12 to bedroom				
	and,					
	- At 1:16 p.m. NA-G and NA-H placed R12 in EZ stand (a mechanical standing lift) and stood R12					
		2's pants down and said "he is				
		is dry in front." Requested				
		s incontinence brief. R12's				
		ct, coccyx was red but				
		d been incontinent of stool.				
		ashed R12's bottom and				
	applied a new incor	itinence brief.				
	During continuous (	observation on 1/28/16, from				
		a.m. R12 went for three hours				
		nout being repositioned.				
	- At 7:15 a.m. R12					
		Broda chair in the hallway,				
	- At 7:45 a.m. R12 i					
		assisting R12 to eat				
	breakfast,	_				
	- At 9:15 a.m. R12					
		remained in TV room,				
		2 taken to shower room by				
		oned and checked and,				
		stood up in standing lift.				
	NA-C and NA-F pulled pants down and removed					
		Incontinence brief was wet.				
		old was red. LPN-A verified				
		een repositioned since R12 got				
		R12's skin and indicated it				
	was blanchable.					
	R12's Minimum Do	ta Sot dated 11/2/15 indicated				
		ta Set dated 11/3/15, indicated cognitively impaired, required				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	assistance with all a incontinent of bowe development of pre The Pressure Ulcer 11/3/15, indicated p because R12 requir bed mobility, freque incontinence, and is development.  Care plan printed 1/2 continues to be at rist to history of pressur mobility psychotropic Interventions instructed and perform peri-cachange and as need check and change and an on rounds through and on rounds through the properties over right buttock to the Treatment Admidated Jan 16, indicated Jan 16,	activities of daily living, was I and bladder and at risk for source ulcers.  Care Area Assessment dated ressure ulcers were triggered red extensive assistance with ant urinary and bowel dentified risk for pressure ulcer (28/16, instructed staff R12 isk for skin breakdown related re ulcer, incontinence impaired ic drug use and diuretic use. It is the continuous and diuretic use. It is the continuous and ded, wound care as ordered, before breakfast after lunch ugh night and as needed.  The signed by doctor on 1/6/16, apposition R12 in wheelchair in thouse barrier cream to skin wice a day.  The box for the AM on 1/27/16, and signed  The Surviving Assistant instructed staff check and kfast after lunch before bed ugh night as needed.	2 565			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					i) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAMDEN	I CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	During interview on stated, "[R12] has repositioned yet sin During interview on said I got [R12] up a intact. Na-A stated, repositioned today. get people up or toi During interview on director of nurses (I how often the reside we look at tissue to Residents need to be two hours minimum hour. If the wound is only be up for meals turning/repositioning assignment sheets  The facility's Repos dated July 2012, ins "3. Residents' will be unless otherwise do NAR [nursing assis sheets." R12 was not the plan of care while reposition every two SUGGESTED MET director of nursing of follow care plans in cares and services. compliance.	1/27/16, at 12:57 p.m. LPN-A not been laid down or ce he got up this morning."  1/28/16, at 10:21 a.m. NA-A at 7:30 a.m. [R12]'s skin is "[R12] has not been We are so short we cannot leted or repositioned."  1/27/16, at 2:31 p.m. the DON) stated, "To determine ents need to be repositioned lerance and comorbidities. De turned at baseline, every at the individualized grachedule should be on the and care plans."  itioning of resident's policy structed staff: e repositioned every 2 hours becamented on care plan and that registered] assignment of the instructed staff to turn and on hours per the TAR.  THOD OF CORRECTION: The could in-service all staff to regards to specific resident	2 565			

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER		DRESS CITY S	STATE, ZIP CODE	01/2	0/2010
			AVENUE NO			
CAMDER	I CARE CENTER	MINNEAP	OLIS, MN 5	5430		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 570	Continued From page 14		2 570			
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision		2 570			
	care must be review interdisciplinary tea physician, a registe for the resident, and disciplines as deter and, to the extent participation of the guardian or chosen quarterly and within the comprehensive by part 4658.0400,	resident, the resident's legal representative at least seven days of the revision of resident assessment required subpart 3, item B.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the plan of care for 2 of 3 residents (R10, R34) reviewed for pressure ulcers and/or non-pressure related skin conditions.					
	Findings include:					
	R10 was observed on 1/26/16 at 8:07 a.m. to be transferred into the wheelchair. During the period of continuous observation, the resident was transferred to bed with a mechanical lift at 10:23 a.m. Registered nurse (RN)-A, nurse consultant (NC)-A, and licensed practical nurse (LPN)-D were present to assess R10's skin. During the observation R10 stated, "my skin is falling apart, it hurts when I sit in the wheel chair." R10's bed was observed to have an air mattress in place over the mattress and a thick white pillow was observed in place over a cushion in the wheel chair. Nursing assistant (NA)-J turned R10 and					

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STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				B) DATE SURVEY COMPLETED	
			A. BUILDING.				
		00166	B. WING		01/2	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE	
2 570	removed her incontimoderate amount of incontinent brief. Lifebeen a dressing over buttock and that no dressing had come buttocks was obsertissue and RN-A micentimeter (cm) lordepth. There was wound bed. When to clean it, R10 retresculd have been clikely friction." NC-A and shearing playe of the wound since was right there. I do R10's record was readmission Record R10 had been admission R10/21/15, indicated 10/21/15, indicated 10/21/15, indicated 10/21/15, indicated, "Scarring A Temporary Care include a detailed pdevelopment, include a detailed pdevelopment, include incontinents, include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include a detailed pdevelopment, include incontinents include inc	ge 15  cinent brief. There was a of bright red blood on the PN-D stated there should have er a wound on the resident's one had reported the off. A wound on the right wed to be localized on scar easured the area to be 4 og, 2 cm wide, and to have no 100 % red bleeding over the LPN-D touched R10's wound acted. RN-A stated the wound aused by pressure, or more a stated it appeared "friction d a big role in the development the brief [incontinent brief] line on't think it is a pressure ulcer."  Eviewed. According to the documentation dated 12/8/15, itted to the facility on 10/21/15 uding: unspecified kidney on, peripheral vascular disease, ing Assessment document icated R10's left side was resident's skin risks included red mobility, and being chair R10's body was marked to in three areas: on the coccyx, k. The documented or the left and right buttocks from old pressure sore."  Plan dated 10/26/15, did not old of the repositioning schedule. The records of the records of the records of the records of the repositioning schedule. The records of the	2 570				

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_	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE	_	
CAMDEN	N CARE CENTER	•	AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 570	participation pa	ge 16 ach initiated 10/19/15 that	2 570			
		every two hours in the				
	assessment dated dependent on two semobility, transfers, any unhealed pressed developing pressure limitation of range of side; and used a wife the corresponding dated 11/9/15, indice INTERVENTIONS DECREASING THE PRESSURE AREA BREAKDOWN. "  A Braden scale (too ulcer risk) assessment to the semonth of the s					
	"abrasion noted on amount of blood dri also indicated the re	tted 11/24/15 included, LF [left] buttocks, sm [small] pping from area". The note esident was laid down after oned/offloaded every two				
	treatment order of: cream used to treat and apply foam dre am [morning] and F 2 hrs [every two hot dated 12/16/15, inc	r dated 11/24/15, identified a "apply silverstatin cream [a twounds] to Lt [left] buttocks ssing and change q [every] PRN [as needed]. Reposition qurs]." A Physician's Order luded, "apply silverstatin k and apply foam dressing				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430  [X4] ID.  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY TAG  SUMMARY STATEMENT OF DEFICIENCY  SUMMARY STATEMENT OF DEFICIENCY  MINNEAPOLIS, MN 55430  ID.  PROVIDERS PLAN OF CORRECTION (EACH CORRECTION EXCLION SIXULD BE CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  2 570  Continued From page 17  and change q 3 days + PRN [as needed]."  The Physical Therapy Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use).  R10's care plan, and TARs were not updated to include the recommendations for hourly repositioning.  During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated.  The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches to the individual care plan as changes occur."	STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
CAMDEN CARE CENTER    SUMMARY STATEMENT OF DEFICIENCIES   PRECIDED BY FULL   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  2 570   Continued From page 17   2 570   and change q 3 days + PRN [as needed]."  The Physical Therapy Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use).  R10's care plan, and TARs were not updated to include the recommendations for hourly repositioning.  During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated.  The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches			00166	B. WING		01/2	8/2016
(X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X4) ID PREFIX TAG  (X5) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 570  Continued From page 17  and change q 3 days + PRN [as needed]."  The Physical Therapy Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use).  R10's care plan, and TARs were not updated to include the recommendations for hourly repositioning.  During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated.  The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 570  Continued From page 17  and change q 3 days + PRN [as needed]."  The Physical Therapy Daily Notes dated 12/28/15, indicated R10 had complained of right buttocks pain, and indicated PT had educated nursing staff to "perform position change every hour to decrease pain and take pressure off coccyx ulcer," and had recommended ROHO cushion (specialty pressure reduction cushion for wheel chair use).  R10's care plan, and TARs were not updated to include the recommendations for hourly repositioning.  During interview with the director of nursing (DON) on 1/28/16 at 9:46 a.m., the DON stated she would expect resident care plans to be updated.  The facility's undated Resident Care Planning policy included: "Between Interdisciplinary Conferences, each discipline is responsible for adding/deleting problems, goals, and approaches	CAMDE	N CARE CENTER					
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R34's was observed on 1/27/16 to receive wound care from RN-A for the following wounds:  1) Left breast: crescent shaped wound that looked like a ruptured blister, measured as 3.5 centimeters (cm.) x1 cm. x 0 cm. There was no drainage.  2) Abdominal slits: a) slit in left groin fold 9.2 cm long. b) 0.5 cm long slit to the right of the left groin slit c) slit in right groin fold 2.8 cm long.  3) Right ischial tuberosity: Stage 3 pressure ulcer measuring 1 cm. x 0.8 cm. x 0 cm. Wound bed	2 570	and change q 3 day  The Physical Thera 12/28/15, indicated buttocks pain, and inursing staff to "per hour to decrease par coccyx ulcer," and incushion (specialty part wheel chair use).  R10's care plan, an include the recommore repositioning.  During interview with (DON) on 1/28/16 as she would expect resupdated.  The facility's undate policy included: "Be Conferences, each adding/deleting proto the individual care  R34's was observed care from RN-A for 1) Left breast: cress looked like a ruptur centimeters (cm.) x drainage.  2) Abdominal slits: long, b) 0.5 cm long groin slit c) slit in rig 3) Right ischial tub	ys + PRN [as needed]."  Apy Daily Notes dated R10 had complained of right indicated PT had educated form position change every ain and take pressure off had recommended ROHO pressure reduction cushion for data to the director of nursing at 9:46 a.m., the DON stated esident care plans to be  and Resident Care Planning etween Interdisciplinary discipline is responsible for blems, goals, and approaches to plan as changes occur."  and on 1/27/16 to receive wound the following wounds: seent shaped wound that ed blister, measured as 3.5 and an an an an an an an an an an an an an	2 570			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING.			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	Continued From pa	ge 18	2 570			
	slough. No drainag will cover it with bor orders from the ME 4) Coccyx: Slit ber cm. in length.  R34's care plan dat at risk for impaired of resolved pressur incontinence, immor neuropathy, chronic sacral coccyx area previously healed ustomach related to interventions instructed interventions instructed interventions in the and change, to encoposition changes as bed, to report skin in and to conduct skir with bath and as ne indicated R34 was bladder and require with toileting, and ir incontinence issues	e observed. RN-A stated, "I rder dressing until I can obtain [medical doctor]." ween buttocks measuring 8 seed 6/3/15, indicated R34 was skin integrity and had a history e ulcers related to obility, diabetes, pain, c issues of open areas to the related to scar tissue from lcers, and multiple ulcers on R34 picking at skin. Care plan cted staff to assist R34 with eded, and with each check ourage R34 to make frequent is able when in the chair or in ssues to MD as they arise, a checks per facility protocol eded. The care plan also incontinent of bowel and ed extensive to total assistance astructed staff to manage is by checking and changing last, after lunch and during the				
	dated 8/5/15, indicated breakdown related	are Area Assessment (CAA) ated R34 was at risk for skin to incontinence, immobility, on related to past stroke, and for repositioning.				
	10/30/15, indicated cognitively impaired all activities of daily further indicated R3	imum Data Set (MDS) dated R34 was moderately d and required assistance with living (ADLs). The MDS 84 was incontinent of bowel as at risk for developing				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0.72	0,=010
CAMDEN	N CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 570	pressure ulcers.  The Nursing Assista 11/10/15, instructed assist of two to che breakfast, after lund rounds/or as needed repositioning.  A Progress Note daindicated, "Resident right inner buttock, Resident has pain in granulation. Protect site." The information care plan.  During interview on stated, "I was not at abdomen or coccyabecause the wound while I was on vacated wounds should have wound nurse the disknown if the information sheets. It should be updated the care planth on R34*  RN-B was interview RN-B stated, "I don repositioning schedule compliance issue. In the compliance issue. In the compliance issue. In the compliance issue of the compliance issue. In the compliance issue of the compliance issue of the compliance issue of the compliance issue. In the compliance issue of the	ant Assignment Sheet dated I staff that R34 required total ck and change before ch, and during the night on d, and to encourage  atted 12/31/15, at 10:51 a.m. thas an o/a [open area] on measures 1 cm x 1 cm. n area, 7 % slough 25% tive barrier cream applied to on was not updated on the  1/27/16, at 9:00 a.m. RN-A ware of the slits on her and the slits on her area. There are no wound sheets as developed in December attion. The nurse who found the e called the MD. I am not a rector is a wound nurse. I don't are to is on the weekly skin and the example of the slits on the staff to red at 11:00 a.m. on 1/27/16, 't care plan turning and the shecause it is a four cannot get the staff to	2 570			

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STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00166	B. WING		01/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 0:72	0,2010
CAMDEN	I CARE CENTER		AVENUE NO			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	OLIS, MN 5	PROVIDER'S PLAN OF CORRECTION	)NI	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
2 570	Continued From pa	ge 20	2 570			
	every two hours."					
	director of nurses s that the aides would when they find an o chart on it and tell the [RN-A]. The nurses interventions for the	1/27/16, at 2:31 p.m. the tated, "My expectation is d tell the nurse right away pen area. The nurse needs to he wound nurse about it need to put the appropriate e open area in place and se needs to update the care				
	dated July 2012, increpositioned every 2	citioning of resident's policy cluded: "3. Residents will be 2 hours unless otherwise e plan and NAR (nursing ent sheets."				
	director of nursing or responsible for accresident cares and	THOD OF CORRECTION: The could in-service staff uracy of care plans to add services when a change is monitor for compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 800	MN Rule 4658.0510 Staffing requiremen	O Subp. 1 Nursing Personnel;	2 800			
	home must have or number of qualified registered nurses, I nursing assistants t residents at all nurs in all buildings if mo	requirements. A nursing a duty at all times a sufficient nursing personnel, including icensed practical nurses, and to meet the needs of the ses' stations, on all floors, and one than one building is ades relief duty, weekends, sements.				

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		SURVEY PLETED
		00166	B. WING		01/	28/2016
	PROVIDER OR SUPPLIER	512 49TH	DRESS, CITY, S AVENUE NO POLIS, MN 58			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 21	2 800			
	by: Based on observati review, the facility for staffing was provide needs of 5 of 6 res R21) who required skin care, pressure the potential to affer in the facility.  Findings include:  Refer to F309: The appropriate care an assessment, care p implementation of in residents (R34) who skin issues.	ent is not met as evidenced on, interview and document ailed to ensure sufficent ed to meet the individual idents (R34, R10, R15, R12, assistance with repositioning, ulcer, catheter care. This had ct all 52 residents who resided facility failed to provide a services including plan development and interventions, for 1 of 2 to had non pressure related				
	services to promote	assess and provide care and healing for a facility acquired of 3 residents (R10) reviewed				
	appropriate indwelli	cility failed to provide ng Foley catheter care to 1 of the sample reviewed with heter.				
	8:54 a.m. to 11:22 a - At 8:54 a.m. R12 with the dining room, - At 8:59 a.m. nursi	continuously on 1/27/16, from				

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
	00166	B. WING		01/2	8/2016
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN CARE CENTER		AVENUE NO			
T		OLIS, MN 5	5430		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFICIENCY)	D BE	(X5) COMPLETE DATE
2 800 Continued From page	ge 22	2 800			
without adhesive. N dining room, - At 9:15 a.m. R12 s room, - At 10:37 a.m. R12 room asleep, - At 10:53 a.m. R12 and, - At 11:22 a.m. R12 sleeping. The observation wa 12:45 p.m. R12 sittii - At 12:57 p.m. aske (LPN)-A if R12 had repositioned. Since LPN-A verified R12 repositioned yet since LPN-A stated, "[R12 were going to lay [R hours and 15 minute - At 1:10 p.m. NA-G and, - At 1:16 p.m. NA-G stand (a mechanica up. NA-H pulled R1: dry in back and he is NA-H remove R12's skin intact was intact blanchable. R12 had NA-G and NA-H was applied a new inconduction.  During continuous of 7:30 a.m. to 10:46 a and 16 minutes with - At 7:15 a.m. R12 versus - At 7:30 a.m. up in - At 7:45 a.m. R12 in - At 7:	A-G returned R12 to the sitting in the television (TV) remained sitting in the TV sitting in the TV room awake still sitting in TV room as resumed on 1/27/16, at ng in TV room sleeping ed licensed practical nurse been toileted and R12 got up that morning. had not been laid down or ce R12 got up that morning. In the laid just eaten lunch staff [12] down." R12 went for four es without being repositioned. If wheeled R12 to bedroom and NA-H placed R12 in EZ all standing lift) and stood R12 [2's pants down and said "he is stry in front." Requested incontinence brief. R12's ct, coccyx was red but d been incontinent of stool. Shed R12's bottom and attinence brief.	2 800			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER	*	I AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	- At 9:15 a.m. R12 s - At 10:30 a.m. R12 s - At 10:40 a.m. R12 s - At 10:46 a.m. R12 s -	sitting in TV room, a remained in TV room, a taken to shower room by oned and checked and, a stood up in standing lift. Iled pants down and removed incontinence brief was wet. It is old was red. LPN-A verified one repositioned since R12 got R12's skin and indicated it a Set (MDS) dated 11/3/15, severely cognitively impaired, with all activities of daily ent of bowel and bladder and nent of pressure ulcers. It is care Area Assessment dated are extensive assistance with ent urinary and bowel dentified risk for pressure ulcer with an activities of daily ent of bowel and bladder and nent of pressure ulcers. It is a severely cognitively impaired are extensive assistance with ent urinary and bowel dentified risk for pressure ulcer with a comparison of the comparis				
		h before bed and on rounds eded. Reposition during check				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAMDE	CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 24	2 800			
	and changes.					
	instructed staff to re	ers signed by doctor on 1/6/16, eposition R12 in wheelchair d house barrier cream to skin wice a day.				
	16, indicated R12 w WHEELCHAIR EVI	ninistration Record dated Jan was to be "REPOSITION IN ERY 2 HOURS (Started of for the AM shift was left blank ned 1/28/16.				
	Copy of R12's tissue tolerance requested but not received.  During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning."					
	said, "I got [R12] up intact." NA-A furthe repositioned today.	1/28/16, at 10:21 a.m. NA-A o at 7:30 a.m. [R12]'s skin is r stated, "[R12] has not been We are so short we cannot leted or repositioned."				
	cognition was intac physical assistance toileting, transfers a addition, the MDS i wheelchair for mob	DS dated 11/13/15, indicated t and R21 required extensive of two staff with dressing, and personal hygiene. In indicated R21 used a lility.				
	asked if he felt ther to make sure you g	p.m. during interview when e was enough staff available et the care and assistance you g to wait a long time resident				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
	PROVIDER OR SUPPLIER	512 49TH	DRESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	stated, either Friday week, when she ha p.m., someone had the light off at 10:25 night shift would tak not come back until indicated she had redirector of nursing.  R13's admission Mi cognition was severextensive physical awith bed mobility, drygiene. In addition a wheelchair for more on 1/25/16, at 6:31 asked if he felt there to make sure you greed without having stated, "You wait for things."	or Saturday of the previous d the light on at around 10:00 come into the room turned in p.m. and had told her the see care of it. The night staff did about 11:30 p.m. Resident exported the concern to the assistance of one to two staff ressing, toileting and personal, the MDS indicated R13 used ability.  p.m. during interview when expose was enough staff available et the care and assistance you go to wait a long time resident when they are ready for	2 800			
	dressing, toileting, t	assistance of two staff with ransfers and personal , the MDS indicated R49 used bility.				
	asked if he felt then to make sure you g need without having stated, the facility w would hear other re	a.m. during interview when e was enough staff available et the care and assistance you to wait a long time resident as understaffed and at time sident hollering for help as e not being answered.				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE	•	
CAMDEN	CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 26	2 800			
	cognition was intact physical assistance dressing, toileting a addition, the MDS is wheelchair and wall On 1/26/16, at 9:40 asked if he felt there to make sure you gneed without having stated, "sometimes	S dated 11/26/15, indicated and required extensive of two staff with bed mobility, and personal hygiene. In adicated R46 used both a ker for mobility.  a.m. during interview when was enough staff available et the care and assistance you to wait a long time resident have to wait. I have wet ad to wait. Weekends are the				
	R34 had moderatel total dependence to assistance of one to daily living. In additi used a wheelchair f On 1/26/16, at 2:50 asked if he felt ther to make sure you g need without having stated, "I wait for 1	o two staff with activities of on, the MDS indicated R34 or mobility.  p.m. during interview when e was enough staff available et the care and assistance you to wait a long time resident hour to get out of bed."				
	indicated cognition required extensive pataff with dressing, personal hygiene. In R15 used a wheelc	day MDS dated 1/6/16, was intact and resident ohysical assistance of two toileting, transfers and addition, the MDS indicated hair for mobility and had a in range of motion on both the tremities.				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430   (X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 27  On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired.  Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a wheelchair for mobility.		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430  (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  COMPLETE TAG  CONTINUED FROM 1, 126/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired.  Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a			00166	B. WING		01/2	8/2016
(X4) ID PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 27  On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired.  Family interview  R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a	NAME OF	PROVIDER OR SUPPLIER	STREET ADI			,	
PRÉFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  2 800  Continued From page 27  On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired.  Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a	CAMDE	N CARE CENTER					
On 1/26/16, at 4:49 p.m. during interview when asked if he felt there was enough staff available to make sure you get the care and assistance you need without having to wait a long time resident stated one of the NA's would leave the tray in the room. When NA had been asked to remove the tray would state, "I don't have time. I need to help other people." Resident also stated some of the aides at the facility were quite mean and thought a couple had been fired.  Family interview R12's annual MDS dated 11/3/15, indicated R12 had severely impaired cognitive skills, required extensive physical assistance of two staff with transfers from bed to wheelchair and used a	PRÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BE	COMPLETE
On 1/26/16, at 11:20 a.m. during interview with a family member, when asked if they felt there was enough staff available to make sure resident get the care and assistance he needed without having to wait a long time family member stated "I never see staff at shift change. I am here every afternoon. They need to re-think the way they do it. They have good aides. They have started switching aides every month. This causes him to swing at them when they approach him wrong he likes to know what is going to happen."  Staff interviews On 1/27/16, at 7:19 am registered nurse (RN)-B, was working the North medication cart, and stated, "Hopefully not for long, I have to fill in once in a while, but, it takes me a long time because I have to read everything, and I wasn't planning on this today."  -At 10:30 a.m. LPN-C, verified she had been	2 800	On 1/26/16, at 4:49 asked if he felt ther to make sure you g need without having stated one of the Ni room. When NA ha tray would state, "I cother people." Res aides at the facility a couple had been a couple had been stated one of the Ni room. When NA has tray would state, "I cother people." Res aides at the facility a couple had been stated as a couple had been stated wheelchair for mobility of the care and assistated as a stated as a stated as a stated as a stated. They have good switching aides ever swing at them wher likes to know what it stated, "Hopefully nonce in a while, but because I have to replanning on this tod	p.m. during interview when e was enough staff available et the care and assistance you to wait a long time resident A's would leave the tray in the deen asked to remove the don't have time. I need to help ident also stated some of the were quite mean and thought fired.  dated 11/3/15, indicated R12 ed cognitive skills, required assistance of two staff with to wheelchair and used a en asked if they felt there was ble to make sure resident get ance he needed without g time family member stated "I hift change. I am here every ed to re-think the way they do aides. They have started ry month. This causes him to a they approach him wrong he is going to happen."  am registered nurse (RN)-B, orth medication cart, and ot for long, I have to fill in takes me a long time ead everything, and I wasn't ay."	2 800			

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY LETED
712 . 271	0. 0020		A. BUILDING:	<del></del>	30	
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 28	2 800			
	called in to cover sh					
	called in to cover si	iort stair.				
	we are not short sta staff."  - At 8:33 a.m. the sobserved passing in approached and as trained medication are short of one numedications and the treatments." When	a.m. LPN-D stated "Usually aff here but today we are short taffing coordinator (SC) was nedications. When ked SC who also was a aide (TMA) stated "today we rse and I am passing e nurses are doing the asked if staffing was a "Usually on PM's we have a				
	problem with nurse them as the other n doubles or pick up a	shifts but we are able to cover burses would either work as we are giving bonuses so				
	hallways yesterday they were short.	A stated he had worked both and it was big mess, because				
	assigned to the We floating around and help, because those	stated there was no aide st hallway today, she was just helping everyone who needs two aides called in sick. A stated, "[R34] has not been				
	get people up or toi you yesterday it wa	We are so short, we cannot leted or repositioned. I told s not too bad here. It is bad." F stated, "It is so hard working				
	done. We cannot re as we should. An e	e we cannot get everything eposition people or toilet them ntire hallway called in. I am				
	do what I can but it miserable when we					
	We are down three to seven aides. I an hallways and we are	C stated, "We are so short. people. We normally have six making beds on the other e trying to make sure and toileted. It is not working.				

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-	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BUILDING:			
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	We are late on just - At 1:00 p.m. NA-A break As you know crazy, it'd be differed - At 2:30 p.m. NA-C short staffed and it all resident cares, the lights was done. Not hard to get all the cowas heavy and a loneeds yet there was facility to meet resident taking break weren taking break weren taken a break good.  - At 2:30 p.m. other had restorative herenough staff, but storinging it back.  - At 3:06 a.m. NA-E at the facility but at the staffing would the staffing work would just end would be completed when asked if residue to the facility, they work the sides and staff management and staff management and staff management did not because of the issufficient work assistant work assistant work as sistant		2 800			

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A. BUILDING:	
<b>00166</b> B. WING	01/28/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
CAMDEN CARE CENTER 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION SHOULD PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
going on and staff were asked to leave at around 9:00 p.m. and at that time there were many residents still up waiting to go to bed and two staff were asked to leave for the night yet one staff in the wing was not able to met the resident needs. When asked if staff was able to meet resident needs timely. NA-E stated not all the time and residents had to wait for a while for staff to come provide cares and at times residents were not toileted or repositioned on a timely manner as directed by the plan of care. During conversation NA-E appeared upset and stated resident care was more important than the money yet management did not see it the same way.  - At 3:22 p.m. an outside agency hospice RN stated, "There has been so much turn over and it is hard to know who to go to with concerns and to ensure continuity of care."  Document review:  The following was noted during a review of the actual staffing and staff postings.  On 1/25/16, day shift, group 1 was a "split group," On 1/26/16, evening shift, group 1 was a "split group," as there was one NA call in, On 1/27/16, day shift, RN/MDS nurse and health unit coordinator (HUC)/LPN pulled to medication cart due to nurse call in, Evening shift - two NAs called in so the evening shift split group 1.  On 1/28/16, day HUC/LPN call in, Receptionist/TMA pulled to medication cart North/East, split group 1, and two NAs called in from West hallway (not replaced), working three NAs short "everyone sharing everyone in building."  The facility failed to provide the requested actual staffing sheets for 11/11 through 11/15/15 requested on 11/28/16, at 3.02 p.m.	

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO			
			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 800	On 11/10/15, indicatin RN manager or Land reflected in the On Sunday 11/15/1 listed on the 24 hou On 11/125/15, no Ron Saturday 11/28/On Sunday 11/29/1 On Sunday 11/29/1 On Sunday 12/27/1 double shift, On Sunday 1/17/16 a.m. and p.m. shifts On Sunday 1/24/16 hallway nurse. The staffing pattern staffing sheets for 1 missing as well as 1 the staffing schedul for 11/25 through 1. On 1/28/16, at 2:57 human resources (linterviewed for staff explained the usual South - Day shift: on South/East Evening NAs, West - Day shift: or North/West Evenings: one TMA Night shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift: one to the NAs for the building Further explanation when there was not the sunday of the shift of the sunday of the shift of the	ted 8 RN hours (not recorded LPN manager hours) that are actual daily staffing sheet. 5, there was no RN coverage its actual staffing sheet. N coverage. 15, no RN coverage. 5, no RN coverage. 5, no RN coverage and LPN planned split group 1 on both s. , MDS RN planned as South could not be reviewed as the 1/16 through 11/24/15, were the staff postings. In addition, e and postings were missing 1/28/15.  p.m. the staffing coordinator, HR) person and the DON were fing. The staffing coordinator staffing: ne nurse and three NAs, g shift: one nurse and three he nurse and two NAs, and two NAs and, wo nurses and two to three pl. of a split group, indicated the enough staff to fill the staffing ned to other groups would split in the staffing the doto ther groups would split in the staffing ned to other groups would split.	2 800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 800	Continued From pa	ge 32	2 800			
	interviewed and ind	p.m. the HR director was icated the facility had a last month and that they are				
	the director of nursi hiring, as a lot of nu the facility was hirin interview process. I	p.m. a staffing interview with ing, revealed they currently are urses have called and asked if g but they did not show for the Per the DON the facility than other facilities.				
	Facility administraticould utilize employ to evaluate staffing places where those be adjusted and imorder to meet all remanner. Facility posufficient staffing conficient employee policies/ practices. developed to observare, meeting all retheir care plan. The & Assurance commitmed findings and developed actions for any patterns.	CHOD OF CORRECTION: on and the director of nursing vee, resident and family input patterns and identify times/ staffing patterns could/should plement those adjustments in sident needs in a timely plicies and procedures for puld be reviewed/ revised. It is could be retrained on those and tools could be vee for timely and complete sident needs as identified in the facility's Quality Assessment point in the polyment corrective the polyment corrective the polyment compliance.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			
		general. A resident must e and treatment, personal and				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from the	supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ng home resident must be out possible unless there is a ne attending physician that the in in bed or the resident	2 830			
	by: Based on observati review, the facility facare and services in plan development a	ent is not met as evidenced on, interview and document ailed to provide appropriate including assessment, care and implementation of of 2 residents (R34) who had d skin issues.				
	R34 was observed 7:05 a.m. until 8:42 observed: At 7:27 a.m. nursing R34's room and obcares. At 7:30 a.m. was a pink dressing outer side of R34's resident's incontine R34's abdominal fotold R34 there was fold, and verified the between R34's abda.m. registered nursident and registered nursident.	continuously on 1/27/16, from a.m. the following was g assistant (NA)-A and entered tained permission to observe during morning care there g observed in place on the top left breast. NA-A removed the nce brief and washed under ld. R34 said that "hurts." NA-A a tear under left abdomen ere was no gauze dressing ominal fold and groin. At 8:09 se (RN)-A arrived to perform easurements and descriptions followed:				

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-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CAMDE	N CARE CENTER		I AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	1) Left breast: A cr looked like a ruptur centimeters (cm.) x drainage. The wour Island dressing (ste to a wound to prom 2) Abdominal slits: long. b) 0.5 cm long groin slit c) slit in rig R34's care plan prir at risk for impaired of resolved pressur incontinence, immoneuropathy, chronic sacral coccyx area previously healed u stomach related to interventions instruct repositioning as nechange, encourage position changes w chair or in bed, reposition changes w chair or in bed, reposition changes w chair or in bed, reposition changes with bath and as nechange and skin with bath and as nechange and skin with bath and as nechange extensive with toileting, and in incontinence issues R34 before breakfanight on rounds or a care plan provided 11/30/15, did not ac issues.  Pressure Ulcer Car 8/5/15, indicated [R breakdown related]	escent shaped wound that ed blister measured 3.5  1 cm. x 0 cm. There was no not was cleansed, and an erile pad or compress applied ote healing) was applied.  a) slit in left groin fold 9.2 cm as slit to the right of the left ght groin fold 2.8 cm long.  Inted 6/3/15, indicated R34 was skin integrity and had a history e ulcers related to bility diabetes, pain, as issues of open areas to the related to scar tissue from lacers and multiple ulcers on R34 picking at skin. The coted staff to assist R34 with eded and with each check and R34 to make frequent hen R34 was able when in the cort skin issues to physician as checks per facility protocol eded. The care plan indicated at of bowel and bladder and assistance to total assistance astructed staff to manage as by checking and changing st, after lunch and during the as needed. In addition, the by facility with print date of lidress skin or incontinence.  e Area Assessment dated 34] was at risk for skin to incontinence, immobility, an related to past stroke, and				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 35	2 830			
	10/30/15, indicated cognitively impaired all activities of daily always incontinent of quarterly MDS indicated developing pressure diagnoses included kidney disease and Nursing Assistant A 11/10/15, instructed assist of two to chebreakfast after lunc rounds or as neede repositioning.	ssignment Sheet dated I staff that [R34] required total ck and change before h and during the night on				
	January 2016, instr DRY ABDOMINAL I 4X4 TO SKIN FOLI treatment was set u information was not assistant assignme	ucted staff to "WASH AND FOLDS AND GROIN, APPLY OS [Started 01/20/15]." The up for every shift. The ton care plan or nursing nt sheet.				
	stated, "I was not a abdomen. There are the wounds develop on vacation. The nushould have called not a wound nurse I don't know if the ir skin sheets. It shou updated the care pl	1/27/16, at 9:00 a.m. RN-A ware of the slits on her e no wound sheets because bed in December while I was urse who found the wounds the MD (medical doctor). I am the director is a wound nurse. Information is on the weekly Id be. The nurse should have an."				
	repositioning sched					

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	compliance issue, y follow the schedule  On 1/27/15, at 11:00 frequently a resider stated, "I would nee When asked how fr wound like R34's sh stated, "at least every buring interview on director of nurses s the slit on R34's rigit told me about the onot a treatment for the aides would tell they find an open a on it and tell the wo The nurses need to interventions for the document. The nurse need immediately from the follow up weekly an would expect a com to be completed. The tolerance. There sh for all residents. To residents need to be turned a minimum. If there is the wound is nasty, for meals. The indivischedule should be and care plans."	you cannot get the staff to "."  9 am RN-A was asked how at should be repositioned and ad to check the care plan." requently a resident with a nould be repositioned RN-A ary two hours."  1/27/16, at 2:31 p.m. the tated, "[NA-A] told me about the groin this morning. No one ther wounds or that there was [R34]. My expectation is that the nurse right away when rea. The nurse needs to chart and nurse about it [RN-A]. The put the appropriate to open area in place and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and see needs to update the care and the control open and the care and the c	2 830			

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STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.1.12 . 27.11	G. GG2G.1.G.		A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDEN	I CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 37	2 830			
	Director of Nursing polices and procedumonitoring non-presonant The Director of Nursing educate staff on the Director of Nursing a monitoring system the appropriate care	THOD OF CORRECTION: The or her designee could developures regarding assessing and ssure related skin conditions. sing or her designee could expolicies and procedures. The or her designee could developen to ensue residents receive expenses.				
0.040	. , -	O ha O B A day also and	0.040			
2 840	MN Rule 4658.0520 Proper Nursing Car	) Subp. 2 B Adequate and e; Clean skin	2 840			
		r determining adequate and criteria for determining er care include:				
	odors. A bathing pl resident's plan of ca condition requires the must be given a condition other day and more incontinent resident every two hours, and	and freedom from offensive an must be part of each are. A resident whose hat the resident remain in bed mplete bath at least every often as indicated. An must be checked at least id must receive perineal care ode of incontinence.				
	Notwithstanding Min 4658.0520, an inco checked according written in the reside attending physician interval longer than	. Incontinent residents. nnesota Rules, part ntinent resident must be to a specific time interval ent's care plan. The resident's must authorize in writing any two hours unless the resident, amily member or legally				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	.0/2010
	N CARE CENTER		AVENUE NO	,		
			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 840	appointed conserval agent of a resident in writing to waive p determining this into documented in the Clean linens or clot promptly each time Perineal care include the perineal area. It to keep the bed dry comfort. Special at skin to prevent irritatypes of protectors completely covered contact with the resident areas to provide the perineal area. The skin to prevent irritatypes of protectors completely covered contact with the resident areas to provide the perineal area. The skin to prevent irritatypes of protectors completely covered contact with the resident areas to provide the sample follows and the sample follows are sampled for the sample follows. Findings include:  R15 was observed in the bed. During in staff did not always morning, and she requested them, where the morning and perine sample for the provide the sample follows.	ator, guardian, or health care who is not competent, agrees obysician involvement in erval, and this waiver is resident's care plan. ]  hing must be provided the bed or clothing is soiled. des the washing and drying of Pads or diapers must be used and for the resident's tention must be given to the ation. Rubber, plastic, or other must be kept clean, be and not come in direct ident. Soiled linen and moved immediately from revent odors.  The provide appropriate the tercare to 1 of 2 residents are reviewed with indwelling on 1/27/16, at 8:23 a.m. laying the review R15 stated she felt clean her properly in the exceived cares only when she nich included a partial bath in ari care. R15 had an indwelling	2 840			
	requested them, wh the morning and pe Foley catheter, with attached to it. R15 s	nich included a partial bath in				

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STATEMENT OF DEFICIENCIES (X1)

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 840	catheter. R15 also bedpan when she had the cathete urologist when in trouble to the diletter of the diletter of the Admission Nur 12/1/15, indicated to UTI's. The tempora noted toileting assis plan did not indicate medical conditions not indicate cares roughly the Admission Nur re-admission) dates of Foley catheter, where the Admission Nur 12/23/15 (second roughly catheter, where the Admission Nur 12/23/15 (second roughly catheter, where the Admission Nur 12/23/15, indicated and pad use. The correspondent of the Correspondent of	if supposed to care for her stated she preferred to use the had bowel movements, but ys had bed pan available to 1:35 p.m. R15 was stated she have not received vicare or catheter care yet exed in with her yet today ming needs. R15 also stated er for a long time, and saw the bouble with kidney failure.  sing assessment dated eatheter use, and history of any care plan dated 12/1/15, st of one or two staff. The care the presence of Foley catheter, related to urinary tract, and did	2 840			
	12/30/15, indicated was frequently inco	R15 had indwelling catheter, ntinent of bowel, and was taff's assistance with bed				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN CARE CENTER		AVENUE NO OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
	depicted R15 as be to have clear comp to clearly state need.  The Urinary Incontic Care Area Assessmente facility would procatheter care and noutcomes associated. The comprehensive and bladder needs, and catheter use withere any interventiwith cares.  The nursing assistation of the comprehensive and catheter use withere any interventiwith cares.	and toilet use. The MDS also ing cognitively intact and able rehension of others and able ds.  nence and Indwelling Catheter nent dated 1/4/16, indicated oceed to care plan for Foley nonitoring of adverse ed with the Foley catheter use.  The care plan 12/23/15, for bowel activities of daily living needs as not developed nor was ons identified to assist R15  ant (NA) care sheet (undated) wo with grooming, dressing,				
	toileting, and transfer However, the sheet indwelling Foley car The Physician's Proindicated R15 had a chronic indwelling Fyears due to immost The note also indicated recently of bladder had urine analysis wone organism isolation ordered a three day (antibiotic). Addition diabetes, osteoarth On 1/27/16, the NA care of R15 or regist nurse manager were	er with Hoyer to commode. did not indicate presence of theter, or related cares.  Ogress Notes dated 1/14/16, chronic kidney disease and foley catheter for the past six bility, and had history of UTI's. ated R15 had complaints spasm, started on oxybutynin, with mixed flora (more than ted from urine culture), and or course of Levaquin hal diagnoses included ritis, and depression.  Who was assigned to take stered nurse (RN)-A (also te not available for interview.				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/28/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO			
	I		OLIS, MN 5		NI.	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
2 840	Continued From pa	ge 41	2 840			
2 040	nurse (LPN)-B was nursing assistants of twice daily pericare morning", get reside and nurses were re "everything is done stated she was not that morning. LPN-I dead", and preferred On 1/27/16, at 3:22 (DON) stated she was morning cares, suc resident had Foley care along with the aware R15 did not morning.  On 1/28/16, at 10:1 day 21 of admission comprehensive care	interviewed and stated the were expected to complete, "wipe the catheter every ent cleaned up in the morning, sponsible to make sure " (meaning cares). LPN-B told R15 did not receive cares B than stated "my brain is ed to conclude interview.  p.m. the director of nursing would expect staff to complete h as partial baths, and if a catheter to complete catheter pericare. The DON was not receive those cares this  1 a.m. the DON also stated by a she would expect to see a e plan written by the MDS viewed R15's record and	2 040			
	stated she would ex developed for activi (include grooming, care.	xpect R15 to have care plan ities of daily living care needs toileting) and Foley catheter				
	The director of nurs develop and implen to ensure that resid with catheter care r educate staff as ap monitoring systems	ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures ents who require assistance eceive timely services; propriate; then develop or audit to ensure ongoing the findings to the Quality tee.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty one				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 865	Continued From pa	ge 42	2 865			
2 865	MN Rule 4658.0520 Proper Nursing Car	) Subp. 2 G Adequate and e; Bed Linen	2 865			
	proper care. The cadequate and proper E. Bed linen mu	ust be changed weekly, or led. Beds must be made daily				
	by: Based on observati failed to ensure app	ent is not met as evidenced on and interview, the facility propriate bedding was resident (R15) in the sample tric bed.				
	Findings include:					
	laying in her bed. The oversized bariatric ray which did not cover R15's head and ned R15 stated the staff	on 1/25/16, at 4:58 p.m. to be here was no sheet on the mattress, only a bed spread, the top of the mattress and ck were on the bare mattress. I had told her for the last three e no bed sheets available for				
	(DON) was interview just received a ship Saturday (1/23/16). had six bariatric because expected to make the sheets. The DON so not have an adequation went to R15's at 5:20 p.m., stated	p.m. the director of nursing wed, and stated the facility ment of bariatric bedding last The DON stated the facility ds in use, and staff were he beds appropriately using aid she was unaware staff did ate supply of linens. The DON room and when she returned the lack of linens of R15's stable." The DON also stated				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3  A. BUILDING:			X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 865	she would have expabout missing reside bedding.  SUGGESTED MET The director of nursidevelop, review, an procedures to ensure with appropriate benursing (DON) or diappropriate staff on The director of nursidevelop monitoring compliance.	ge 43 Dected the staff to inform her ent care supplies including CHOD OF CORRECTION: Sing (DON) or designee could d/or revise policies and re bariatric beds are made d linens. The director of esignee could educate all the policies and procedures. Sing (DON) or designee could systems to ensure ongoing CR CORRECTION: Twenty-one	2 865			
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a n provides that:  A. a resident who without pressure sores unle condition demonstrate authenticates, that is a resident who receives necessary.	sores. Based on the ident assessment, the director must coordinate the ursing care plan which  o enters the nursing home pres does not develop less the individual's clinical lates, and a physician they were unavoidable; and they were unavoidable; and ho has pressure sores of treatment and services to revent infection, and prevent reloping.	2 900			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BUILDING:			
	00166	B. WING		01/28	3/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN CARE CENTER		I AVENUE NO POLIS, MN 5			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
by: Based on observation review the facility faireassess and provide promote healing for a ulcer for 1 of 3 reside pressure ulcers; In ac provide repositioning R12) identified at risk.  Findings include:  R10 was not compreidentify risk factors in further skin breakdow after a pressure ulcer R10's buttocks on 11 home admission).  On 1/26/16, during cofollowing was observed At 8:07 a.m. R10 was chair, and brought to At 8:30 a.m. R10 was wheel chair. At 9:22 activity room. At 10:2 back to her room who (NA)-J put her coat of going out for lunch to residents and activity 10:23 a.m. R10's skin registered nurse (RN consultant/RN (NC)-A assessment along with (LPN)-D. When internis falling apart" and a in the wheel chair." First revised to the residents and activity 10:23 a.m. R10's skin registered nurse (RN consultant/RN (NC)-A assessment along with the wheel chair." First revised to the revised and activity 10:23 a.m. R10's skin registered nurse (RN consultant/RN (NC)-A assessment along with the wheel chair." First revised to the revised and activity 10:23 a.m. R10's skin registered nurse (RN consultant/RN (NC)-A assessment along with the wheel chair." First revised to the revised and activity 10:23 a.m. R10's skin registered nurse (RN consultant/RN (NC)-A assessment along with the wheel chair." First revised to the facility of the revised to the revised	n, interview and document led to comprehensively e care and services to a facility acquired pressure ents (R10) reviewed with ddition, the facility failed to for 2 of 2 residents (R34, a for pressure ulcers.  The ensively reassessed to a order to prevent potential who, and to promote healing r was identified by staff on /24/15 (33 days after nursing continuous observation the ed:  Is transferred into the wheel the dining room, sobserved still sitting in the a.m. R10 was wheeled to the 18 a.m. R10 was brought ere a nursing assistant on her. R10 stated she was a 50's Style Grill with other a staff. At approximately in was assessed by 1-A. The nurse				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO			
			OLIS, MN 5		ONI	0/5
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 45	2 900			
	chair. When NA-J r a moderate amount pad. LPN-D stated dressing on the work been informed by shad come off. The localized on the scalit to be 4 centimete with no depth, and bed. When LPN-D it, R10 retracted in could have been camore likely friction. and shearing player of the wound since didn't think it was a	top of the cushion in the wheel emoved R10's pad, there was to foright red blood on the there should have been a und, and stated she had not staff that the previous dressing right buttocks wound was ar tissue, and RN-A measured (cm) long and 2 cm wide, 100 % bleeding in the wound touched R10's wound to clean pain. RN-A stated the wound used by pressure, but was NC-A also stated, "Friction d a big role in the development the brief line was right there. I pressure ulcer." R10 went for ninutes without being				
	The Admission Record dated 12/8/15, indicated R10 was admitted to the facility on 10/21/15, with diagnoses including unspecified kidney failure, hypertension, peripheral vascular disease, diabetes.					
	10/21/15, indicated "paralyzed", at skin impaired mobility, c had three circles or buttocks, and the d	sing Assessment dated R10's left side was risk included incontinence, hair fast. The body diagram n coccyx, and bilateral escription noted for left and rring from old pressure sore."				
	indicated R10 trans (mechanical lift use					

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	28/2016
	CAMDEN CARE CENTER 512 49TH		DRESS, CITY, S AVENUE NO POLIS, MN 58			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	The admission Mini 10/27/15, indicated staff member's ass transfers, and toilet unhealed pressure developing pressure functional limitation impairment on one mobility. R10 did no care plan developer completed.  The Braden scale (pressure ulcer risk) 16, indicating mild rulcer. However, acquestionable due to perception impairm sided paralysis, and friction and shear beven though R10 rein moving. No addit found in the medical The Nutritional Assit 11/3/15, the record	imum Data Set (MDS) dated R10 was dependent on two istance with bed mobility, use; R10 did not have any ulcers and was at risk for e ulcer; R10 had had of range of motion side; and used wheel chair for thave a skin comprehensive d after the MDS had been tool used to determine dated 11/13/15, had score of risk for developing pressure curacy of the result was a staff indicating no sensory ent even though R10 had left d also due to staff indicating eing only potential problem equired maximum assistance ional Braden assessment was	2 900			
	dated 11/9/15, indic INTERVENTIONS DECREASING THE PRESSURE AREA BREAKDOWN."					
	"abrasion noted on	LF [left] buttocks, sm [small] pping from area." The note				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	also indicated resid and repositioned/of nurse practitioner worker dated between reviewed, no other buttocks wound.  The Physician Order treatment order: "acream used to treat and apply foam dream [sic-morning] and Reposition q 2 hrs [Physician Order data silverstatin cream to dressing and changed The Physician/Nursen Notes dated 12/9/13 all indicated "SKIN:  The Physician Thera 12/28/15, noted R1 pain, and nursing sit position change ever take pressure office or recommended ROP pressure reduction  The Hospital Dischaft 12/29/15, indicated ulcers: "Wound button The January 2016 Record (TAR) indicated 11/24/15, (R10 to be hours) and 12/16/16	ent was laid down after meals, floaded every two hours. The vas updated. All progress en 10/21/15, and 1/26/15, were entries found related R10's  er dated 11/24/15, indicated oply silverstatin cream [a wounds] to Lt [left] buttocks ssing and change q [every] and PRN [as needed]. every two hours]." The ted 12/16/15, indicated "apply to left buttock and apply foam ge q 3 days + PRN."  se Practitioner (NP) Progress 5, 12/15/15, 12/23/15, 1/12/15, normal, no rash."  py Daily Notes dated 0 complained of right buttocks taff was educated "to perform ery hour to decrease pain and	2 900			
		rapy) Resident Referral and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	28/2016
	PROVIDER OR SUPPLIER	512 49TH	DRESS, CITY, S  AVENUE NO POLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	Recommendations not put pillow on top wheelchair."  The undated NA As 1/22/16, indicated for top of ROHO cushid did not indicate free presence of buttock.  The medical record assessments, or an buttocks wound. The evidence of compredetermine causative changes in R10's condevelopment of the On 1/26/16, at 9:30 nurse (LPN)-D state right buttocks, more since 11/24/15. Whis progress notes date R10 had one pressileft side versus right mistake.  On 1/26/16 at 9:45 nursing (DON) were R10 did not have an or her buttocks or conot aware R10 had the right buttocks.  On 1/26/16 10:29 a about the observation.	dated 1/8/16, indicated "Do of ROHO cushion in signment Sheet dated or R10, "do not put pillow on on in wheel chair", however, quency of the repositioning, or as wound.  I lacked evidence of weekly my measurements of the ne medical record also lacked chensive reassessment to be factor, evaluate risk and condition that caused the buttocks wound.  a.m. the licensed practical and the likely pressure related en inquired about the left of 11/24/15, LPN-D stated are ulcer only, documenting at side must have been a side must have been a side must have been a side must have been a side must have been a side must have been a side must have been a side must have been a side must have been a facility acquired wound on the control of the interviewed, RN-A stated they were a facility acquired wound on the control of the interviewed and the side of the pressure ulcers or wounds onceyx. Both stated they were a facility acquired wound on the control of the interviewed at least every two hours, and stated R10 should oned at least every two hours,	2 900			
	On 1/26/26 at 10:32	2 a.m., NA-J was interviewed,				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO POLIS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 900	and could not reme repositioned R10. Not repositioned or transferred into her that morning. NA-J repositioned at least During interview on DON (director of nusupposed to be conwhen they developed causative factors; with scale, tissue perfusito see a compreher contributing factors expect dietary staff updated, and week started to monitor high RN-A was responsiput in place. The Doany assessments from developed new wouthere was no compowhich the MDS cook At 9:55 a.m. RN-B the conversation, a comprehensive car after she transferre SUGGESTED MET The DON or design and/or revise policical residents at risk they are receiving the treatment/services from developing an pressure ulcers. The educate all appropriate into the property of the conversation of the property	mber when she had last IA-J acknowledged R10 was offloaded since she was wheel chair before breakfast stated R10 should have been at every two hours.  1/28/16, at 9:46 a.m. the arsing) stated residents were inprehensively reassessed and a new wound, to determine would expect staff to do Braden ion test, and she would expect included. She would also to be informed, care plan by wound measurements realing process. DON stated ble making sure all these were ON stated she could not find from 11/24/16, when R10 and on the buttocks crease, rehensive care plan written, redinator was responsible for. (also MDS coordinator) joined and stated "didn't believe" a replan was written for R10, defrom the other facility.  THOD OF CORRECTION: the could develop, review, reside and procedures to ensure for pressure ulcers to assure the necessary to prevent pressure ulcers do promote healing of the DON or designee could develop or designee could develop.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1			) DATE SURVEY COMPLETED	
			A. BUILDING:				
		00166	B. WING		01/2	8/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
CAMDEN	CARE CENTER		AVENUE NO OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 50	2 900				
	compliance.						
	TIME PERIOD FOR CORRECTION: Twenty-one (21) days.						
2 905	MN Rule 4658.0525	5 Subp. 4 Rehab - Positioning	2 905				
	Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval.						
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide repositioning for 2 of 2 residents (R34, R12) identified at risk for pressure ulcers.						
	Findings include:						
	7:05 a.m. until 8:42 observed: - At 7:27 a.m. NA-A room and obtained - At 7:30 a.m. durin pink dressing in pla R34's left breastNA-A removed incounder R34's abdom-NA-A verified there	continuously on 1/27/16, from a.m. the following was and surveyor entered R34's permission to observe cares. g morning cares observed a ce on the top outer side of ontinence brief and washed final fold. e were no folded 4X4's gauze R34's abdominal fold and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/0	01/28/2016	
					01/2	0/2010	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CAMDEN CARE CENTER		AVENUE NO OLIS, MN 5					
040.15	CLIMMA DV CTA				ON!	0/5)	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
2 905	Continued From pa	ge 51	2 905				
	was a tear under le barrier cream and v-NA-A requested Nacheck R34's bottom - At 8:09 a.m. regis perform wound care descriptions of wou 1) Right ischial tub measuring 1 cm. x was 20 percent (%) slough. No drainage will cover it with bor orders from the MD 4) Coccyx: Slit betwom. in length.	tered nurse (RN)-A arrived to e. The measurements and nds were as followed: erosity: Stage 3 pressure ulcer 0.8 cm. x 0 cm. Wound bed granulation tissue and 50% e observed. RN-A stated, "I der dressing until I can obtain [medical doctor]."					
	-8:42 a.m. observation of wound treatments						

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
CAMDE	N CARE CENTER		AVENUE NO				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 905	Continued From page 52		2 905				
	incomplete care plan (pages 8-14) provided by facility with print date of 11/30/15, did not address skin or incontinence issues.						
	dated 8/5/15, indicated breakdown related	e Area Assessment (CAA) ated [R34] was at risk for skin to incontinence, immobility, on related to past stroke, and for repositioning.					
	R34's quarterly Minimum Data Set (MDS) dated 10/30/15, indicated R34 was moderately cognitively impaired and required assistance with all activities of daily living (ADLs). R34 was always incontinent of bowel and bladder. R34's quarterly MDS indicated R34 was at risk for developing pressure ulcers. R34's quarterly MDS diagnoses included diabetes mellitus, chronic kidney disease and hypertension.						
	dated 11/10/15, instrequired total assist before breakfast after	ssistant Assignment Sheet tructed staff that (R34) t of two to check and change ter lunch and during the night eded, and encourage					
	"Resident has an obuttock, measures pain in area, 7 % sl Protective barrier co	dated 12/31/15, at 10:51 a.m. /a [open area] on right inner 1 cm x 1 cm. Resident has ough 25% granulation. ream applied to site." The tupdated on the care plan.					
	stated, "I was not a abdomen or coccyx because the wound while I was on vaca	1/27/16, at 9:00 a.m. RN-A ware of the slits on her a. There are no wound sheets is developed in December ation. The nurse who found the e called the MD. Lam not a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	28/2016
NAME OF PROVI	DER OR SUPPLIER			STATE, ZIP CODE		
CAMDEN CAR	RE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
work knows she updown thick thick neck down ulcase with a Atright about bott more [Lick More creates ask - At turn a confollor on how state ask R32 ever the right slitter at the atrick neck ask ask R32 ever the right slitter at the attrick neck as the attrick neck a	wif the informa ets. It should be lated the care ple wound on R34 kness skin loss rosis of subcuta on to, but not three presents clinically undermining 9:16 a.m. NA-A tileg has been to but three weeks. It is getting worstom and on [R34 rning. I told the rensed practical and many morning. It am on and watched for the nurse of the nurse of the schedule of the schedu	rector is a wound nurse. I don't tion is on the weekly skin a. The nurse should have an with a new pressure ulcer. Is bottom is a stage 3 (full involving damage to or uneous tissue that may extend ough, underlying fascia. The cally as a deep crater with or g of adjacent tissue)." In stated, "The sore on [R34's] here since I started here, They normally put cream on it is a. I first saw the slit on [R34's] abdomen Monday nurse Monday. I think nurse (LPN)-B] was the nurse LPN-B] told me to put barrier the it. It looks worse that is why I is."  B said, "I don't care plan oning schedules because it is . You cannot get the staff to	2 905			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	find an open area. and tell the wound nurses need to put for the open area ir nurse needs to uponeeds to get a treadoctor. The nurse needed until resolv comprehensive skill completed. There should be we residents. To detern need to be reposition tolerance and come be turned at baseling of there is a wound nasty, the resident.	The nurse needs to chart on it nurse about it [RN-A]. The the appropriate interventions in place and document. The late the care plan. The nurse timent immediately from the would follow up weekly and as ed. I would expect a in assessment to be should be a tissue tolerance. Beekly skin checks for all mine how often the residents oned we look at tissue orbidities. Residents need to the, every two hours minimum, every one hour. If the wound is should only be up for meals. Turning/repositioning schedule essignment sheets and care	2 905			
	8:54 a.m. to 11:22 a - At 8:54 a.m. R12 the dining room, - At 8:59 a.m. nursi to room and put up without adhesive. N dining room, - At 9:15 a.m. R12 room, - At 10:37 a.m. R12 room asleep, - At 10:53 a.m. R12 and, - At 11:22 a.m. R12 sleeping. The observation wa	continuously on 1/27/16, from a.m. was sitting in a Broda chair in mag assistant (NA)-G took R12 per dentures in R12's mouth IA-G returned R12 to the sitting in the television (TV) 2 remained sitting in the TV 2 sitting in the TV room awake 3 still sitting in TV room as resumed on 1/27/16, at ing in TV room sleeping				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
	PROVIDER OR SUPPLIER	512 49TH	ORESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 905	- At 12:57 p.m. aske (LPN)-A if R12 had since R12 got up th R12 had not been Is since R12 got up th "[R12] had just eate [R12] down." R12 wind minutes without bei - At 1:10 p.m. NA-G and, - At 1:16 p.m. NA-G stand (a mechanica up. NA-H pulled R1 dry in back and he in NA-H remove R12's skin intact was intact blanchable. R12 had NA-G and NA-H was applied a new incord During continuous of 7:30 a.m. to 10:46 and 16 minutes with - At 7:15 a.m. R12 in - At 7:45 a.m. R12 in - At 3:52 a.m. NA-A breakfast, - At 9:15 a.m. R12 in - At 10:40 a.m. R12 in - A	ed licensed practical nurse been toileted and repositioned at morning. LPN-A verified aid down or repositioned yet at morning. LPN-A stated, en lunch staff were going to lay vent for four hours and 15 ng repositioned. If wheeled R12 to bedroom and NA-H placed R12 in EZ al standing lift) and stood R12 2's pants down and said "he is is dry in front." Requested incontinence brief. R12's et, coccyx was red but d been incontinent of stool. Inshed R12's bottom and intinence brief.  Deservation on 1/28/16, from a.m. R12 went for three hours hout being repositioned. Was lying in bed, Broda chair in the hallway, in dining room, assisting R12 to eat	2 905			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			A. BOILDING.			
		00166	B. WING	· · · · · · · · · · · · · · · · · · ·	01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 905	Continued From page 56		2 905			
	severely cognitively with all activities of bowel and bladder pressure ulcers.	1/3/15, indicated R12 was impaired, required assistance daily living, was incontinent of and at risk for development of				
	pressure ulcers we required extensive frequent urinary and	r CAA dated 11/3/15, indicated re triggered because R12 assistance with bed mobility, d bowel incontinence, and essure ulcer development.				
	Care plan printed 1/28/16, instructed staff R12 continues to be at risk for skin breakdown related to history of pressure ulcer, incontinence impaired mobility psychotropic drug use and diuretic use. Interventions instructed staff follow repositioning schedule per nursing, provide moisture barrier and perform peri-care during each check and change and as needed, wound care as ordered, check and change before breakfast after lunch and on rounds through night and as needed.					
	Assignment Sheet change before brea	o 3 Nursing Assistant instructed staff check and akfast after lunch before bed ugh night as needed. heck and changes.				
	instructed staff to re	ers signed by doctor on 1/6/16, eposition R12 in wheelchair d house barrier cream to skin wice a day.				
	16, indicated R12 w WHEELCHAIR EVI	ninistration Record dated Jan was to be "REPOSITION IN ERY 2 HOURS (Started of for the AM shift was left blank ned 1/28/16.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					(X3) DATE COMP	SURVEY LETED
		00166	B. WING _		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	0/2010
	N CARE CENTER		AVENUE NO	,		
			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 905	Continued From page 57		2 905			
	Copy of R12's tissue tolerance requested but not received.					
	During interview on 1/27/16, at 12:57 p.m. LPN-A stated, "[R12] has not been laid down or repositioned yet since he got up this morning."					
	During interview on 1/28/16, at 10:21 a.m. NA-A said I got (R12) up at 7:30 a.m. [R12]'s skin is intact. Na-A stated, "[R12] has not been repositioned today. We are so short we cannot get people up or toileted or repositioned."					
	director of nurses (I needs to chart on it about it [RN-A]. The appropriate interver place and document the care plan. The rimmediately from the follow up weekly an would expect a comto be completed. The tolerance. There she for all residents. To residents need to be turned a minimum. If there is wound is nasty, the meals. The individual	1/27/16, at 2:31 p.m. the DON) stated,". The nurse and tell the wound nurse enurses need to put the ntions for the open area in at. The nurse needs to update nurse needs to get a treatment needoctor. The nurse would as needed until resolved. In a prehensive skin assessment needs how often the erepositioned we look at a comorbidities. Residents at baseline, every two hours as a wound every 1 hour. If the resident should only be up for alized turning/repositioning on the assignment sheets				
	6/28/05, indicated "facility without press	care Protocol dated revised on That a resident who enters the sure sores does not develop less the individual's clinical ated that they were				

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (			(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING:		COIVIE	LETED	
		00166	B. WING		01/2	8/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE			
CAMDEN	CARE CENTER		AVENUE NO OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 905	unavoidable; and a sores receive neces as the facility is able healing, prevent inferom developing."  The facility's Repost dated July 2012, inserted will be unless otherwise do NAR assignment strain all staff on ensurance and repositi their assessed need then perform obsercompliance.	resident having pressure ssary treatment and services, e to provide, to promote ection, and prevent new sores sitioning of resident's policy structed staff: e repositioned every 2 hours ocumented on care plan and	2 905				
21426	(21) days.  MN St. Statute 144. Prevention And Cor  (a) A nursing home maintain a comprehinfection control procurrent tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control plaunpaid employees, residents, and volun	A.04 Subd. 3 Tuberculosis	21426				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 59	21426			
	regarding implemen	ntation of the guidelines.				
	(b) Written compliance with this subdivision must be maintained by the nursing home.					
	by: Based on interview agency failed to en had proper interpre (TST) result. In add resident (R46, R32	ent is not met as evidenced and document review, the sure 1 of 5 employees (E-3) tation for Tuberculin Skin Test lition failed to ensure 5 of 5 , R33, R9, R63) had TST's eening completed as State guidelines.				
	Findings include:					
	E-3's file indicated a Test (TST) had bee read 7/11/15, with 0	revealed a hire date of 7/7/15. a step one Tuberculin Skin en administered on 7/9/15, and millimeters (mm) no "Positive or Negative."				
	medical record indi	to the facility on 8/24/15. R46's cted resident had TB symptom /15, however had not received or step two TST's.				
	medical record indi	to the facility on 10/5/15. R32's cted resident had not had the ning, step one and step two				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '			(X3) DATE SURVEY COMPLETED	
71112 1 27111	or connection	BERTH TOXITION TROMBETT.	A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21426	Continued From page 60		21426			
	was re-admitted ag record indicted resi screen done 12/29/either the step one admitted to the faci.  R9 was admitted to medical record indical record reversed step one as 0 mm with a "Ne not received step to the R63 was admitted to medical record indication and been complete one TST was given	the facility on 11/5/15. R9's cted a TB symptom screening d on the same day. The ealed even though R9 had FST on 11/5/15, read 11/7/15, egative" interpretation, R9 had				
	Health Care Setting Health Care Worke "TST documentatio the test (i.e., month millimeters of indur document "0" mm) positive or negative directed "Screening hours of admission consists of three co 1. Assessing for cu disease, 2. Assessing for TE and 3. Testing for the pr	erculosis Control in Minnesota gs dated July 2013, Screening ers (HCW's) directed: en should include the date of aton (if no induration, and interpretation (i.e., e) In addition the regulation g should be initiated within 72 and "Baseline TB screening emponents: rrent symptoms of active TB B risk factors and TB history, resence of infection with erculosis by administering				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	8/2016
	PROVIDER OR SUPPLIER	512 49TH	DRESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21426	either a two-step TS SUGGESTED MET The Director of Nur monitor to assure to procedures were de ensure staff was fre working with reside TIME PERIOD FOR (21) days.	ST or single IGRA"  CHOD FOR CORRECTION: sing and/or designee could uberculin screening eveloped and implemented to be of tuberculosis prior to ents.  CORRECTION: Twenty-one  Subp. 1 Medicine Cabinet	21426			
	Subpart 1. Storage must store all drugs under proper temper only authorized nursaccess to the keys.  This MN Requirement by: Based on observation review, the facility for refrigerator temperation manufacturer's reconstructurer was motential to affect 12 R15, R62, R14, R3-R53) currently residenced and secured dated when opened.	e of drugs. A nursing home in locked compartments erature controls, and permit sing personnel to have  ent is not met as evidenced on, interview and document ailed to ensure the medication ature was kept within ommendation range, and the ure the refrigerator onitored. This had the 2 of 52 residents (R39, R45, 4, R70, R36, R10, R21, R69, led in the facility. In addition kept in the room were not I, and insulin vial was not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.110 1 12/114	01 0011112011011	BEITH IOMIGITIES	A. BUILDING:		00Mii 22125	
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER	512 49TH	AVENUE NO	RTH		
OAMBLI	TOARE OFFICE	MINNEAP	OLIS, MN 5	5430		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 62	21610			
	presence of the lice on 1/28/16, at 9:08 refrigerator was at SLPN-D stated reside such as insulin was temperature was to above the refrigerate months ago) and haresults recorded. We temperature log, LF any for the past 6 munopened medication the refrigerator:  - Afluria 5 milliliter - Nine vials of Infuvintravenous infusior - One Novolog insuliabetes) for R45,  - Two Novolog insuliabetes) for R45,  - Three Novolog insuliabetes) for R34,  - One Lantus insuliing - One Lantus insuliing - One Lantus insuliing - One Humalog insuliing - One Humalog insuliing - One bottle of Lata (eye drops) for R53 - One vial of Lorazeresident name on)  LPN-Z was not sure accurate or not, sugtemperature with an	ensed practical nurse (LPN)-D a.m. the medication 55 degrees Fahrenheit (F). ent's extra medication supply stored in this refrigerator, and o high. The temperature log for was from July 2015 (from 6 ad only four temperature then asked for the current ent ensked for the current ent ensked she could not find fronths. The following ens were observed stored in (ml) (influenza virus vaccine) eite (multiple vitamins for en) for R39 ulin pen (used to treat en vial for R15, sulin pens for R62, es insulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R10, ulin pens for R21, ulin (also used to treat en vial for R36, en pens for R41, ulin (also used to treat en vial for R36, en pens for R40	21010			
	(DON) verified the r should have been b	refrigerator temperature between 36 and 46 degree F, aff were responsible for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00166	B. WING		01/2	28/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21610	night. The DON als checks were done of the checks were	erator temperature daily at o verified the last temperature of months ago in July 2015.  5 a.m. the medication ature was checked again by at 48 degrees (still too high).  se consultant (NC)-C was ted the refrigerator have been kept between 36 and the refrigerator ared daily.  facturer's recommendation for rost eye drops, Lantus, lumalog, and Lorazepam stored at 36 F- 46 F.  sultant (PC) was interview via 16, at 3:10 p.m., and stated gerator temperature should ween 36 and 46 degrees F, dimedications also should ween these temperature sted refrigerator monitoring temperature checks. PC dimany conversations in the trefrigerator temperature into aware the refrigerator mining so high.  ation Storage in the Facility edications requiring ept at temperatures ranging C/F [Celsius/Fahrenheit] to a refrigerator not accessible	21610			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 64	21610			
	Charge Nurse will on the front of the f	d 4/12, indicated "Night check refrigerator temp nd record on monitoring sheet ridge". The policy did not uency of temperature checks.				
	interviewed in his recontainer with blood insulin observed on When interviewed I blood sugar checks insulin, and showed was a Novolog pen another Novolog pen and an opened Lan opened (with pharm R62 also showed to Metformin 1000 mg stated he kept his rethe bedside table, co	p.m. R62 was observed and com. There was plastic disugar check supplies and the top of the nightstand. R62 stated he did his own and self-administered the did the content of the box. There dated opened on 1/17/16, and dated opened on 1/24/16, tus vial not dated when it was nacy delivery dated 1/11/16). Wo medication carts with an each with 30 tablets. R62 nedication supply usually on did not lock them in the drawer ling room, only if he left the t.				
	eating breakfast in the plastic containe	a.m. R62 was observed the dining room. At this time r with the insulin was attended/ unlocked in R62's e table.				
	medication box with bedside table, and residents rooms su the top drawer of the	a.m. the DON verified the insulin supply was on the stated medications in pposed to be kept locked in e dresser. DON also stated hould have been dated with ned.				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
CAMDEN	N CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
21610	Continued From pa	ge 65	21610			
	R62's medications	8 a.m. LPN-D also stated should have been locked in drawer of the dresser.				
	The undated Medication Storage in the Facility policy did not include instructions for medication storage requirements in resident's rooms.  SUGGESTED METHOD OF CORRECTION: The director of nursing or her designee could development and implement policies and procedures to ensure that medications are stored appropriately. The director of nursing or her designee could then monitor the licensed staff for adherence to the policies and procedures.  TIME PERIOD FOR CORRECTION: Twenty -					
21695	Subp. 4. Houseke provide housekeepi necessary to mainta comfortable interior	5 Subp. 4 Plant eration, & Maintenance eping. A nursing home must ing and maintenance services ain a clean, orderly, and r, including walls, floors, iixtures, equipment, lighting,	21695			
	by: Based on observati review, the facility fa maintained in a clea of 1 resident (R27). of 3 residents (R12 wheelchairs mainta	ent is not met as evidenced ion, interview and document ailed to ensure a chair was an and sanitary manner for 1. In addition failed to ensure 3, R41, R21) had their lined in good repair reviewed oncerns. In addition, the				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00166	B. WING		01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
CAMDEN	CARE CENTER		OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 66	21695			
	and transfers was p	ure assist bar for positioning properly secured to resident use for 1 of 1 resident (R12) pars.				
	Findings include:					
	1/26/16, at 8:57 a.n with spots on the arsecretions from trace.  On 1/28/16, at 12:0 the environmental to (RM) verified the la	4 p.m. to 12:32 p.m. during our with the regional manager zy boy which was covered with				
	spots of perhaps secretions stated would have to bring a spot cleaner and use disinfectant to clean the chair when resident was not up on it. During the tour resident was observed seated on the chair and was able to acknowledge all the spots and stated he would not blame anyone for it and gave surveyor thumbs up when surveyor indicated RM was going to clean it.					
	at 11:46 a.m. during	chair right armrest on 1/25/16, g room observation was nd was missing front edge of				
	the environmental ton his Broda wheel both the administra (RM) verified the wappeared to be dry the regional managon the right armres underneath making	4 p.m. to 12:32 p.m. during our R12 was observed seated chair in the North dining room tor and the regional manager heelchair had simmers of what food on the side. In addition the verified foam was missing than and was exposing gray foam it not a cleanable surface.				

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00166	B. WING		01/2	8/2016	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
CAMDE	N CARE CENTER		AVENUE NO OLIS, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21695	shaving the wheeld overheard indicated armrest was going R12's annual Minim 11/3/15, indicated F cognitive skills, req assistance of two swheelchair and use R41's wheelchair w On 1/28/16, at 12:2 tour R41 was seated dining table waiting was observed crace off and was exposimaking it an unclear R41's annual MDS had severely impair total dependence for unit and used a wh R21's wheelchair w On 1/26/16, at 12:0 the electric wheelch cracked, peeled off foam underneath m surface. On 1/28/16, at 12:4 environmental tour wheelchair was reswheelchair. RM stafamily member if the	chair under the tables. RM was do to the administrator the to be replaced.  Inum Data Set (MDS) dated R12 had severely impaired uired extensive physical staff with transfers from bed to ed a wheelchair for mobility.  It is p.m. during the environment ed on the wheelchair at the for lunch and the left armrest ked and the vinyl was peeled ing the foam underneath anable surface. RM verified it.  I dated 11/13/15, indicated R41 red cognition skills, required for locomotion on and off the eelchair for locomotion.  I p.m. R21's left armrest of the nair was observed with vinyl and was exposing the yellow making it an uncleanable.	21695				

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NAME OF PROVIDER OR SUPPLIER  CAMDEN CARE CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430   (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGG REGULATORY OR LSC IDENTIFYING INFORMATION)  21695  Continued From page 68  verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issue.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."		NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430   (X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  Continued From page 68  verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."				71. BOILBING.			
CAMDEN CARE CENTER  512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430  (IX4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21695  Continued From page 68  verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."			00166	B. WING		01/2	8/2016
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES PRECOEDE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21695  Continued From page 68  verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."	NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
PRÉFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  21695  Continued From page 68  verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."	CAMDE	N CARE CENTER					
verified the wheelchair was with ill repair and acknowledged staff should have reported the concern immediately to his department to be addressed to prevent causing skin issues.  R21's admission MDS dated 11/13/15, indicated R21 had intact cognition, required extensive physical assistance with transfers, had a functional limitation of both lower extremities and used a wheelchair for locomotion.  Environmental- Cleaning of Equipment policy dated April 1, 2008 indicated "All unit equipment (e.g., refrigerator, commodes, water pitchers, water glasses, urinals, lifts, wheelchairs, respiratory equipment, suction equipment, and enteral equipment) is cleaned on a routine basis."	PRÉFIX	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETE
During initial tour on 1/25/16, at 4:09 p.m. the right assist rail which was attached to the bed, nearest the door, was noted to bow outward. R12 was in the day room sitting in a wheelchair.  On 1/27/16, at 7:07 a.m. R12 was observed lying in bed with head turned to the left. The right assist rail was bowing outward.  R12's Minimum Data Set (MDS) dated 11/3/15, identified diagnosis of right sided hemiplegia, stroke and dementia.  R12's Fall Care Area Assessment dated 11/3/15, indicated R12 had balance problems during transfers between bed and wheelchair.  Care plan printed 1/28/16, indicated R12 was at risk for fall related to hemiplegia, dementia, impaired mobility and urinary and fecal	21695	verified the wheelch acknowledged staff concern immediate addressed to prever R21's admission MR21 had intact cographysical assistance functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a wheelchair functional limitation used a water glasses, uring respiratory equipment enteral equipment)  R12's Enabler bar:  During initial tour or right assist rail which head turn assist rail was bowing the diagnosis stroke and dementional limitation diagnosis stroke and dementional limitation used functional limitatio	nair was with ill repair and is should have reported the ly to his department to be ent causing skin issues.  DS dated 11/13/15, indicated nition, required extensive with transfers, had a of both lower extremities and for locomotion.  aning of Equipment policy indicated "All unit equipment ommodes, water pitchers, als, lifts, wheelchairs, ent, suction equipment, and is cleaned on a routine basis."  In 1/25/16, at 4:09 p.m. the ch was attached to the bed, as noted to bow outward. R12 in sitting in a wheelchair.  In a.m. R12 was observed lying med to the left. The right ing outward.  It a Set (MDS) dated 11/3/15, of right sided hemiplegia, a.  In a Assessment dated 11/3/15, of alance problems during oned and wheelchair.  In a Assessment dated R12 was at o hemiplegia, dementia,	21695			

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Minnesota Department of Health

-	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
	PROVIDER OR SUPPLIER	512 49TH	ORESS, CITY, S AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	within reach, perime the potential of falls with transfers and be potential for falls, at when in bed.  On 1/27/16, at 9:22 verified the enabler manager stated the off, ensure the hole tightened and then manager stated the to audit all assist racheck every bar in treport indicated tha rails was done on 1 for the week of 1/9/12/31/15.  On 1/27/16, at 12:5 (LPN)-A stated [R12 roll from side to side SUGGESTED MET administrator, envir (s) could revise polithat the environmer hazards, safe, function for the designee (s) could related how to ensure policies and proced administrator, envir (s) could monitor the conditions periodical	eter mattress on bed to reduce, extensive to total assistance bed mobility to decrease the end resident uses enabler bars  a.m. the regional manager bar was loose. The regional assist bar should be taken shave not been rounded off, replaced. The regional maintenance technicians are ils every week. They are to the building. Work history to Facility Safety: Check assist 1/25/16, 1/22/16, not recorded 16 and was last done on  7 p.m. licensed practical nurse 2 will grab the bar and help to be commental director or designee cies and procedures to ensure at for the residents is free from	21695			

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUR COMPLETE (X3) BUILDING: (X3) DATE SUR				
		00166	B. WING	<del></del>	01/2	28/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
21695	Continued From pa	ge 70	21695			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty One				
21705	MN Rule 4658.1415 Housekeeping, Ope	5 Subp. 6 Plant eration, & Maintenance	21705			
	ventilation. A nursi maintain the mecha comfortable and sa and humidity levels areas must be main C:  A. For construct nursing home must of 71 degrees Fahre Fahrenheit at all tim B. For existing must maintain a m degrees Fahrenheit C. Variations of titems A and B are a	air conditioning, and ing home must operate and anical systems to provide fe temperatures, air changes, . Temperatures in all resident ntained according to items A to etion of a new physical plant, a maintain a temperature range enheit to 81 degrees nes. facilities, a nursing home inimum temperature of 71 t during the heating season. he temperatures required by allowed if the variations are ted resident preferences.				
	by: Based on observati review, the facility fa temperatures were for 2 of 5 residents	ent is not met as evidenced on, interview and document ailed to ensure comfortable maintained in a shared room (R46, R12) reviewed for com temperature concerns.				
	Findings include:					
		imum Data Set (MDS) dated resident had intact cognition.				
		a.m. when asked during as any problems with the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00166	B. WING	· · · · · · · · · · · · · · · · · · ·	01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDEN	N CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 71	21705			
	building that affected was not warm enough R46's bed was obstraction on the wall three heavy blankers not facility blankets.  On 1/28/15, at 7:40 reported the cold records.	g, noise or anything else in the ed his comfort, R46 stated "It igh." During the interview erved right next to the heat and was also covered with its on top of him which were a.m. R46 stated he had som temperature to the staffmen it was going to be				
	addressed and in the blankets to keep was	ne meantime was using heavy arm.				
	R12's annual MDS dated 11/3/15, indicated resident severely impaired cognition skills and family was involved in care decisions as a result.					
	On 1/26/16, at 11:28 a.m. during a family interview with R12's family when asked if there were any problems with the temperature, lighting, noise or anything else in the building that affected R12's comfort, family member stated during visits to the facility the room was always cold which R12 was not able to verbalize.					
	environmental tour regional manager (I During the tour the temperatures twice registered at 68 decenders are second reading reg Fahrenheit. Both the verified the reading the thermostat local The administrator a staff about ensuring	2:04 p.m. to 12:32 p.m., an was conducted with the RM) and the administrator. RM checked the room. The first temperature reading grees Fahrenheit, and the istered at 69 degrees e administrator and the RM s and stated they would adjust ted by the door to the room. Ilso stated she would educate graintenance were aware of about room temperatures.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.1.12 . 27.11	o. oo20		A. BUILDING:			
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDEN	CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	.D BE	(X5) COMPLETE DATE
21705	Continued From pa	ge 72	21705			
	(General) dated Ap	Environment - Quality of Life ril 1, 2008, indicated afe temperature levels (71-81				
	maintenance direct and implement polic resident rooms are temperatures; educ monitoring systems compliance and rep committee for revie	oort the findings to the quality				
21800	MN St. Statute144. Residents of HC Fa	651 Subd. 4 Patients & ac.Bill of Rights	21800			
	residents shall, at a are legal rights for stay at the facility of treatment and main that these are described written statement or responsibilities set case of patients ad as defined in section statement shall also person 16 years old provided in section shall list the names individuals and organdocacy and legal residential program accommodations si	tion about rights. Patients and dmission, be told that there their protection during their rethroughout their course of a tenance in the community and ribed in an accompanying of the applicable rights and forth in this section. In the mitted to residential programs in 253C.01, the written of describe the right of a discribed for older to request release as 253B.04, subdivision 2, and and telephone numbers of anizations that provide services for patients in s. Reasonable hall be made for those with pairments and those who				

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Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 01/2	J, 2010
	N CARE CENTER		AVENUE NO			
			OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 73	21800			
	facility policies, insplocal health authorith the written statement to patients, resident chosen representation the administrator person, consistent of the statement of the sta	other than English. Current pection findings of state and cies, and further explanation of nt of rights shall be available ts, their guardians or their ives upon reasonable request or other designated staff with chapter 13, the Data section 626.557, relating to				
	by: Based on interview facility failed to prov Nursing Facility Adv (SNFABN) or unifor termination of all Moservices for 1 of 5 r liability notice and b addition, the facility Notice of Medicare	and document review, the vide the required Skilled vanced Beneficiary Notice m denial letter upon edicare (MC) Part A skilled esidents (R43) reviewed for beneficiary appeal rights. In failed to provide R43 with the Non-coverage CMS-010123 d in the facility until discharge.				
	Findings include:					
	R43 had been adm and had been disch record indicated R4 physical and occup	d was reviewed and indicated itted to the facility on 7/29/15, narged 8/11/15. In addition, the 3 had received skilled ational therapy. The record ment source had been MC.				
	the MC denial notic manager stated she notice(s) provided.	on 1/28/16 at 8:50 a.m., about e for R43, the business office e was unable to locate the After looking through R43's business office manager				

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STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00166	B. WING		01/2	8/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
CAMDE	N CARE CENTER		AVENUE NO			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21800	stated, "I can't find on 1/28/16, at 2:35 (RN)-B responsible assessments stated Medicare notices to therapy." When ask given a notice prior therapy services, R left before the notice stated she didn't habecause the persor resident the notice facility.  On 1/28/16, at 2:48 stated she would exappropriate and time required by MC.  On 1/28/16, at 3:17 assistant (PTA) stated therapy notes, the tweekly therapy meeting which was skilled services it have seeing which was skilled services it have going to be disstated the resident had met their maximal resident had been put through 8/10/15, which therapy. The resident facility for another recoverage.  The facility provided Medicare Compliant Letter, Appeals Pro Billing-HDGR (Heal	p.m., the registered nurse for Minimum Data Set d, "Typically we would give the wo days before the end of sed whether R43 had been to the end of the skilled N-B stated the resident had e could be provided. RN-B we any other information, a responsible for giving the no longer worked at the p.m. the director of nursing spect residents to be given ely MC denial notice as  p.m., the physical therapy sed after having reviewed the herapy department had held etings and during the 8/7/15, a week before the end of the end been discussed resident charged from therapy. PTA had made good progress and mum potential. PTA stated the provided therapy from 7/29/15 hen R43 was discharged from ent had then stayed in the hight not eligible for MC	21800			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00166	B. WING		01/2	8/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
CAMDEN	I CARE CENTER		AVENUE NO OLIS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
21800	Continued From pa	ge 75	21800			
	given at least two (2) days prior to the end of skilled services for the resident."					
21910	The administrator of review, and/or revise ensure staff are eduliability notices to proper Medicare services, are communicated. The administrator of appropriate staff on The administrator of monitoring systems compliance.  TIME PERIOD FOR (21) Days	R CORRECTION: Twenty-one	21910			
21810	Residents of HC Fa Subd. 6. Appropriate and person needs. Appropriate care designed to enhighest level of phy This right is limited	de the right to appropriate and e the right to appropriate all care based on individual e care for residents means able residents to achieve their sical and mental functioning. Where the service is not blic or private resources.	21810			
	by: Based on observati review, the facility fa accessible for 2 of 2	ent is not met as evidenced on, interview, and document ailed to ensure call lights were 2 residents (R15, R10) ed call lights to summon staff				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
		00166	B. WING		01/2	8/2016						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
CAMDEN CARE CENTER 512 49TH AVENUE NORTH MINNEAPOLIS, MN 55430												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	(X5) COMPLETE DATE							
21810	Continued From page 76		21810									
	assistance.											
	Findings include:											
	her room sitting in the was observed on the wheelchair, and was interviewed, R15 st so she could call for happened in the paleft within reach, and before leaving the rewithin reach. At that (NA)-I entered the reach within R15's reach and handed it to R1	on 1/25/16, at 11:45 a.m. in the wheelchair. R15's call light he floor next to R15's sout of R15's reach. When ated she needed her call light r help. R15 also stated it had ast that the call light was not he she needed to remind staff from to place the call light to point the nursing assistant room, verified the call light was ach, picked up the call light 15. NA-I stated the call lights ced always within residents										
		inimum Data Set (MDS) dated R15 was cognitively intact.										
	interviewed in her r bed, and stated she when she needed reall light but could reall light but could reall light at 11:25 a. capable of using the R10's call light was for the call light. RN was wrapped up in resident's bed. RN-to place the call light resident when they	DS dated 10/27/15, indicated										
		cognitive impairment.										

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
7.1.5 . 5 . 1. 0. 00 . 1. 1. 20 . 1. 0. 1			A. BUILDING.									
		00166	B. WING		01/2	8/2016						
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STATE, ZIP CODE									
CAMDEN CARE CENTER  512 49TH AVENUE NORTH  MINNEAPOLIS, MN 55430												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMPLETE							
21810	Continued From page 77		21810									
	On 1/28/16, at 9:43 a.m. the director of nursing stated staff were expected to make sure call light were placed within residents' reach all the time.  The facility's call light policy was requested, but											
	not provided.											
	The call light policy provided.	was requested, but not										
	The DON or design and/or revise policic call lights are kept v DON or designee c staff on the policies	THOD OF CORRECTION: lee could develop, review, les and procedures to ensure within resident reach. The lould educate all appropriate and procedures. The DON or lelop monitoring systems to impliance.										
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one										

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