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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QJ99

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00166

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

2.STATE VENDOR OR MEDICAID NO.
(L2) **699435200**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **11/12/2015**

6. DATE OF SURVEY **05/08/2017** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **87** (L18)

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

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Gary Nederhoff, Unit Supervisor — 05/08/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 06/07/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30) **00**

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
06201
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/18/2017
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245544
June 7, 2017

Ms. Shelley Solberg, Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

Dear Ms. Solberg:

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, 2017 the above facility is certified or recommended for:

87 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 7, 2017

Ms. Shelley Solberg, Administrator
Victory Health & Rehabilitation Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Number S5544027

Dear Ms. Solberg:

On April 7, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 23, 2017 that included an investigation of complaint number H5544054. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 8, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on 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 March 23, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 2, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 23, 2017, effective May 2, 2017 and therefore remedies outlined in our letter to you dated April 7, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245544 Y1	A. Building B. Wing Y2	5/8/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
VICTORY HEALTH & REHABILITATION 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0156	Correction	ID Prefix F0176	Correction	ID Prefix F0241	Correction
Reg. # 483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18)	Completed	Reg. # 483.10(c)(7)	Completed	Reg. # 483.10(a)(1)	Completed
LSC	05/02/2017	LSC	05/02/2017	LSC	05/02/2017
ID Prefix F0253	Correction	ID Prefix F0274	Correction	ID Prefix F0282	Correction
Reg. # 483.10(i)(2)	Completed	Reg. # 483.20(b)(2)(ii)	Completed	Reg. # 483.21(b)(3)(ii)	Completed
LSC	05/02/2017	LSC	05/02/2017	LSC	05/02/2017
ID Prefix F0311	Correction	ID Prefix F0323	Correction	ID Prefix F0406	Correction
Reg. # 483.24(a)(1)	Completed	Reg. # 483.25(d)(1)(2)(n)(1)-(3)	Completed	Reg. # 483.65(a)(1)(2)	Completed
LSC	05/02/2017	LSC	05/02/2017	LSC	05/02/2017
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix	Correction
Reg. # 483.55(b)(1)(2)(5)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. #	Completed
LSC	05/02/2017	LSC	05/02/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GN/KJ	06/07/2017	10160	05/08/2017
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
3/23/2017

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QJ99

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00166

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

2. STATE VENDOR OR MEDICAID NO. (L2) **699435200**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) **11/12/2015**

6. DATE OF SURVEY **03/23/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **87** (L18)

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

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	87			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Name Changed. This facility previously operated under the name of Camden Care Center.

17. SURVEYOR SIGNATURE Date :
Sarah Strenke, HFE NE II 04/13/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/15/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/01/1991** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **06201** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 7, 2017

Ms. Shelley Solberg, Administrator
Camden Care Center
512 49th Avenue North
Minneapolis, MN 55430

RE: Project Numbers S5544027, H5544054, H5544058 and H5544061

Dear Ms. Solberg:

On March 23, 2017, 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. In addition, at the time of the March 23, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint number H5544054. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the March 23, 2017 standard survey the Minnesota Department of Health completed an investigation of complaint numbers H5544058 and H5544061 that were found to be unsubstantiated.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
Email: gary.nederhoff@state.mn.us
Telephone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 2, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 23, 2017 (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 September 23, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 03/23/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. " A recertification survey was conducted and complaint investigation(s) were also completed at the time of the standard survey. " An investigation of complaint H5544054 was completed and substantiated with deficiencies at F282 & F311. An investigation of complaint H5544058 was completed and found not to be substantiated. An investigation of complaint H5544061 was completed and found not to be substantiated.	F 000		
F 156 SS=C	483.10(d)(3)(g)(1)(4)(5)(13)(16)-(18) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES (d)(3) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care. §483.10(g) Information and Communication.	F 156		5/2/17

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

Electronically Signed | 04/13/2017

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 03/23/2017

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 156	Continued From page 1 (1) The resident has the right to be informed of his or her rights and of all rules and regulations governing resident conduct and responsibilities during his or her stay in the facility. (g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and (D) A statement that the resident may file a	F 156		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 156	Continued From page 2 complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.) [§483.10(g)(4)(ii) will be implemented beginning November 28, 2017 (Phase 2)] (iii) Information regarding Medicare and Medicaid eligibility and coverage; [§483.10(g)(4)(iii) will be implemented beginning November 28, 2017 (Phase 2)] (iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program; [§483.10(g)(4)(iv) will be implemented beginning November 28, 2017 (Phase 2)] (v) Contact information for the Medicaid Fraud Control Unit; and [§483.10(g)(4)(v) will be implemented beginning	F 156		

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F 156	Continued From page 3 November 28, 2017 (Phase 2)] (vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. (g)(5) The facility must post, in a form and manner accessible and understandable to residents, resident representatives: (i) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State agencies and advocacy groups, such as the State Survey Agency, the State licensure office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman program, the protection and advocacy network, home and community based service programs, and the Medicaid Fraud Control Unit; and (ii) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42 CFR part 489 subpart I) and requests for information regarding returning to the community.	F 156		

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F 156	Continued From page 4 (g)(13) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. (g)(16) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay. (i) The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. (ii) The facility must also provide the resident with the State-developed notice of Medicaid rights and obligations, if any. (iii) Receipt of such information, and any amendments to it, must be acknowledged in writing; (g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the	F 156		

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F 156	Continued From page 5 facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in paragraphs (g)(17)(i)(A) and (B) of this section. (g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.	F 156		

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F 156	Continued From page 6 (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure the most current Combined Federal and State Bill of Rights (BOR) for Residents in Medicare/Medicaid Certified Skilled Nursing Facilities or Nursing Facilities dated 11/28/16 was provided to the facility residents. This had the potential to affect all 60 residents currently residing in the facility. Findings include: During the initial tour of the facility on 3/20/17 at 9:57 a.m., the Bill of Rights poster hanging on a wall in the facility located by the nurse's station was found not be the most current BOR. On 3/21/17, at 2:00 p.m., registered nurse (RN)-A confirmed the Bill of Rights hanging on the wall was outdated and not the most current as of 11/28/16. On 3/21/17, at 2:00 p.m., social worker (SW)-A showed surveyor the Bill of Rights she was currently providing residents which was dated 12/2015. SW-A asked surveyor to show her the appropriate Bill of Rights to be providing. Surveyor informed the current Bill of Rights to be provide was dated 11/28/16 and could be found	F 156	Submission of this Response and Plan of correction is not a legal admission that a deficiency exists or that this Statement of Deficiency was correctly cited, and is also not to be construed as an admission of fault by the facility, the Executive Director or any employees, agents or other individuals who draft or may be discussed in this Response and Plan of Correction. In addition, preparation and submission of this Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the correctness of any conclusions set forth in the allegations. Accordingly, the Facility has prepared and submitted this Plan of Correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a Plan of Correction within ten (10) days of the survey as a condition to participate in Title 18 and Title 19 programs. This Plan of Correction is submitted as the facility's credible allegation of compliance. 1. All new admissions since 3/22/2017	

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F 156	Continued From page 7 on the MDH (Minnesota Department of Health) website. On 3/21/17, at 2:00 p.m., executive director (ED)-D confirmed the Bill of Rights provided in the admission packet was dated 12/2015 and not the most current dated 11/28/16. A policy for the Bill of Rights was requested, but not provided.	F 156	have had correct Bill of Rights given to them per the MDH website. Contact information on pages 29-30 has been hung on the wall by the nurses' station and a binder has been established with the updated Bill of Rights that would be available upon request to residents and families. 2. Social Services has given the correct Bill of Rights to all residents who reside in the facility per the MDH website. 3. Three resident files will be reviewed weekly for four weeks and monthly thereafter until full house has been reviewed. Social worker will report results and trends of audit to the QAPI monthly meeting for three months with follow up as needed.	
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure removal of medications from a resident room for 1 of 1 residents (R51) observed to have medications on a bedside tray table during the initial tour, who had been assessed unable to self-administer medications safely. Finding include:	F 176	1. Resident #51 has been reassessed for self-administering medications 2. All residents will be interviewed to determine if they would want to self-administer medications. 3. Any resident requesting self-administering of medications will be	5/2/17

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F 176	Continued From page 8 R51' room was checked during the initial tour on 3/20/17, at 10:06 a.m., observation revealed the following medications were laid on R51's bedside tray table: Dulera 100 mcg/5 mcg inhaler and a bottle of Fluticasone nasal spray. R51 was in bed and stated at the time the nurse had brought them into the room. At 10:22 a.m., licensed practical nurse (LPN)-C stated I left the medications on the tray table. LPN-C stated R51 was not able to self-administer medications and stated I should not have left the medications in R51's room. R51's physician orders dated 2/16/17, identified orders for Dulera (bronchodilator) 100 mcg/5 mcg inhaler inhale two puffs twice daily and Fluticasone (corticosteroid) 50 mcg spray install one spray each nostril daily. R51's Self-Administration of Medications assessment dated 3/17/17, revealed does the resident request to self-administer medications - no (if no, it is not necessary to proceed with the assessment). On 3/23/17, at 11:08 a.m., the director of nursing stated the medications should have been taken out of the room after administration of the medication. The facility policy Self Administration of Medications dated revision 11/16, indicated an individual resident may self-administer medications if the resident requests and the interdisciplinary team has determined that self-administration is clinically appropriate.	F 176	assessed for appropriateness and safety per the facility policy. 4. Education of nursing staff will be completed by 4/21/2017 regarding protocol related to self-administering of medications 5. Audits of medication pass will be completed twice weekly for four weeks and monthly thereafter. DON will report results and trends of audit to the QAPI monthly for three months with follow up as needed	
F 241	483.10(a)(1) DIGNITY AND RESPECT OF	F 241		5/2/17

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F 241 SS=D	Continued From page 9 INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care in a manner to promote dignity for 1 of 1 resident (R32) observed in the dining room and during administration of medication. Findings include: R32 had been observed in the north dining room on 3/21/17, at 5:15 p.m., R32 was seated in a Broda chair in the dining room. R32 was asking licensed practical nurse (LPN)-D to be taken out of the dining room. LPN-D stated to R32 you look comfortable right now (in reference to positioning in Broda chair). R32 replied I am not. LPN-D stated to R32 that they had someone else that needs her right now and walked out of the dining room. No one came in to assist R32 until R32 said again she wanted to leave the dining room at 5:21 p.m. Nursing assistant (NA)-C stated to R32 your food is coming. You eat first then I will take you out. R32 stated I have already eaten. NA-C stated not yet, the food is coming right now. I promise to take you out when you are done eating, ok. R32 did not respond to NA-C. At 5:29 p.m., the cart arrived with the supper meal for the residents in the north dining room. At 5:31 p.m., R32 stated to NA-C I want to leave the dining room now! I can come back and NA-C stated to	F 241	1. Resident #32 has had medications explained as well as the indications of use. 2. All residents will be treated with dignity and assisted as requested. 3. Staff education will be completed by 4/21/2017 regarding facility policy related to Dignity Quality of Life and ways to appropriately interact with resident requests to include naming of medications and being removed from an area when requested. 4. Dignity audits will be completed three times weekly for four weeks and monthly thereafter until compliance is achieved. DON will report results and trends of audit to the QAPI monthly for three months with follow up as needed.	

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F 241	Continued From page 10	F 241		

R32 I will do that right after you eat. At 5:32 p.m., R32 looked at LPN-D and stated will you help me? LPN-D brought R32 her tray and stated here is your pizza. At 5:34 p.m., R32 stated to the registered dietician (RD)-E help me please, help me and stared to cry, I am burning up, take me to the door and then I will come back to the table. RD-E stated to staff I will take R32 to the front door for a cool breeze and bring her right back. RD-E assisted R32 out of the dining room at that time. At 5:44 p.m., RD-E brought R32 back into the dining room and R32 began eating her pizza without crying or asking to be taken out of the dining room.

On 3/21/17, at 6:08 p.m., LPN-D when asked regarding assisting R32 with going out of the dining room and coming back in , stated it was a daily behavior for R32, and R32 said that all the time.

On 3/21/17, at 7:00 p.m., trained medication aide (TMA)-A was observed administering a medication to R32. R32 asked TMA-A what the name of the medication was that TMA-A was giving her. TMA-A stated Torsemide a diuretic. R32 asked TMA-A about getting some Tylenol and TMA-A replied you will get some Tylenol at 8:00 p.m. R32 asked TMA-A what was the name of the other pill (in regards to pain control) at 5:40 p.m. TMA-A responded to her question and said to R32 to drink your water. R32 again asked TMA-A what was the name of the other pill and TMA-A again stated to R32 drink your water. The TMA completed giving R32 her medications then left and never answered R32's question about the name of the other pain medication.

On 3/21/17, at 7:11 p.m., TMA-A had been asked

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F 241	Continued From page 11 why she had not given R32 the name of the pain medication when asked. TMA-A said it was Hydromorphone one of her other pain medications she had received earlier in p.m. shift. On 3/23/17, at 10:57 a.m., the director of nursing (DON) stated he expected staff to tell the resident the name of the medication. The facility policy Dignity Quality of Life dated 4/1/08, indicated in full recognition of his or her individuality the facility promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect.	F 241		
F 253 SS=B	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Surveyor: Hamersma, Vicky Based observation, interview and document review, the facility failed to provide a odor pleasant environmental on the south hallway which had the potential to effect 25 out of 25 residents that reside on the south hall out of a total facility census of 62 residents. Findings include: During initial with R39 on 3/20/17, at 11:30 a.m. R39 stated, this hallway always smells of urine, partly because on certain shifts they have bags sitting in the hallway with "diapers [incontinent	F 253	1. Environment Quality of Life and Linens-Handling policies were reviewed and revised as needed. 2. Staff will be educated by 4/21/2017 regarding appropriate procedures for containment and disposal of incontinence products. 3. Audits of appropriate handling of soiled incontinence products will occur twice weekly and monthly thereafter until compliance is achieved. DON will report results and trends of audit to the QAPI monthly for three months with follow up as	5/2/17

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F 253	Continued From page 12 products]" in them. R39's room is halfway down south hall. During observations on 3/22/2017, at 4:21 a.m. it was noted that two large plastic trash bags, one containing soiled linens and one containing soiled wet incontinent briefs was sitting on carpeted floor 20 feet from soiled utility door. The hallway had a strong foul urine smell. The large plastic bags remained on the floor until 5:40 a.m. when NA-I completely closed both plastic bags (as they were open the entire time while in hallway) containing soiled linens and soiled briefs. NA-I then was observed to pull the two soiled bags while dragging them on floor to the soiled utility room. During interview with NA-I on 3/22/17, at 5:53 a.m. she stated that, "I used them [plastic bags] only today, because there where so many bowel movements, that is was easier, than running to the soiled utility room after each time." "We normally take them to the soiled utility room after each room." During interview with LPN-H on 3/22/17, at 6:08 a.m. When asked correct procedure for disposing of soiled linens and soiled briefs while doing night rounds. LPN-H stated that, they are to take them to the soiled utility room after they complete the resident or two residents in the same bedroom. LPN-H then said, "They carry the bags with them because it is easier than running to the soiled utility room." During interview with the Director of Nursing (DON) on 3/22/17, at 6:39 a.m. explained that observation of two large plastic bags containing soiled linen and soiled briefs was sitting on	F 253	needed	

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F 253	Continued From page 13 carpeted hallway floor 20 feet from the soiled utility room from 4:21 a.m. to 5:40 a.m. before staff closed bags and removed them to the soiled utility room. DON stated, "That [the bags with soiled products] should not be in the hallway." They have containers to use with lids. Review of policies titled "Environment- Quality of Life (General)" dated April 1, 2008; the facility provides a safe, clean comfortable and homelike environment. In addition, "Linens-Handling" dated March 1, 2014: indicates when handling, storing, processing and transporting linens, facility personnel use procedures designed to prevent the spread of infection. Procedure point number three stated: soiled linen is immediately removed from the resident's room and taken to the laundry/utility room.	F 253		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE (b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interviews and document review, the facility failed to complete a comprehensive	F 274	1. Resident #35 MDS significant change has been completed.	5/2/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245544	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 274	Continued From page 14 assessment for significant change of status assessment (SCSA) for 1 of 1 resident (R35) reviewed for hospice services. Findings include: R35's record included she was enrolled in hospice services through St. Croix hospice agency as of 12/19/16. During review of the Minimum Data Set's it was noted that there had not been a significant Minimum Data Set completed following R35's admission to hospice services as required by the assessment directions. During interview on 3/23/17, at 9:08 a.m. registered nurse (RN)-B verified a significant change Minimum Data Set should have been completed no later than 1/2/17. Review of the policy and procedure for Comprehensive assessments, "CMS's RAI (Center of Medicare Service's Reimbursement Assessment Instrument) Version 3.0 Manual: Chapter 2: Assessment for the RAI indicates that a SCSA is a comprehensive assessment that must be completed when the interdisciplinary team has determined that a resident meets the significant change guidelines for either improvement or decline. And a SCSA is required to be performed when a terminally ill resident enrolls in a hospice program.	F 274	2. All residents who have a terminal diagnosis could be affected. All residents who have a terminal diagnosis have been reviewed and MDS's are complete. 3. Education will be completed with IDT on timely communication when terminal diagnosis has been identified by 4/21/2017. Education will be completed with MDS nurse when significant change is warranted. 4. Audits of MDS will be completed as a terminal diagnosis is presented. Education will be completed with MDS nurse on when a significant change is warranted by 4/21/2017. 5. DON will report results and trends of audit to the QAPI monthly for three months with follow up as needed.	
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan,	F 282		5/2/17

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F 282	Continued From page 15 must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the plan of care for 1 of 3 residents (R21) who required assist with cleaning and trimming fingernails and oral cares. Findings include: R21's current care plan identified one (1) staff assist with all activities of daily living (ADL). The nursing assistant (NA) care sheet undated, identified one (1) staff assist for dressing and grooming and a bath scheduled on Tuesday and Friday morning. R21 was observed on 3/20/17, at 2:52 p.m. with long fingernails with black debris underneath the nails on both hands. On 3/21/17, at 11:53 a.m. R21's nails remained the same. On 3/23/17, at 8:14 a.m., R21's fingernails remained the same. On 3/22/17, at 7:17 a.m. NA-B was observed to assist R21 with washing, including peri-cares, changed R21's incontinent product (wet with visible urine), dressed R21 and combed R21's hair. After providing the cares, NA-B assisted R21 to the dining room. NA-B failed to offer R21 oral cares. On 3/22/17, at 11:50 a.m. NA-B verified R21's fingernails were long and had black debris underneath the nails. NA-B stated "I never trim fingernails". NA-B stated activities and/or the bath	F 282	1. Resident #21's care plan and care guide were reviewed and found to be accurate. 2. All other residents will have the care guide reviewed to ensure accurate reflection of ADL needs specific to oral and nail care. 3. Nursing staff will be educated related to care of nails and oral care to reinforce the importance of this ADL on 4/21/2017. 4. Audits will be completed three times weekly for four weeks and monthly thereafter until compliance is achieved. DON will report results and trends of all audits to the QAPI monthly for three months with follow up as needed	

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F 282	Continued From page 16 aide does nails. NA-B confirmed she did not offer nor provide oral cares for R21 that morning. On 3/22/17, at 2:07 p.m. NA-G stated she had given R21 a bath on Tuesday (3/21). NA-G stated she had not trimmed R21's fingernails and had cleaned R21's fingers and nails using a soapy towel. On 3/23/17, at 9:45 a.m. registered nurse (RN)-B observed R21's nails and confirmed R21's nails were long and had black debris underneath the nails. On 3/23/17, at 11:11 a.m. the director of nursing (DON) stated cleaning and trimming fingernails was part of the bath aide assignment on the resident bath days. The bath aide should check whether the resident's fingernails need to be trimmed and cleaned at the time the resident was given a bath. The DON stated he would expect oral care to be provided and offered every a.m. The DON stated the expectation was for oral care to be provided in the a.m. and at bedtime, except if a resident requested more frequently. The facility policy Activities of Daily Living dated revision 11/16, indicated a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene.	F 282		
F 311 SS=D	483.24(a)(1) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS (a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b)	F 311		5/2/17

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F 311	Continued From page 17 of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure staff provided oral care and clean, trimmed fingernails for 1 of 3 residents (R21) reviewed who required assistance with activities of daily living (ADLs). Findings Include: R21 was observed on 3/20/17, at 2:52 p.m. to have long fingernails with black debris underneath the nails on both hands. On 3/21/17, at 11:53 a.m. R21's nails remained the same. On 3/23/17, at 8:14 a.m., R21's fingernails remained the same. On 3/22/17, at 7:17 a.m., nursing assistant (NA)-B was observed to assist R21 with washing, dressing and combing hair. After providing the cares, NA-B assisted R21 to the dining room. NA-B failed to provide or offer oral cares. On 3/22/17, at 11:50 a.m., NA-B verified R21's fingernails were long and had black debris underneath the nails. NA-B stated I never trim fingernails. NA-B stated activities or the bath aide does nails. On 3/23/17, at 9:45 a.m., registered nurse (RN)-B observed R21's nails and confirmed R21's nails were long and had black debris underneath the nails. The annual Minimum Data Set (MDS) assessment dated 2/15/17, identified that R21 required extensive assist of one for personal hygiene and one person physical assist with	F 311	1. Resident #21's nail and oral care has been completed. 2. All other residents are receiving oral care and nail care per their identified ADL needs. 3. Nursing staff will be educated by 4/21/2017 regarding oral care and nail care. 4. Audits will be completed three times weekly for four weeks and monthly thereafter until compliance is achieved. DON will report results and trends of all audits to the QAPI monthly for three months with follow up as needed.	

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F 311	Continued From page 18 bathing. R21's current care plan identified one assist with all ADL's. The nursing assistant care sheet undated, identified R21 required one (1) staff assist for dressing and grooming and had a bath on Tuesday and Friday a.m. On 3/22/17, at 11:50 a.m., NA-B confirmed she did not offer nor provide oral cares for R21. On 3/22/17, at 2:07 p.m. NA-G stated she had given R21 a bath on Tuesday (3/21). NA-G stated she had not trimmed R21's fingernails and had cleaned R21's fingers and nails using a soapy towel. On 3/23/17, at 9:50 a.m., licensed practical nurse (LPN)-D stated resident nails were trimmed and cleaned on the resident bath days by the NA's, unless the resident was diabetic, then the nurse would trim/clean fingernails. LPN-D stated the NA's were responsible for cleaning and trimming R21's fingernails. On 3/23/17, at 11:11 a.m. the director of nursing (DON) stated cleaning and trimming fingernails was part of the bath aide assignment on the resident bath days. The bath aide should check whether the resident's fingernails need to be trimmed and cleaned at the time the resident was given a bath. The DON stated he would expect oral care to be provided and offered every a.m. The DON stated the expectation was for oral care to be provided in the a.m. and at bedtime, except if a resident requested more frequently.	F 311		

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F 311	Continued From page 19 The facility policy Activities of Daily Living revision date 11/16, indicated a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene. The policy did not address the facility standard expectation related to providing oral cares in the morning and at bedtime.	F 311		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		5/2/17

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F 323	Continued From page 20 Based on observation, interview and record review facility failed to ensure an accurate smoking assessment was completed and safe smoking conditions were implemented for 1 of 1 resident (R72) reviewed for accidents and who smoked. Findings include: R72's diagnoses on the admission document dated 1/5/17, indicated: chronic obstructive pulmonary disease (COPD), pulmonary embolism, acute respiratory failure with hypoxia and respiratory failure unspecified with hypercapnia (abnormal level of carbon dioxide in blood) . The care plan dated 1/16/17, indicated R72 has shortness of breath related to COPD and respiratory failure with intervention-administer oxygen per MD order. The care plan had not been updated to include smoking until 3/20/17, after discussion with surveyors. Review of the medication/treatment record identified oxygen 2 liters/nasal cannula initiated on 1/5/17, the date of admission. Smoking Safety Assessment was completed for R72 on 1/11/17, which indicated R72 as a non-smoker. In addition, the facility resident list indicating which resident's smoke provided upon entrance conference on 3/20/17, did not list R72 as a smoker. On 3/20/17, at 4:30 p.m. R72 was observed standing on the curb outside the front of the facility facing the road. A portable oxygen tank was located on top of R72's walker, with R72 standing in front of the walker. R72 was smoking and when staff approached, R72 was no longer smoking and re-applied the nasal cannula.	F 323	1. Resident #72 has had an updated smoking assessment completed. 2. All residents who smoke could be at risk and all have been reassessed per smoking assessment. 3. Nursing staff will by educated by 4/21/2017 regarding smoking policy and procedure as well as assessments. 4. Audits will be completed three times a week for four weeks and monthly thereafter until compliance is achieved. DON will report results and trends of all audits to the QAPI monthly for three months with follow up as needed.	

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F 323	Continued From page 21	F 323		

When interviewed on 3/20/17, at 5:00 p.m. nursing assistant (NA)-E stated R72 utilizes oxygen but was unsure whether R72 smoked.

Interview on 3/20/17, at 5:03 p.m. with licensed practical nurse (LPN)-B stated she was aware R72 smoked and had instructed R72 not to go outside with his oxygen; stating R72 was aware of not being able to take the oxygen along while he smokes outside.

Interview on 3/20/17, at 5:05 p.m. with NA-F stated he was unaware R72 smoked.

Interview on 3/20/17, at 5:05 p.m. with trained medication aide (TMA)-A stated R72 utilizes continuous oxygen and was aware R72 smokes but had not observed R72 smoking with oxygen present.

When interviewed on 3/20/17, at 5:14 p.m. R72 stated he had resided in the facility for about 90 days. R72 reaffirmed he requires 2 liters continuous oxygen. R72 stated he gets SOB when he doesn't wear his oxygen. R72 explained he started smoking when he was 12 years old but at this time is only smoking one cigarette a day. R72 stated the facility policy is to smoke in the back designated smoking area. R72 stated he does not take his oxygen outside when he smokes and doesn't keep his own supply of cigarettes but asks other residents for them. R72 verified when he was observed smoking at the front of the building earlier, he had his oxygen tank with him but had turned it off.

An interview was conducted on 3/20/17, at 4:34 p.m. with the administrator and director of nursing

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F 323	Continued From page 22 (DON). The administrator stated she was unaware of R72 smoking but the DON verified he was aware R72 started smoking. The DON indicated he had a conversation with R72 instructing him to leave his oxygen tank inside before going outside to smoke. The DON verified R72 has an order for continuous oxygen administration-2 liters by nasal cannula. The DON verified a risk vs. benefits form had not been provided nor completed for R72, discussing the risks of removing the continuous oxygen while smoking and confirmed his conversation with R72 related to education concerning not smoking with oxygen present had not been documented. DON also verified a smoking assessment had been completed on 1/11/17, indicating R72 to be a non-smoker. The DON verified after becoming aware of R72's smoking habit, a reassessment should have been completed but had not. Policy titled, "Smoking Policy", dated 2/15/17, identifies, "all residents who smoke will be assessed for their safety at time of admission, quarterly and when there is a change in condition by social worker and or nurse. Assessments to include physical, cognitive, mood and behavior that may affect their ability to smoke without supervision. Smoking area is designated as the patio off of the north dining room. Oxygen tanks are not permitted in designated smoking areas. Unsupervised smokers will leave their oxygen tank at the reception desk, place the cannula in a plastic bag before entering the unsupervised smoking area."	F 323		
F 406 SS=D	483.65(a)(1)(2) PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES (a) Provision of services. If specialized	F 406		5/2/17

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F 406	Continued From page 23 rehabilitative services such as but not limited to physical therapy, speech-language pathology, occupational therapy, respiratory therapy, and rehabilitative services for mental illness and intellectual disability or services of a lesser intensity as set forth at §483.120(c), are required in the resident's comprehensive plan of care, the facility must- (1) Provide the required services; or (2) In accordance with §483.70(g), obtain the required services from an outside resource that is a provider of specialized rehabilitative services and is not excluded from participating in any federal or state health care programs pursuant to section 1128 and 1156 of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and record review facility failed to ensure a level II PASRR (Preadmission Screening and Resident Review) was completed for 1 of 1 resident (R4) with a mental illness diagnosis. Findings include: R4's diagnosis noted on the admission record dated 10/27/15, indicated other Schizophrenia and Bipolar Disorder. R4 had a completed initial PASRR assessment dated 9/10/14, which indicated a primary diagnosis of Schizophrenia. The PASRR assessment indicated R4 required respite care and stabilization before returning to an assisted living facility. The PASRR indicated that R4 met the level of care for the facility admission for 40 days with a follow-up PASRR assessment	F 406	1. Resident #4 has had an updated PASSR completed on 3/22/2017 2. All other residents in facility have been reviewed to validate the screenings are correct and up to date. 3. Social Worker and Admissions have been educated to check new admissions PASSR to validate there is not a specific "expiration" date of the PASSR. 4.Audits of PASSR will be completed of new admissions for three months. SW will report results and trends of all audits to the QAPI monthly for three months with follow up as needed.	

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

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F 406	Continued From page 24 required if an extension of care was necessary past the initial 40 days. When interviewed on 3/22/17, at 11:16 a.m. the social worker (SW) verified the only PASRR assessment documented for R4 was dated September 2014. SW stated reassessment PASRR's are completed if residents are hospitalized and/or with a change of condition. The SW verified the initial PASRR on record was only valid for the first 40 days in the facility and a follow-up assessment was required if R4 were to remain in the facility. The SW stated she would work on getting an updated PASRR on record. The policy titled, "Pre-Admission Screening and Resident Review" dated 11/2016, does not identify when reassessment PASRR assessments are required.	F 406		
F 412 SS=D	483.55(b)(1)(2)(5) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS (b) Nursing Facilities The facility- (b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; (b)(2) Must, if necessary or if requested, assist the resident-	F 412		5/2/17

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F 412	Continued From page 25 (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; (b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan. This REQUIREMENT is not met as evidenced by: Based on interview, observation and document review, the facility failed to follow-up on a recommended dental referral for 1 of 3 residents (R15) reviewed for dental concerns. Findings include: During interview/observation on 3/22/17, at 6:14 a.m. R15 indicated she wants new teeth and it was observed that R15 had no upper teeth evident. R15 denied any pain and/or discomfort. R15 indicated she had seen a dentist last fall, but could not recall the exact date. R15 explained she is able to eat without dentures,"but I like to eat so I want dentures." Review of the document from In-House Dental, dated 10/25/16, identified the completion of the initial comprehensive evaluation. The document identified, "If patient opts for a full upper denture, she will need to see oral surgery first for a panoramic x-ray and removal of any root tips on the upper arch. After 6-8 weeks, we can take impression for an upper denture." No dental appointments, referrals or reference to follow-up of dental evaluation were documented in the medical record.	F 412	1. Resident will be given dental treatment on 5/9/2017. 2. All other residents dental consults were reviewed to ensure proper follow up was given. 3. All residents may be affected by this practice but none show any ill effects. 4. Education was provided to HUC and nursing staff on proper follow up for dental referrals. 5. Audits will be completed weekly to ensure timely follow up on dental referrals. 6. DON or designee will report results and trends of audits to QAPI committee.	

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	245544	A. BUILDING _____ B. WING _____	C 03/23/2017

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F 412	Continued From page 26 When interviewed on 3/23/17, at 8:32 a.m. registered nurse (RN)-C was questioned whether a referral appointment for oral surgery had been made for R15. RN-C stated, "I know that it was missed" and indicated a call to schedule a follow up appointment was completed "yesterday" by the health unit coordinator (HUC). During a follow-up interview on 3/23/17, at 8:39 a.m. with HUC-A, she stated, "I had to have In-House Dental send x-ray and referral to Minnesota School of Oral Surgery and then they will look it over and get back to us within a day or two." She verified she had made the call on 3/22/17 (prior day). The care plan for R15 identified: potential for alteration in nutritional status due to missing teeth, although able to eat and chew with current dentition; missing all top teeth and majority of bottom teeth but states she can chew just fine; and able to feed herself after assistance with meal set-up. Review of the Dental services (general) policy and procedures for Health Dimensions group, revised November 2016, indicated: The community provides or obtains, from an outside resource, routine and emergency dental services to meet the need of each resident. The community will assist the resident in making appointments by arranging transportation to and from dentist's office and will promptly refer residents with lost or damaged dentures to a dentist.	F 412		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/2/17

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F 441	Continued From page 27 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 28 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly clean and store nebulizer equipment to prevent infection between use for 1 of 1 resident (R51) observed with nebulizer equipment stored in room; failed to implement proper glove and hand hygiene when cleaning a glucometer for 1 of 1 resident (R40) who required blood glucose monitoring and failed to implement proper hand hygiene during the provision of toileting for 1 of 3 residents (R21) reviewed for urinary incontinence.	F 441	1. Resident #51, 40 and 21 experienced no negative impact as a result of the practice. 2. All residents within facility have the potential for impact related to inconsistency with hand washing hygiene procedure, nebulizer cleaning procedure and glucometer cleaning procedure. 3. Education will be provided to staff by 4/21/2017 related to infection control of	

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F 441	Continued From page 29 Findings include: CLEANSING NEBULIZER EQUIPMENT: During the initial tour on 3/20/17, at 10:06 a.m., observation revealed a nebulizer machine was laid on R51's bedside tray table with the medication cup and spacer attached (used to administer the medication). Moisture was noted inside the medication cup. At 10:22 a.m., licensed practical nurse (LPN)-C confirmed the nebulizer equipment (medication cup and spacer) had not been cleaned. LPN-C stated, "I think last night R51 had medication via nebulizer, as I have not given any medication via the nebulizer". On 3/23/17, at 11:08 a.m., the director of nursing (DON) sated the nebulizer equipment should be cleaned immediately after administration of medication and left to air dry after cleaning. The facility policy Nebulizer Therapy dated revision 4/09, indicated the following procedure: (15) Turn off the nebulizer compressor machine; (18) Disconnect tubing; (19) Shake out excess liquid and (20) Air dry nebulizer cup. GLOVE USE AND HAND HYGIENE CLEANING GLUCOMETER: On 3/22/17, at 7:35 a.m., LPN-F was observed to check R40's blood sugar. LPN-F removed her gloves after checking R40's blood sugar and washed hands. LPN-F, with bare hands, proceeded to clean the glucometer with a Sani-cloth (disinfectant) disposable wipe and placed the glucometer on top of the medication cart wrapped in the wipe. LPN-F then prepared an insulin pen (cleansed rubber tip of pen, attached a needle to the pen, primed the pen and dialed dose of insulin) for administration of insulin	F 441	hand washing hygiene, nebulizer cleaning and glucometer cleaning procedures. 4. Audits of hand washing hygiene procedure, nebulizer cleaning procedure and glucometer cleaning procedure will be completed three times weekly for four weeks and monthly thereafter until compliance is achieved. DON will report results and trends of audits to the QAPI monthly for three months with follow up as needed	

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F 441	Continued From page 30	F 441		

for R40 and then washed hands. LPN-F failed to donn gloves when cleansing the glucometer and failed to wash hands immediately after cleansing. LPN-F confirmed at the time no gloves were worn during cleaning the glucometer and hands had not been washed immediately after cleansing the glucometer.

During interview on 3/23/17, at 11:37 p.m. the DON stated that inside the container where the glucometers are stored were instructions for cleaning the glucometer from the glucometer manufacturer and staff could review the instructions when cleaning the glucometer.

The DON provided the following: Even Care Glucose Meter Cleaning Guide: Materials needed: gloves; Even Care Meter, Sani-Cloth Disinfectant.
(1) Wash hands with soap and water. (2) Put on disposable gloves. (3) Inspect Even Care Meter for blood, debris, dust or lint anywhere on the meter. Blood and bodily fluids MUST be thoroughly cleaned from the surface of the meter. (4) To clean/disinfect the meter clean the meter surface with the Sani-Cloth wipe. Allow the surface of the meter to remain wet at room temperature for 2 minutes. To achieve this, wrap meter in disinfectant wipe. Meter must be visibly wet. Then allow to air dry. Avoid wetting the meter test strip port as this may cause the meter NOT to work. (5) Remove gloves and dispose of the disinfectant wipe. The DON stated staff were to use gloves when cleaning the glucometer and were trained to use gloves when cleaning the glucometer. The DON stated if no gloves were worn, the expectation would be to wash hands immediately after cleaning the glucometer. The DON stated staff were to follow the Even Care

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F 441	Continued From page 31 Glucose Meter Cleaning Guide when cleaning the glucometer. The facility policy Glucometer Infection Control Guidance dated 3/14, indicated Hand Hygiene and Glove Use (1) Wear gloves during fingerstick glucose monitoring, administration of insulin and any other procedure that involves potential exposure to blood or body fluids. (5) Perform hand hygiene (i.e., hand washing with soap and water or use of an alcohol-based hand rub) immediately after removal of gloves and before touching other medical supplies intended for use on the other resident. The facility policy Gloves, Non-Sterile dated 4/1/08, indicated Gloves should be worn to protect the employee from exposure to bloodborne pathogens and other contaminants, as defined in the standard precautions. RESIDENT HAND HYGIENE AFTER TOILETING During observation on 3/22/17, at 11:43 a.m., R21 was in the bathing room seated on the toilet and had voided. NA-B assisted R21 to stand and handed R21 toilet paper. R21 wiped peri-area with toilet paper and disposed of the toilet paper in the toilet. NA-B assisted R21 with pulling up pants and assisted R21 to walk out of the bathing room to the north dining room. At the time, NA-B confirmed she had not offered R21 the opportunity to wash her hands after wiping her own peri-area after voiding. On 3/23/17, at 11:11 a.m., the DON stated he would expect staff to offer R21 the opportunity to wash her hands after voiding and wiping self. The facility policy Handwashing dated 4/1/08,	F 441		

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F 441	Continued From page 32 indicated the facility requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. Hand washing is also conducted as per recommendations form the CDC (Centers for Disease Control) guidelines.	F 441		

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	245544	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 21, 2017. At the time of this survey, Camden Care Center was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Camden Care Center is a 1-story building with a partial basement. It was constructed in 1990 and was determined to be of Type II(222) construction. This building is fully protected throughout by an automatic fire sprinkler system. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is centrally monitored for automatic fire department notification. The facility has a capacity of 72 beds and had a census of 66 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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