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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RN81

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00757

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245353**

2.STATE VENDOR OR MEDICAID NO.
(L2) **231243300**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMILIA ROSE CARE CENTER LLC**
(L4) **11800 XEON BOULEVARD**
(L5) **COON RAPIDS, MN** (L6) **55448**

4. TYPE OF ACTION: 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)

6. DATE OF SURVEY **05/28/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Michelle Thompson, HFE NE II — 05/29/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist 06/23/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/13/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 07/01/2014 Co.

31. RO RECEIPT OF CMS-1539
(L32)

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

DETERMINATION APPROVAL

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

CCN: 24-5353

Post Certification Revisit to verify that the facility has achieved and maintained compliance with Federal Certification Regulations.

Please refer to the CMS 2567B. Effective 05/25/2014, the facility is certified for 80 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245353

June 12, 2014

Mr. Grant Brandon, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

Dear Mr. Brandon:

TThe 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 25, 2014, the above facility is certified for:

80 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 80 skilled nursing facility beds.

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

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

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
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
June 12, 2014

Mr. Grant Brandon, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353023

Dear Mr. Brandon:

On April 29, 2014, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective June 13, 2014. (42 CFR 488.417 (b))

Also, we notified you in our letter of April 2, 2014, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 13, 2014.

This was based on the deficiencies cited by this Department for a standard survey completed on March 13, 2014, and lack of verification of substantial compliance with the Life Safety Code (LSC) and Health deficiencies at the time of our April 2, 2014 notice. The most serious health deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 28, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on June 2, 2014, the Minnesota Department of Public Safety to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 13, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 25, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 13, 2014, as of May 25, 2014.

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 our letter of April 2, 2014. 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 June 13, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective June 13, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective June 13, 2014, is to be rescinded.

In our letter of April 2, 2014, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 13, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on May 25, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245353	A. Building B. Wing	5/28/2014

Name of Facility	Street Address, City, State, Zip Code
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0287** Reg. # **483.20(f)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **04/22/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **04/22/2014**
ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0368** Reg. # **483.35(f)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/22/2014**
ID Prefix **F0466** Reg. # **483.70(h)(1)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0501** Reg. # **483.75(i)** LSC	Correction Completed **04/22/2014**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **04/22/2014**

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	06/06/2014	28598	05/28/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/13/2014			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245353	A. Building B. Wing 01 - MAIN BUILDING 01	6/2/2014

Name of Facility	Street Address, City, State, Zip Code
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	05/25/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/KJ	Date: 06/06/2014	Signature of Surveyor: 28598	Date: 06/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 3/13/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
May 19, 2014

Mr Grant Brandon, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353023

Dear Mr. Brandon:

On April 2, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 13, 2014. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Compliance with the Health and Life Safety Code (LSC) deficiencies issued pursuant to the March 13, 2014 standard survey has not yet been verified. Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective June 13, 2014. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective June 13, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 13, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Camilia Rose Care Center Llc is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective 6/13/2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met.

Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: RN81

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00757

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245353**
2.STATE VENDOR OR MEDICAID NO.
(L2) **231243300**

3. NAME AND ADDRESS OF FACILITY
(L3) **CAMILIA ROSE CARE CENTER LLC**
(L4) **11800 XEON BOULEVARD**
(L5) **COON RAPIDS, MN** (L6) **55448**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/13/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **80** (L18)

13.Total Certified Beds **80** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	80			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jessida Sellner, HFE NE II 04/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Certification Specialist 04/29/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/13/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

CCN: 24-5353

At the time of the standard survey completed March 13, 2014, the facility was not in substantial compliance and the most serious deficiencies were found to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 2, 2014

Mr. Grant Brandon, Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, Minnesota 55448

RE: Project Number S5353023

Dear Mr. Brandon:

On March 13, 2014, 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 isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), 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:

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:

Brenda Fischer, Supervisor
St. Cloud Survey Team A
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

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 April 22, 2014, 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 April 22, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (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. 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 will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and 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 13, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 13, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure 1 of 5 residents (R65) reviewed for activities, was provided with activities to meet their individual preferences related to a comprehensive resident assessment, including activities which took place outside of the resident room. Findings include: R65 Annual Minimum Data Set (MDS) 9/6/13 identified R65 activity preferences were listen to music, participate in religious activities and family was involved with resident care decisions. The	F 248	The care sheet for R65 was updated to include activity preferences. Activity logs for all clients were reviewed to identify those with patterns of not attending programs of interest. Care sheets were updated as indicated. Clients will be engaged in meaningful activities of interest. The care sheet format was modified to include client preferences, including activities of interest. The Seasons Coordinator on the memory care unit will maintain activity preferences on the care sheet. Nursing staff will receive training related to	4/22/14

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

Electronically Signed | 04/11/2014

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F 248	Continued From page 1 Activity Care Area Assessment dated 9/6/13 indicates resident needs assistance to get to activities. The quarterly MDS of 2/21/14 identified R65 had severe cognition and was totally dependent upon staff for all activities of daily living. R65 care plan dated 12/18/13 identified therapeutic recreation and that R65 needs to be invited to church and music and to assist R65 to these activity and program areas. During observation on 3/12/14 at 9:50 a.m. R65 was dressed, lying in bed but awake with no television or radio turned on. There was no one observed to offered R65 to attend the church services in the day room even though she was aware. During observation on 3/12/14 at 1:30 p.m. a gentleman was playing music in the day room. There was no one that offered or assisted R65 to attend this activity. During interview on 3/13/14 10:15 a.m. the therapeutic recreation assistant (TRA)-B stated she was aware that music and attending Catholic church services are important to R65 as she was a Catholic nun at one time before starting a family and has always enjoyed music in her lifetime. TRA-A stated, "When she can not attend Catholic church services downstairs, I bring her to non denominational church services up here." R65 was observed on 3/13/14 2:50 p.m. lying in bed on her back. There was no music playing in the room. At 3:01 p.m. there were other residents in the main dining room participating in a sing a long with activities staff.	F 248	client-centered care, identifying activity preferences, and assisting clients to participate in activities of interest as needed. Training will be complete by 4/22/2014. The Therapeutic Recreation Director or designee will monitor activity logs monthly and follow up as indicated. The Therapeutic Recreation Director will be responsible for monitoring compliance.	

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F 248	Continued From page 2	F 248		

During interview 3/13/14 3:10 p.m. licensed practical nurse (LPN-B) stated, therapeutic recreation tells us what is going on for activities. Sometimes she goes down stairs to church. When asked about music playing in her room, LPN-B said it is playing right now, LPN-B and surveyor went to R65 room at this time, and R65 was up, but there was no music playing in her room. LPN-B verified all staff are responsible to assist R65 to activities.

Review of the quarterly therapeutic recreation note on 2-28-14, identified R65 was unable to verbalize and unable to accept or decline activities. "Staff to anticipate and be aware of client's hx [history] of interests." The note also identified, "Client attends church on the main floor on occasion, as she is sleeping during this time. Needs assist to all destinations."

Review of R65 attendance and participation activity record from January through March 2014 identified R65 had only attended music twice in March, three times in February, and eight times in January 2014. The same record also indicate R65 had only attended church once in March, once in February, and once in January 2014, even though attending Catholic mass was important for R65.

During interview on 3/13/14 3:51 p.m. TRA-A stated R65 had not attended Catholic Mass and the music yesterday (3/12/14). "We have trouble with the coordination with nursing in mornings and frequently [R65] is not dressed in time for

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F 248	Continued From page 3 church". She also stated R65 does not go downstairs to the music event less there are extra staff to assist. TRA-A stated the"Downstairs is for higher functioning people," and R65 can become restless and agitated. Although R65's preferences were to listen to music and attend Catholic mass, this was not being consistently provided for R65.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	F 279	Pain: A new pain assessment was	4/22/14

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F 279	Continued From page 4 review, the facility failed to ensure the care plan addressed pain for 1 of 3 residents (R164) reviewed for pain. In addition, 1 of 1 residents (R106) who received hospice services did not have a comprehensive care plan for hospice care. Findings include: PAIN R164's Resident Admission Record indicated diagnoses of pain. R164's admission Minimum Data set (MDS) dated 11/29/13 indicated the resident had moderate cognitive impairment, had no pain, and needed extensive assistance with activities of daily living (ADL's). The facility Observation Report dated 12/13/13 indicated a pain scale score of zero, indicating the resident was having no pain. R164's current Physician Orders (PO) dated 1/22/14 indicated Tylenol 325 mg (milligrams) two tabs three times a day. A physician progress note dated 2/3/14, indicated blisters on both heels that are deflated and to have purple centers. The progress note also indicated open area to right buttock superficial and positive pain in both heels. R164's care plan dated 1/31/14 indicated the resident had bilateral heel blisters with a history of pressure ulcers/open areas. The care plan indicated interventions included various pressure reduction mattress, cushion in wheelchair and turning schedule. The care plan did not address pain or discomfort, as a result of developing the heel ulcers even though R164 had pain medication ordered since 1/22/14, before the care plan date of 1/31/14.	F 279	completed for R164 4/9/2014. R164 was seen by his provider on 4/8/2014 and his treatment goals were revised to include comfort care. His care plan and interventions, including new pain management orders, were updated 4/9/2014. Hospice: Health Partners Hospice and facility staff met 4/8/2014 to discuss R106□s status and care plans. Care plans were reviewed and revised to ensure integration of care and identification of disciplines responsible. Pain: Rounds were conducted with unit staff, Unit Managers, and the Director of Nursing to identify clients that may need additional pain management interventions. New pain assessments were initiated for clients of concern. Hospice: Hospice and facility care plans were reviewed for all clients receiving hospice care to ensure integrated care plans were in place and all relevant notifications have been made to hospice staff. Pain: Pain management policies and procedures were reviewed and remain appropriate. All staff will receive training on recognizing and reporting client pain and licensed staff will receive additional training on pain management by 4/22/2014. Hospice: All hospice visit schedules were compiled and placed in a central location on each unit, accessible to all nursing staff. Updated contact information was placed in the medical records to instruct staff to contact hospice staff and the primary MD/NP with all hospice client updates. Clients receiving hospice care were also identified on the	

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F 279	Continued From page 5 R164 was continuously observed on 3/12/14, from 10:30 a.m. until 1:00 pm. At 1:00 p.m. nursing assistant (NA)-G and NA-H were using a EZ-Stand (mechanical lift used to transfer) and transferred R164 into bed. NA-G attempted to straighten out R164's legs and R164 yelled loudly, "Ouch, ouch, ouch," while making facial grimaces. NA-G stated R164 had "pain" when his legs are moved because he has "sores" on his heels. NA-G placed a pillow under R164 legs to prevent his heels from touching the bed. During interview on 3/13/14 at 7:20 a.m. registered nurse (RN)-A stated R164 is having severe pain. She stated staff tried to give the resident Tylenol, but he has been refusing his medications. RN-A verified R164's pain has increased in the last two to three weeks. Although R164 was observed having pain was identified by staff as having increased pain, the facility care plan did not identify pain and what interventions could be provided to reduce the residents pain. HOSPICE R106's had a diagnosis from the hospice agency's hospice admission summary, dated 2/8/2014, which included a terminal diagnosis of bowel obstruction with other contributing factors of increased weakness, fatigue, weight loss, increased dependency in assist with activities of daily living and loss of ability to walk due to weakness.	F 279	nursing assistant care sheets. A Hospice Collaboration of Care policy and procedure was developed to address protocols for collaboration with hospice staff, including hospice notifications with condition changes, and integration of care. Nursing staff will receive training related to hospice care protocols and on the revised Hospice Communication policy and procedure by 4/22/2014. Random weekly pain care plan audits will be conducted by the Clinical Manager or Director of Nursing at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Random weekly hospice care plan audits will be conducted by the Director of Social Services at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Results of these audits will be submitted to the appropriate department head if corrective action is required. All audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance QA&A Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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F 279	Continued From page 6	F 279		

R106's initial care plan, dated 2/7/2014, lacked identification identifying R106 was on hospice care.

The resident's admission orders, dated 2/7/2014, identified R106 was to be admitted to hospice tomorrow [2/8/2014].

The physician's orders, dated 2/8/2014, identified R106 was admitted to hospice with terminal diagnoses of bowel obstruction with contributing condition of dementia.

R106's facility care plan, dated 2/25/2014, indicated R106 had specialized needs as evidenced by end stage disease; hospice program. The care plan directed staff to follow hospice CP approaches; maintain comfort with medications, repositioning; involve family in all aspects of care; and update MD/NP/Hospice & family with changes in status.

R106's hospice care plan, fax stamped and printed date 3/4/2014, identified interventions for pain, constipation, a volunteer to provide companionship, comfort and symptom management, and coordination of care. The care plan identified the discipline responsible for each of these as SN (Skilled Nursing).

Neither the facility or hospice care plans for R106, were integrated, indicating responsibility, measurable goals, outcomes or a delineation of services and lines of communications between the two entities.

During interview, on 3/12/2014 at 1:15 p .m., the director of nursing (DON) stated she did not think that the facility had a specific hospice care plan

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F 279	Continued From page 7 for R106. In addition, the DON stated the hospice nurse, a social worker and a volunteer do not have a set time of day they come to the facility. On 3/13/2014 at 10:22 am., the DON stated the hospice nurse puts the visits on the staff desk calendar and verified there were no scheduled visits beyond the last visit on the calendar of 3/7/3014.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to follow the care plan for 3 of 5 residents (R164, R104 and R14) reviewed for pressure ulcers, and 2 of 4 (R104 and R14) residents reviewed for nutrition. Findings include: PRESSURE ULCER R164's Resident Admission Record indicated diagnoses of pain, diabetes mellitus and cerebral vascular disease. R164's admission minimum data set (MDS) dated 11/29/13 indicated he needed extensive assistance with bed mobility, transfers and was incontinent of bowel and bladder. The mds also indicated R164 had no pressure ulcers and was at risk for developing a	F 282	Pressure Ulcer: A new comprehensive skin assessment was completed for R164 on 4/10/2014 and his care plan was revised to include a low air loss bed. The new Director of Nursing assumed responsibility for the wound care program on 4/10/2014. Wound rounds were conducted 4/10/2014 and 4/11/2014 and R164 was among those clients assessed. R164□s left heel and coccyx wounds are resolved. The right heel ulcer is unstageable and treatment continues as ordered. R164 will be assessed weekly during wound rounds until wounds are resolved. R14□s coccyx wound was also assessed 4/9/2014. He has one pressure ulcer on his coccyx surrounded by fragile	4/22/14

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F 282	Continued From page 8 pressure ulcer. R164's care area assessment (CAA) dated 11/23/13 indicated he is at risk for skin breakdown has incontinence and has interventions in place to maintain integrity of his skin. R164's care plan dated 1/31/14, indicated he had bilateral heel blisters with a history of pressure ulcers/open areas. The care plan indicated interventions for staff to turn and reposition every two hours, pressure reduction mattress, cushion in wheelchair, observe for signs of irritation/breakdown, skin prep to bilateral heels twice a day. The care plan further indicated he is incontinent of bowel and bladder and to offer toileting every two to three hours while awake and check and change ever two to three hours at night. During interview 3/12/13, at 11:36a.m., family member (F)-A stated she arrived at the facility at 10:30 a.m. and the staff had not repositioned or changed his pad. She further stated she is at the facility daily and the staff usually don't check him until they lay him down around 1:fpm. R164 was continuously observed on 3/12/14, from 10:30a.m. until 1:00pm. (total of two and half hours) without being assisted to have incontinence care provided or being repositioned. At 1:00p.m. nursing assistant (NA)-G and NA-H were observed using a EZ-Stand (lift used to transfer) and place R164 in bed. NA-G attempted to straighten out R164's legs R164 yelled out in pain saying ouch, ouch, ouch and was grimacing in the face, NA-G stated R164 has been having pain and it hurts to move his legs because he has sores on his heels. NA-G then placed a pillow under his heels. NA-G then	F 282	pink skin. He remains on an hourly repositioning plan although he prefers to lie on his back and is able to move to that position independently. His wound will be assessed weekly during wound rounds until fully resolved. A new comprehensive skin assessment was completed for R104 on 4/11/2014 and her care plan was revised to include hourly repositioning. All other pressure reduction interventions remain in place. Her wounds were assessed during wound rounds on 4/9/2014. Her left foot has three necrotic areas, including the entire first toe. The Nurse Practitioner was updated and no further orders were given at this time. Her wounds will be assessed at least weekly with wound rounds until resolved.Nutrition: A calorie count flow sheet was initiated for R104 on 4/11/2014. The Registered Dietician (RD) will continue to monitor her status as a nutritional risk and determine the stop date for these calorie counts. R14□s intake is monitored for all five meals, beginning 3/20/2014. His care sheet was updated to direct staff to keep extra snacks in his room. Pressure Ulcer: Clients at high-risk for skin breakdown were audited to ensure all appropriate interventions were in place to prevent pressure ulcers. Random toileting/ repositioning audits have been conducted to identify concerns related to toileting and repositioning per care plan. Ongoing corrective action and/or education was conducted as indicated . Nutrition: Weight logs were reviewed by the Diet Technician to identify clients with recent weight loss that are not on risk	

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F 282	Continued From page 9 lowered his bed to the floor and covered him up. NA-G and NA-H hand not attempted to check or change R164's incontinent brief. At 1:15p.m. NA-G stated that R164 had fallen asleep just after they laid him down and did not want to wake him to change his pad since it would agitate him. NA-G stated the last time R164 was checked and changed and repositioned was at 10:00a.m. (three hours ago). She indicated they would let the surveyor know when he wakes up so they could check and change his incontinent product. During observation 3/12/14, at 4:15p.m. (over 6 hours since incontinent product was checked) registered nurse (RN)-B and NA-D was observed to change R164's incontinent brief with stool. R164 had a stage one reddened area on his coccyx which RN-B measured as 1cm (centimeter) by 1.3cm. RN-B then proceed to measure the wounds on the heels. The left heel measured 1.5cm x 1cm and RN-B stated it was never open so she would stage the pressure ulcer as unstagable, the right heel measured 2cm x 1cm she then stated she would stage it as a stage one and verified she was measuring the black part of the wound and it was a stage one because she could see around the edges of the black center. During interview 3/13/14, at 7:44a.m. RN-B stated on 1/31/14, was when R164 was noted to have pressure ulcers on his heels he had a blister on his right heel and a partial blister on his left. RN-B further stated the last time she looked at R164's heels was the end of February and since then stated the left heel looked more black and the black tissue had increased since she last looked at it. RN-B also stated R164 had a open stage two pressure ulcer on his coccyx on	F 282	monitoring. One client was changed to a nutritional risk status and will be monitored by the Registered Dietician as such. Pressure Ulcer: Skin care policies and procedures were reviewed and revised as indicated. Nursing staff will receive additional training regarding appropriate skin/wound care, pressure ulcer reduction interventions and care plan compliance expectations by 4/22/2014. Nutrition: Food and fluid intake monitoring for all five meals was implemented 3/20/2014. Designated staff on each unit are responsible for ensuring that all clients are offered each meal or snack and that intake is recorded. Refusals are reported to the nurse for investigation. Nursing staff will receive training on intake monitoring, client refusals, and documentation by 4/22/2014. Random weekly compliance audits of skin/wound care plan compliance and appropriate follow-up will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Random weekly compliance audits of meal offering, documentation, and appropriate follow-up for each meal or snack will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Results of these audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance (QA&A) Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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1/29/14 and his nurse practioner (NP) ordered allyven (pressure ulcer dressing) and they were supposed to update the NP the following day. RN-B stated she could not find any documentation of wound measurements to the heels or the coccyx. She further stated they should have been documenting them and keeping the NP updated. RN-B then stated R164's coccyx pressure ulcer had healed but was uncertain when since there was no documentation and verified he now had a stage one pressure ulcer on his coccyx.

Although R164 had pressure ulcers on his heels and coccyx the facility failed follow his care plan to to prevent further breakdown.

R104 Quarterly Minimum data set (MDS) dated 1/23/14 identified the resident had severe cognitive impairment, needed extensive assistance with all activity's of daily living (ADL's), and was at risk for developing pressure ulcers.

Review of a physician visit progress note dated 2/17/14 identified R104 had a "Left heel unstagable pressure ulcer- beginning of month developed 6.5 cm x 1.5 cm spongy area on medial surface of left heel. Small purple in center. Restarted foam boots while in bed..."

R104 care plan dated 3/7/14 indicated the resident was at risk for pressure ulcers and directed "boots as of 2/14/14."

R104 was observed on 3/12/14 at 9:15 a.m. laying in bed fully dressed with no foam boots on her heels as directed by the residents plan of care. R104's knees were bent and her heels were digging into the bed. R104 layed in bed

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without the foam boots on until 10:08 a.m. almost one hour, when nursing assistant (NA)-M began to get the resident up into her wheelchair.

During interview on 3/12/14 at 9:15 a.m. NA-M stated R104 was to wear foam boots at all times while laying in bed. NA-M verified R104 had the boots off since 9:05 a.m., which was about an hour. NA-M stated she had removed the boots to get the resident dressed, however, she just left the boots off because she knew she would be getting the resident up for brunch soon.

Although R104 had pressure ulcers identified on both heels, the facility failed to ensure Interventions were being implemented according to the residents plan of care.

R14 Annual MDS dated 1/24/14 identified the resident had severe cognitive impairment, was at risk for developing pressure ulcers, and required extensive assistance with all ADL's except eating.

R14's care plan dated 2/4/14 identified the resident was at risk for pressure ulcers, had a "pink, fragile bottom", and instructed staff to turn and reposition R14 every one hour.

During observation on 3/12/14 at 1:18 p.m. LPN-A provided treatment to R14's coccyx pressure ulcers. LPN-A stated the last time she observed R14's coccyx was about "a week and a half ago" and at that time there was only one small open area, however, there were now 3 open areas on the residents coccyx. LPN-A stated the current measurements were 1 cm at 8 o'clock, .25 cm at 10 o'clock, and .25 at 3 o'clock. LPN-A stated all three of the pressure ulcers were

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F 282	Continued From page 12 a stage 2. During constant observation on 3/13/14 from 2:40 p.m. to 4:05 p.m. R14 was laying in bed on his back without being repostioned. During interview on 3/13/14 at 4:05 p.m. nursing assistant (NA)-C stated she began her shift at 2:30 p.m. and had not repositioned R14 since she started her shift. NA-C stated on shift report she was told the last time R14 had been repositioned was 10:00 a.m., however, she stated the other shift did rounds at 2:00 p.m. so the resident was "probably" repositioned at that time. NA-C stated R14 was to be repositioned every two hours. However, NA-C looked at R14's care sheet and stated the resident was directed to be repositioned every one hour, which she was not aware of. NUTRITION R104 quarterly Minimum Data Set (MDS) dated 1/23/14 identified the resident had severe cognitive impairment, had no identified weight loss in the prior 6 months of the assessment, and required extensive assistance with all activities of daily living (ADL's). Review of R104's weights revealed the following: 10/27/13- 146 pounds. 12/23/13- 135 pounds. 3/3/14- 127 pounds. (most recent weight.) R104's care plan dated 3/7/14 indicated resident refuses supplements, had a recent weight loss trend, was at "nutritional risk", and does not drink milk. The care plan instructed staff resident	F 282		

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required total assistance with eating and to record intake at each meal.

During interview on 3/12/14 at 10:08 a.m. NA-M stated R104 only gets up for two meals, brunch and dinner. NA-M stated the resident "does not have much of an appetite" and doesn't eat the other three meals.

Upon review of R104's Vitals Report of the residents intake identified the facility was documenting the residents fluids and intake for lunch and dinner, however, the facility was on a 5 meal plan and only 2 of the meals were documented. The documentation from 3/11/14 indicated the resident had 270 cc fluid total for the day, ate no lunch, and ate "1-25%" of dinner. There was no further explanation of what the resident was served for dinner, and why the resident only had 270 cc of fluid for the day.

During observation on 3/12/14 at 10:50 a.m. R104 was observed in the dining room receiving assistance with the brunch meal which consisted of egg bake and fruit. R104 was sleeping during the entire meal, and would not open her eyes or mouth to eat. R104 was brought back to her room at 11:51 a.m. The resident drank 1 and 1/2 cups of juice, but did not eat any of her meal.

During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R104 was at nutritional risk related to weight loss and staff was instructed to monitor and document the residents intakes at meals. DT-B stated R104's nutritional assessment is based off intake for 5 meals and staff should be monitoring all 5 meals according to the plan of care.

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Although R104 was assessed to be at nutritional risk related to weight loss and care planned to have intakes recorded of all 5 meals, the facility was not accurately or consistently documenting the residents intake as addressed in the care plan.

R14 Annual MDS dated 1/24/14 indicated the resident had severe cognitive impairment, required extensive assistance with all ADL's except eating, had no or unknown weight loss in the previous 3 months, and the resident indicated it was "very important" to have snacks available.

Review of R14's care plan dated 2/3/14 indicated resident is underweight, refused supplements, likes hot chocolate, refused to be weighed, and is on a regular diet. Staff was instructed to document residents intakes at each meal, assist resident with set up for meals and offer cheese and crackers at night.

Upon review of R14's weights the last weight documented was 91.5 pounds on 9/27/13. The other weekly weights were documented as "refused."

R104's current physician orders dated 3/13/14 indicated resident "to have a general snack at bedtime."

During observation on 3/10/14 at 8:05 p.m. staff was serving the night snack (the 5th meal of the 5 meal plan at the facility). Dietary staff served residents in the dayroom room yogurt, ice cream, and juice. After the residents in the dayroom were provided snacks, the dietary staff cleaned

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up the snack cart and left the floor. No snacks were provided or offered to R14. R14 was laying in bed and had no snacks observed in his room.

During interview on 3/13/14 at 10:30 a.m. NA-D stated R14 usually eats in his room and staff is to bring meals to his room, however, he is usually sleeping and does not always eat. NA-D stated lunch (brunch) and dinner are the only intakes documented by the facility. The other three meals are served in the dayroom and/ or dining room for the residents who are out of their rooms at that time. NA-D stated staff did not bring the other three meals to R14 nor was she aware R14 was to be provided snacks. NA-D stated R14 didn't have much of an appetite.

During observation on 3/13/14 at 2:57 p.m. R14 was laying in bed and turned his call light on. Nursing assistant (NA)-D went in to assist R14 and the resident asked when they were eating and stated he hadn't eaten all day. NA-D brought the resident in a pack of Lorna Dune cookies and a cup of coffee. The resident drank all of the coffee and ate the whole pack of cookies. There were no snacks observed in R14's room.

During interview on 3/13/14 at 3:47 p.m. R14 stated he "had not eaten all day", and finally got some cookies to eat after requesting something to eat.

During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R14 should be brought all 5 meals to his room, have intake recorded for all 5 meals, and should always have snacks available in his room according to the residents care plan.

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F 287 SS=E	483.20(f) ENCODING/TRANSMITTING RESIDENT ASSESSMENT (1) Encoding Data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. (2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. (3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following: (i) Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an	F 287		4/22/14

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F 287	Continued From page 17 initial transmission of MDS data on a resident that does not have an admission assessment. (4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to encode or transmit Minimum Data Set (MDS) data to the Center for Medicare/Medicaid (CMS) system timely for 2 of 3 residents (R179 and R106) reviewed, and for 79 of 1558 total records which were submitted with errors. Findings include: During the survey on 3/13/14, at appropriately 2:00 p.m., Minimum Data Set (MDS)'s were noted to be incomplete or completed late and the care plans were not completed in a timely manner as identified by the following: R179's entry tracking MDS dated 1/31/14, had not been submitted to the Center Medicare and Medicaid Service (CMS) system until 2/27/14, which was over the 14 day submission time frame. R106's entry tracking MDS dated 2/7/14, was not submitted until 2/27/14, which was over the 14 day submission time frame.	F 287	The Minimum Data Set data was submitted for R179 on 3/27/2014 and for R106 2/27/2014. The current MDS submission status report was reviewed and a plan was developed to complete outstanding MDS assessments by 4/18/2014. Upcoming assessments will be completed by the date due. Additional qualified RNs have been designated as resources to assist in achieving and maintaining compliance. The policy and procedure for maintaining and monitoring compliance with MDS assessments/ submissions has been reviewed and revised. The revised procedure directs the MDS Coordinator or designee to submit a weekly submission status report, including overdue and upcoming assessments, to the Director of Nursing and the Business Office Manager. MDS staff were updated in these revisions 4/11/2014. Status reports related to MDS submissions will be submitted to the Director of Nursing and the Business Office Manager weekly, beginning 4/11/2014. The Business Office Manager	

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F 287	Continued From page 18 A Certification and Survey Enhanced Reports (CASPER) Report, MN (Minnesota) MDS 3.0 Submission Statistics by Facility from 5/6/13 thru 3/9/14, included the facility had submitted 1558 records to the data base. A CASPER Report, MN (Minnesota) Error Number Summary for the facility from 5/6/13 through 3/12/14, showed the facility had a total of 708 errors including: Error number 3810c, Record submitted late: The submission date was greater than 14 days after the date the care plan had been completed. This error occurred 15 times. Error number 3810d, Record submitted late: The submission date was greater than 14 days after the date the resident assessment had been completed. This error occurred 15 times. Error number 3749a, Assessment completed late: The assessment completion date was greater than 14 days after the assessment reference date. This error occurred 13 times. Error number 3749e, Care Plan completed late: For admission assessments, the Care Area Assessment (CAA) process signature date was more than 13 days after the entry date. This error occurred 13 times. Error number 3810a, Record submitted late, the submission date was more than 14 days after the resident entry date. This error occurred 11 times. Error number 3749d, Assessment completed late for admission assessments. This error occurred 9 times. This error occurred 9 times.	F 287	will be responsible for compliance.	

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F 287	Continued From page 19 Error number 3810b, Record submitted late, The submission date was over 14 days after a death in the facility tracking record. This error occurred 3 times. When interviewed on 3/13/14, at 2:30 p.m. the MDS coordinator, registered nurse (RN)-C stated a different nurse was responsible for submitting the MDS's until November or December of 2013, after that, it was up to the unit managers. They discovered the MDS's were not being completed or submitted timely. RN-C stated she had taken over responsibility in February 2014, and had some, "Catching up to do." RN-C stated some of the MDS's she submitted came back as errors due to sequencing, some were rejected because she had accidentally submitted them twice. When interviewed on 3/13/14, at 5:10 p.m. the administrator acknowledged there had been many changes in who was responsible for MDS completion and submission over the last year, but was not aware they were being completed or submitted late. A policy was requested, but not provided by the facility.	F 287		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		4/22/14

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F 309	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide adequate pain management for 1 of 3 residents (R164) reviewed with pain. This resulted in actual harm to R164. In addition, there were 1 of 3 residents (R164) that did not have proper wheelchair positioning and the facility failed to coordinate hospice care for 1 of 1 residents (R106) who had hospice services. Findings include: PAIN R164's Resident Admission Record identified diagnoses of pain, diabetes mellitus and cerebral vascular disease. R164's quarterly Minimum Data Set (MDS) dated 2/14/14, indicated he had pain and received scheduled pain regime, with moderate cognitive impairment. The admission MDS dated 11/29/13 indicated he had no pain and needed extensive assistance with bed mobility, transfers and had no pressure ulcers but was at risk for developing pressure ulcers. R164's care plan dated 1/31/14, identified a problem with bilateral heel blisters and had a history of pressure ulcers/open areas. The care plan interventions directed staff to turn and reposition R164 every two hours, use a pressure reduction mattress, cushion in wheelchair, observe for signs of irritation/breakdown, and apply skin prep to bilateral heels twice a day. The care plan also identified a history of multiple falls and impaired mobility but there was no	F 309	Pain: A new pain assessment was completed for R164 4/8/2014. He was evaluated by his Nurse Practitioner 4/8/2014 and his treatment goals were changed to comfort care. New pain management orders were received 4/8/2014. Wheelchair positioning: Occupational Therapy assessed R164 for wheelchair positioning, beginning 3/27/2014. OT recommendations to use left footrest for long distance transport only. Hospice: Health Partners Hospice and facility staff met 4/8/2014 to review and discuss R106□s status and care plans. The hospice schedule and care plans were updated as indicated. Rounds were conducted on each unit with direct care staff to identify clients that may need additional pain management interventions or adjustments in wheelchair positioning. Clients of concern were formally assessed and interventions were initiated as indicated. Pain: Pain management policies and procedures were reviewed and remain appropriate. All staff will receive training on recognizing and reporting client pain and licensed staff will receive additional training on pain management by 4/22/2014. Wheelchair positioning: Nursing staff will receive additional training on wheelchair positioning and referrals to occupational therapy when necessary. Hospice: All hospice visit schedules were compiled and placed in a	

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F 309	Continued From page 21 identification of R164 having pain. An Observation Report dated 12/13/13 identified R164 had a pain scale score of zero, no pain. R164's current Physician Orders (PO) dated 1/22/14, identified Tylenol 325 mg (milligrams) (analgesic) two tabs three times a day. The PO further indicated an order on 2/3/14 to keep heels off of bed, no shoes and to apply epc (extra protective cream) three times a day and as needed to open area to right buttock. A physician progress note dated 2/3/14, indicated blisters on bilateral heels that are "deflated" with purple centers. The note also identified an superficial open area to R164's right buttock and, " + [positive] pain both heels." R164 was continuously observed on 3/12/14, from 10:30 a.m. until 1:00 pm. (total of two hours and 30 minutes) without being assisted with repositioning and incontinence care. At 1:00 p.m. nursing assistant (NA)-G and NA-H were observed using a EZ-Stand (mechanical lift used to transfer) and transferred R164 into bed. NA-G attempted to straighten out R164's legs out while in bed but R164 yelled loudly, "Ouch, ouch, ouch," while making facial grimaces. NA-G stated R164 had been having "pain" when we move R164 legs because he has "sores" on his heels. NA-G then placed a pillow under his legs preventing his heels from touching the bed. During observation 3/12/14, at 4:15 p.m. registered nurse (RN)-B and NA-D changed R164's incontinent brief. RN-B measured the wounds on the heels which were black.	F 309	central location on each unit, accessible to all nursing staff. Updated contact information was placed in the medical records to instruct staff to contact hospice staff and the primary MD/NP with all hospice client updates. Clients receiving hospice care were also identified on the nursing assistant care sheets. A Hospice Collaboration of Care policy and procedure was developed to address protocols for collaboration with hospice staff and integration of care. Nursing staff will receive training related to hospice care protocols and on the revised Hospice Communication policy and procedure by 4/22/2014. Random weekly Comprehensive Pain audits , including wheelchair positioning, and Hospice Collaboration of Care audits will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Results of these audits will be submitted to the appropriate department head if corrective action is required. All audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance QA&A Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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R164's Resident Progress Notes indicated on 2/19/14, "Over last week or so client has had more episodes of agitation with cares. Increasingly restless, continues to awake during noc multiple times. Not participating in slide board transfers as well, transfer status changed as of 2/18 to EZ stand. Client is unable to communicate basic needs effectively, therefore staff anticipates..." The progress note on 2/28/14, identified the interdisciplinary team (IDT) reviewed R164's falls on 2/27/14, and has become more agitated, refusing medications and does not verbalize needs or why he does not want to take medications. The 3/8/14 Progress Note indicated, "[R164] refused his meds this morning and afternoon Tylenol. Was up all night per report and up all shift roaming up and down the halls." Progress note 3/10/14, indicated resident was sleeping with eyes closed so far and has been awake part of shift. "Keeps moving his feet around in bed and feet are elevated. Heels are on a pillow due to causing pain. Client refuse pain pill. No injury or bruise from fall on PM shift." Progress note 3/12/14 indicated, "Client complaint of feet pain during shift. Client refused prn [as needed] tyl. [Tylenol] 650 mg for pain..."

The Physician Progress Notes dated 3/13/14, indicated staff report over the past several weeks almost daily falls, refusing medications and confused verbally, with bilateral heel pressure ulcers. The physician discontinued the scheduled Tylenol and changed the order to Tylenol 325 mg two tabs every 6 hours as needed for pain.

During interview 3/13/14, at 7:20a.m. with RN-A and NA-F, RN-A stated R164 was having severe pain, we try to give him Tylenol but he has been

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refusing to take pain medications. RN-A further stated his pain has increased in the last two to three weeks. NA-F stated, "I think he is in severe pain he just yells", when we try to move him because of his heels and from the falls he he been having.

During interview 3/13/14, at 8:04 a.m. RN-B stated she has noticed R164 has increased pain in the last one to two weeks.

During interview 3/13/14, at 3:05 p.m. NA-H who stated R164 has pain with movement and they now use the EZ stand to transfer him. NA-H further stated he had pain in his heels and bottom when they move him and his feet fall off the foot rests.

During telephone interview 3/13/14, at 5:00 p.m. R164's physician-A stated he had seen R164 today but was unaware that the resident was having increased pain. He stated the staff told me R164 had increased agitation, falls and refused his medication but they did not mention anything about having increased pain.

Although R164 had been having increased pain, with agitation in the past few weeks, in which staff were unable to move his legs and provide personal cares when they worked with him. The facility did not comprehensively assess and monitor his increased pain with agitation to insure he was comfortable, which resulted in actual harm for R164.

The facilitys Pain Management Data Tool dated 3/13/14, indicated "All clients will be reviewed for the need for pain management at the following designated times" Upon admit, Hospital return,

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Quarterly per MDS schedule, and with significant change MDS criteria (As initiated by MDS Coordinator.) as well as on an as needed basis. To insure that client's comfort needs are being met."

WHEEL CHAIR POSITIONING

R164 was observed on 3/11/14, at 10:45 a.m. in his wheelchair with his left foot off the foot rest. The foot rest, had a strap on the backside of the rest, but was flat, making it difficult for R164 to keep his feet on the rest. There were no calf supports on the foot rest to prevent his feet from falling off. Family member (F)-A came and placed R164's foot back on the foot rest.

During observation 3/12/14, at 8:52 a.m. R164 left foot slid off the foot rest and was resting on the floor. At 11:21a.m. R164 was sitting at the dining room table his left foot off the foot rest on the floor. Staff nor did the resident make any attempts to replaced R164's foot back onto the foot rest.

During interview 3/13/14, at 7:10 a.m. NA-F stated R164 had difficulty keeping his feet on the foot rest, which fall off frequently.

R164's care plan dated 1/31/14, identified a problem with bilateral heel blisters. The care plan interventions directed staff to turn and reposition R164 every two hours, use a pressure reduction mattress, and cushion in wheelchair. There was no mention of R164's feet falling off his wheelchair pedals.

Review of the progress notes, and occupational

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therapy notes from 12/13 to 3/14/14, did not identify any concerns with R164 feet falling off the wheelchair pedals even though he had bilateral heel pressure ulcers.

During interview 3/13/14, at 10:08a.m. with occupational therapist (OT)-A stated she was not informed that R164 had pressure ulcers on his heels and was not aware he had difficulty keeping his feet on the foot rests and should have been alerted to this. The OT-A further stated staff usually fill out a "skin note" so therapy is alerted of any pressure ulcers or skin areas which can be assessed for appropriate interventions.

COORDINATE HOSPICE SERVICES

R106's Hospice Admission Summary, dated 2/8/14, identified a terminal diagnosis of bowel obstruction. The admission Minimum Data Set dated 2/14/14, identified moderate cognitive impairment, with a diagnosis of dementia, and life expectancy less than six months.

R106's facility's hospice care plan dated 2/25/14, indicated R106 had specialized needs related to end stage disease. The goal was R106 would "maintain comfort and be provided with end-of-life care to aid with transition process." Staff were directed to follow the hospice care plan approaches, maintain comfort with medication, repositioning, and involve family in all aspects of care. Staff were to update the doctor, nurse practitioner, hospice, and family with any change in status.

The hospice care plan dated 3/4/14, identified

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interventions for pain, constipation, comfort/symptom management, and coordination of care with the facility. A volunteer would one to four times a month. A registered nurse (RN) would visit 1-3 times per month as needed for symptom management, a social worker would visit 1-2 times in 4 weeks.

R106's Facility Visit Documentation Record, from hospice, identified only two notes from 2/8/14 to 3/13/14. The first note was dated 2/8/14, and signed by the agency Social Worker (SW). The note identified the services of an RN (registered nurse), MSW (Master in Social Work) and a volunteer would be provided for R106. The second note, dated 2/28/14, was a visit note by the agency's registered nurse. There was no indication as to when or if the volunteer had visited R106. R106's interdisciplinary progress notes reviewed from 2/8/14 through 3/13/14, also did not identify any volunteer visits had occurred. A Health Partners Hospice and Palliative Care Patient calendar for February 2014, included an admission date of 2/8/14, and three RN visits. The March 2014, calendar was blank.

R106 was observed continuously, on 3/12/14 from 7:01 a.m. until 12:50 p.m. R106 remained in bed, except she was assisted to and from the bathroom by nursing assistant (NA)-B and NA-A a total of five times, at 7:20 a.m., 7:34 a.m., 8:36 a.m., 10:12 a.m., and 11:08 a.m, for having loose stools which was confirmed with NA-B and NA-A during these times.

During interview, on 3/12/14 at 1:15 p.m. NA-B stated she didn't know when hospice came, she was unsure if it was in the morning or evening.

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F 309	Continued From page 27 NA-B did not know how the hospice visit days and times would be communicated to nursing. During interview on 3/12/14, at 1:20 p.m. the unit coordinator (UC)-H stated R106 does have regular visits from hospice, a volunteer comes on Mondays, she did not know when the nurse or social worker came to visit. If hospice knows their schedule, they will call the facility and UC-H places the visit on the staff calendar, so staff would be aware of the upcoming visits. During interview, on 3/12/14, at 1:15 p.m., the director of nursing (DON) stated hospice does not have a set day of the week they come to the facility, but the visits would be recorded on the staff calendar ahead of time, so the staff would be aware. The staff calendar was reviewed with the DON on 3/13/14, at 10:22 a.m., the DON verified the last hospice visit recorded on the calendar was on 3/7/14, there would be no way to determine if hospice had visited since then, or when the next visit would occur. During interview on 3/13/14, at 11:51 a.m. the hospice (RN)-D stated the facility is not communicating changes in R106's condition such as falls that occurred on 2/21/14, 2/22/14, 3/1/14, and 3/8/14. In addition the facility had not notified hospice when R106 had repeated requests to use the toilet, which had been found in the interdisciplinary team's progress notes dated 3/3/14. She was not aware R106 had required frequent toileting on 3/12/14. Hospice RN-D stated these are things that should be communicated with hospice when they occur.	F 309		

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F 309	Continued From page 28 Hospice tries to call the facility prior to the next visit, which are not scheduled. Hospice did not know if the facility had communicated the upcoming visit to staff or not. A policy was requested, but not provided by the facility.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 3 of 5 residents (R164, R14, and R104) with pressure ulcers, were assessed, monitored and/or provided care to ensure current pressure ulcers were healing and to prevent the development of new pressure ulcers. This resulted in actual harm for R164, and R14 for reoccurring and/or multiple pressure ulcers on their coccyx. Findings include: R164's Resident Admission Record identified diagnoses of pain, diabetes mellitus and cerebral	F 314	A new comprehensive skin assessment was completed for R164 on 4/10/2014 and his care plan was revised to include a low air loss bed. The new Director of Nursing assumed responsibility for the wound care program on 4/10/2014. Wound rounds were conducted 4/09/2014 and 4/10/2014 and R164 was among those clients assessed. R164□s left heel and coccyx wounds are resolved. The right heel ulcer is unstageable and treatment continues as ordered. R164 will be assessed weekly during wound rounds until wounds are resolved. R14□s coccyx wound was also assessed 4/9/2014. He	4/22/14

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F 314	Continued From page 29 vascular disease. R164's quarterly Minimum Data Set (MDS) dated 2/14/14, included three stage two pressure ulcers, (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed without slough) and no unstageable pressure ulcers, identified moderate cognitive impairment, required extensive assistance with bed mobility, transfers, and was incontinent of bowel and bladder. R164's admission MDS dated 11/29/13, indicated no pressure ulcers, but was at risk for developing pressure ulcers. R164's pressure ulcer Care Area Assessment (CAA) dated 11/23/13, indicated he was at risk for skin breakdown, had incontinence, and had interventions to maintain integrity of his skin. R164's Braden Scale (a tool used to determine pressure ulcer risk) dated 12/13/13, identified a score of 15, which indicated a risk for pressure ulcer development with no open areas. R164's care plan dated 1/31/14, identified bilateral heel blisters with a history of pressure ulcers/open areas. The care plan directed the staff to turn and reposition him every two hours, to use a pressure reduction mattress, cushion in wheelchair, observe for signs of irritation/breakdown, skin prep to bilateral heels twice a day. R164 was incontinent of bowel, bladder and was to be offered toileting every two to three hours while awake and was checked and changed every two to three hours at night. R164's physician orders dated 2/3/14 identified keep heels off of bed, no shoes and to apply epc (extra protective cream) three times a day and as needed to open area to right buttock. The physician also ordered on 2/20/14 to apply skin prep to scabs of bilateral heels twice a day.	F 314	has one pressure ulcer on his coccyx surrounded by fragile pink skin. He remains on an hourly repositioning plan although he prefers to lie on his back and is able to move to that position independently. His wound will be assessed weekly during wound rounds until fully resolved. A new comprehensive skin assessment was completed for R104 on 4/11/2014 and her care plan was revised to include hourly repositioning. All other pressure reduction interventions remain in place. Her wounds were assessed during wound rounds on 4/9/2014. Her left foot has three necrotic areas, including the entire first toe. The Nurse Practitioner was updated and no further orders were given at this time. Her wounds will be assessed at least weekly with wound rounds until resolved. Clients at high-risk for skin breakdown were audited to ensure all appropriate interventions were in place to prevent pressure ulcers. Random toileting/ repositioning audits are in progress to identify concerns related to compliance. Corrective action and/or education will be conducted as indicated by the Clinical Manager. The new Director of Nursing assumed responsibility for the wound care program on 4/10/2014. Wound rounds were reinstated 4/10/2014 and will be conducted weekly. Clients with pressure ulcers, stasis ulcers, and complicated traumatic or surgical wounds will be assessed each week during wound rounds by the Director of Nursing and Clinical Manager. Other interdisciplinary	

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F 314	Continued From page 30 R164's physician progress note dated 2/3/14, identified blisters on bilateral heels that were "deflated" with purple centers. The progress note also indicated open area to right buttock which was superficial and, " + [positive] pain both heels." During interview 3/12/13, at 11:36 a.m. family member (F)-A stated she arrived at the facility at 10:30 a.m. and the staff had not repositioned or changed his incontinent pad since she arrived. She further stated she visits the facility daily and staff usually don't check him until they lay him down for a nap around 1:00 p.m. During continuous observation on 3/12/14, from 10:30 a.m. until 1:00 p.m. (total of two and half hours) R164 was not repositioned or assisted with toileting during this time. At 1:00 p.m. nursing assistant (NA)-G and NA-H used an EZ-Stand (mechanical lift) and transferred R164 into bed on his back. NA-G attempted to straighten R164's legs who yelled loudly, "Ouch, ouch, ouch" while grimacing. NA-G stated he was having "pain" when his legs are moved because of the "sores" on his heels. NA-G then placed a pillow under his legs preventing his heels from touching the bed. NA-G and NA-H made no attempts to check or change R164's incontinent brief and left the room. During interview on 3/12/14, at 1:15 p.m. NA-G stated R164 was checked, changed for incontinence and repositioned was at 10:00 a.m. (three hours ago). R164 should be repositioned every two hours, and toileted every two to three hours which was not completed. During observation 3/12/14, at 4:15 p.m. registered nurse (RN)-B and NA-D changed	F 314	team members will be included and/or updated with findings as appropriate. Wound care policies and procedures were reviewed and revised to include the above information. Licensed staff will receive additional training on skin and wound care, including the revised policies and procedures by 4/22/2014. Nursing assistants will receive additional training related to the prevention of pressure ulcers, including interventions and compliance with care plans by 4/22/2014. Random weekly Comprehensive Skin/Wound audits will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Random weekly toileting/ repositioning audits will be conducted on each unit for six weeks or until substantial compliance is achieved, whichever is later. Corrective action and/or education will be conducted as indicated by the Clinical Manager. All audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance QA&A Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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R164's incontinent brief, that was soiled with a small amount of stool. R164 had a red area on his coccyx. RN-B measured the red area as 1cm (centimeter) by 1.3 cm and stated it was a stage one pressure ulcer (An observable, pressure-related alteration of intact skin, persistent redness). RN-B measured the wounds on the heels. The left heel was black and measured 1.5 cm x 1cm, RN-B stated the left heel area had "never opened" so she would stage the pressure ulcer as "unstageable." The right heel was black which measured 2 cm x 1cm and stated she would stage this heel as a "stage one ." RN-B stated these areas were a, "Stage one because I can see around the edges of the black center."

During interview on 3/13/14, at 7:44 a.m. RN-B stated R164 had pressure ulcers which was a blister on his right and left heel identified on 1/31/14. RN-B further stated the last time she looked at R164's bilateral heels was the end of February. The left heel was black, the black tissue area had increased since she last looked at the area. RN-B stated R164 had a open stage two pressure ulcer on his coccyx which developed on 1/29/14. The nurse practitioner (NP)-A ordered Allevyn (pressure ulcer dressing) and staff were supposed to update the physician the following day, however this was not completed. RN-B stated she could not find any documentation of wound measurements to R164's heels or the coccyx since the pressure areas developed. She further stated they should have been monitoring the pressure ulcers and updating the physician or NP-A. RN-B stated R164's coccyx pressure ulcer had healed but was uncertain when this happened. She verified R164's coccyx pressure ulcer had reoccurred and

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now was a stage one.

R164's nursing progress note, dated 2/3/14, included "NP here to see clients bottom and heels. Both heels have deflated blisters and the L [left] blister is open and skin is missing on parts of it. The R [right] blister appears to have a black center. The buttock has a pin point open area. Nursing cream applied. Appears stable." A review of R164's nursing progress notes from 12/1/13 to 3/12/14, lacked any monitoring of pressure ulcers on a weekly basis, to include location, staging, size, exudate, pain, wound bed and description of surrounding wound edges for the bilateral heel and coccyx ulcer. In additon there was no reassessment of R164 risk for skin integrity after the development of pressure ulcers and there were no notes that addressed the new stage one pressure ulcer which was first noted on 3/13/14.

During an interview on 3/13/14 at 7:50 a.m., RN-B stated than skin monitoring "should have been completed" on a weekly basis for R164's pressure ulcers. RN-B verified there were no additional assessments or monitoring for R164's pressure ulcers.

Although R164 had redeveloped a pressure ulcer on his coccyx and his pressure ulcers had increased in size on his heels the facility failed to assess and monitor to prevent further breakdown, which resulted in actual harm for R164.

R14 Annual MDS dated 1/24/14 identified R14 had severe cognitive impairment, was at risk for developing pressure ulcers, required extensive

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assistance with all ADL's except eating and had no pressure ulcers.

R14's care plan dated 2/4/14 identified R14 was at risk for pressure ulcers, and had a "pink, fragile bottom." The care plan instructed staff to turn and reposition R14 every one hour.

During interview on 3/10/14 at 6:45 p.m. R14 stated when he lays in the same spot on his "butt" all the time it "hurts a lot." R14 stated he often needs to turn his call light on to get help turning so he is not laying "in the same spot."

During observation on 3/11/14 at 2:30 p.m. R14 was laying on his back in bed. R14 began to yell, "help--get me off my back!" My ass hurts!!! Get me on my stomach!" An (unknown) NA went into R14's room and closed the door to reposition the resident.

During observation on 3/12/14 at 1:18 p.m. LPN-A provided treatment to R14's coccyx pressure ulcers. The residents coccyx was covered with a thick white cream, which LPN-A stated was "barrier cream." LPN-A stated the resident should really have Allevyn dressing on the area because "scrubbing" the barrier cream off the residents coccyx was making it [pressure ulcers] "worse." LPN-A stated the last time she had seen R14's coccyx was about "a week and a half ago" and at that time there was only one small open area, however, there were now 3 open areas on the residents coccyx. LPN-A stated the current measurements were 1 cm at 8 o'clock, .25 cm at 10 o'clock, and .25 at 3 o'clock. LPN-A stated all three of the pressure ulcers were a stage 2. LPN-A only measured across the

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pressure ulcers, not width and length, and verified this is how she measures pressure ulcers. LPN-A stated this was the first time she had measured R14's pressure ulcers and would chart the measurements in the Progress Notes. LPN-A was not aware if any of the other nurses had been measuring R14's pressure ulcers because the facility was "just keeping an eye on them [pressure ulcers]."

During constant observation on 3/13/14 from 2:40 p.m. to 4:05 p.m. R14 was laying in bed on his back. R14 had repositioned or was assisted to reposition in bed during this time frame.

During interview on 3/13/14 at 4:05 p.m. nursing assistant (NA)-C stated she began her shift at 2:30 p.m. and had not repositioned R14 since she started her shift. NA-C stated during shift report she was told R14 was last repositioned at 10:00 a.m., 6 hours and 5 minutes ago, however, she stated the other shift complete rounds at 2:00 p.m. so the resident was "probably" repositioned at that time. NA-C stated R14 was to be repositioned every two hours. However, when NA-C looked at R14's care sheet she stated the resident should be repositioned every one hour, which she was not aware of.

Upon review of R14's progress notes indicated the following:
3/6/14- A note written by the hospice RN indicated the resident "has a stage one open area on coccyx that is being treated with barrier cream." There is no further monitoring of R14's pressure ulcers on a weekly basis that included: location, staging, size, exudate, pain, wound bed and description of surrounding wound edges.
1/29/14- "Braden scale score of 15 indicates a

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risk for skin breakdown... resident is turned and repositioned every one hour and PRN [as needed]... history of reddened coccyx area..."

A physician visit note dated 3/5/14 identified R14, "Coccyx/ skin breakdown per nursing." There is no further orders, measurements, or description of the pressure ulcer(s). R14's current physician orders dated 3/13/14 instructed, "Allevyn to coccyx for protection every 3 days and PRN [as needed]; check every shift."

Although R14 had one coccyx pressure ulcer on his coccyx on 3/6/14, then developed into three separate pressure ulcers on his coccyx on 3/12/14. The facility did not consistently monitored and provide interventions to promote the healing of these pressure ulcers which caused actual harm for R14.

R104 Quarterly Minimum data set (MDS) dated 1/23/14 identified R104 had severe cognitive impairment, needed extensive assistance with all activity's of daily living (ADL's), was at risk for developing pressure ulcers and had no pressure ulcers.

Review of a physician visit progress note dated 2/17/14 identified R104 had a "Left heel unstageable pressure ulcer- beginning of month developed 6.5 cm x 1.5 cm spongy area on medial surface of left heel. Small purple in center. Restarted foam boots while in bed..."

The most recent physician progress note dated

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F 314	Continued From page 36 3/5/14 did not address the pressure ulcer on R104's heel(s). R104 care plan dated 3/7/14 indicated the resident was at risk for pressure ulcers and directed staff to place "boots as of 2/14/14." R104's Braden with Skin Risk quarterly assessment dated 3/6/14 identified the resident was at high risk for pressure ulcers. The summary indicated, "Resident is at high risk for impaired skin integrity due to multiple diagnosis as well as impaired mobility and cognition. Resident also has a left great toe and inner foot gangrene area which is being treated only with dressing changes... Resident relies on staff assist with all repositioning needs and incontinent care. Otherwise skin is intact except for left foot..." Review of R104's Resident Progress Notes on 2/2/14 indicated, "Wounds to bilateral heels, left side measures 6.5 cm x 1.5 cm. Spongy areas with on area of 1 cm x 1 cm of darkened area. Unable to stage. Unstageable heel pressure ulcer. Right side measures 4 cm x 2.5 cm with small 0.5 cm round darkened area. Spongy total surface bilaterally. Unstageable..." This is the only documentation in the progress notes regarding R104's pressure ulcers on her heels. During observation of 3/12/14 at 7:55 a.m. R104 was observed laying in bed with foam boots on bilateral feet. Licensed Practical nurse (LPN)-A looked at the pressure ulcers on R104's heels. LPN-A stated the staff was not doing any treatment to the residents heels and just leaving the pressure ulcers open to air. She had not been measuring R104's pressure ulcers on her	F 314		

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heels, but thought "other" nurses may have been measuring them and would document in the computer progress notes if they had been. LPN-A verified the left heel pressure ulcer was now completely black and appeared to be approximately 7 cm x 3 cm, and the right heel had a small (approximately 1 cm x 1 cm) black spot in the middle of the heel which appeared to be covered by yellowish skin. LPN-A stated she was not going to measure the pressure ulcers as she had not done this in the past.

R104 was observed on 3/12/14 at 9:15 a.m. laying in bed fully dressed with no foam boots on her heels. R104's knees were bent and her heels were pressing into the bed. R104 remained in the same position until 10:08 a.m. when nursing assistant (NA)-M transferred R104 into her wheelchair.

During interview on 3/12/14 at 9:15 a.m. NA-M stated R104 was to wear foam boots at all times while laying in bed. NA-M verified R104 had the boots off since 9:05 a.m., which was about an hour. NA-M stated she had removed the boots to get the resident dressed, however, she just left the boots off because she knew she would be getting the resident up for brunch soon. NA-M stated she was not aware R104 had any pressure ulcers on her heels.

During interview on 3/12/14 at 12:58 p.m. director of nursing (DON) stated she was currently the clinical manager for R104 and had completed a Braden Skin Risk assessment on 3/6/14. The DON was not aware R104 had any pressure ulcers, however, the DON had not inspected R104's skin, but just reviewed the progress notes written by the nurses to assess R104's skin

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condition. The DON verified if a resident had a pressure ulcer staff should be monitoring it weekly (measuring, staging) and documenting it in the resident progress notes. DON verified R104's pressure ulcer had not been monitored.

On 3/12/14 at 3:20 p.m. the DON provided a handwritten facility document for R104 titled a Skin Care Progress Note. The Skin care Progress Note form was a prefilled form that included a front and back outline of a person's body with an area for the current treatment plan. The form had a graph with spaces for the date, site, stage, size, depth, drainage, color, odor, and progress. The Skin Care Progress Notes form indicated R104 had a left and right heel pressure ulcer and identified the following:

2/10/14- Left heel; stage 1; size- 6.5 cm x 1.5 cm; no depth; no drainage; dark color; no odor.
2/10/14- Right heel; stage 1; size- 4 cm x 2.5 cm; no depth; no drainage; yellowish; no odor.
2/17/14- Left heel; stage 1; size- 6.5 cm x 1.5 cm; no depth; no drainage; dark color; no odor.
2/17/14- Right heel; stage 1; size- 4 cm x 2.5 cm; no depth; no drainage; yellowish; no odor.
2/24/14- Left heel; stage 1; size- 6.5 cm x 1.5 cm; no depth; no drainage; dark color; no odor.
2/24/14- Right heel; stage 1; size- 4 cm x 2.5 cm; no depth; no drainage; yellowish; no odor.
3/3/14- Left heel; stage 1; size- 6.5 cm x 1.5 cm; no depth; no drainage; dark color; no odor.
3/3/14- Right heel; No stage identified; size- 4 cm x 2.5 cm; no depth; no drainage; yellowish; no odor.
3/12/14- Left heel; stage 1; size- 6 cm ("dry area)" x 1.5 cm ("dark area"); no depth; no drainage; dark color; no odor.

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F 314	Continued From page 39 The DON stated on 3/12/14 at 3:20 p.m. that she had "forgot" staff had been charting on the form which was kept in a three ring binder which was not part of R104's medical record. The DON was not aware what nursing staff were documenting on the handwritten form regarding R104's pressure ulcer but stated the handwriting appeared to be LPN-A's. DON stated LPN-A must have went back and measured R104's pressure ulcers after she was observed inspecting them earlier that day on 3/12/14. Although R104 had pressure ulcers identified on both heels, the facility failed to ensure the pressure ulcers were consistently monitored and interventions were being implemented to promote healing of the pressure ulcers. A Skin Care Progress Note policy and procedure dated 9/23/11, directed clinical managers or designee weekly to complete skin rounds on those client's identified on admit as having community acquired pressure ulcer or through receipt of skin change/alert form. In absence of clinical manager for floor due to vacation, etc. arrangements must be made for another clinical manager to complete skin rounds. The policy further stated a minimum of weekly there should be thorough documentation in the integrated progress note including site, type of ulcer if pressure ulcer stage, current measurement, description of exudates if present, description of wound bed, progress toward healing, description of surrounding skin, presence of any tunneling, current pain management and effectiveness (clients response to dressing change),current treatment plan, etc and determine whether	F 314		

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F 314	Continued From page 40 treatment plan needs to be changed.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide timely assistance with toileting for 1 of 3 residents (R164) reviewed for urinary incontinence. Findings include: R164's Resident Admission Record indicated diagnoses of pain, diabetes mellitus and cerebral vascular disease. R164's admission Minimum Data Set (MDS) dated 11/29/13 indicated he needed extensive assistance with transfers, toileting and was frequently incontinent of bowel and bladder. The Urinary Incontinence Care Area Assessment (CAA) dated 11/29/13, indicated he was incontinent of bladder with only infrequent continent episodes staff to toilet on a routine schedule. R164's care plan dated 2/14 included: client is	F 315	A new bowel and bladder assessment was completed for R164 on 4/11/2014 and the findings are consistent with his current toileting plan. Staff was reminded to notify the nurse whenever cares cannot be provided as per care plan. Random toileting/ repositioning audits are in progress to identify concerns related to compliance. Corrective action and/or education will be conducted as indicated by the Clinical Manager. The policy and procedure was reviewed and remains appropriate. Nursing staff will receive training related to timely assistance with toileting and repositioning, pressure ulcer prevention, and reporting care concerns or refusals of care to the nurse by 4/22/2014. Random weekly toileting/ repositioning audits will be conducted on each unit for	4/22/14

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F 315	Continued From page 41 experiencing incontinence related to cerebral vascular accident (CVA) decreased mobility and impaired cognition and communication. The care plan directed staff to toilet R164 every two to three hours while awake and check and change his incontinent brief every two to three hours during the night. R164 was continuously observed on 3/12/14, from 10:30 a.m. until 1:00 pm. (total of two hours and 30 minutes) without being assisted with toileting or incontinence care. At 1:00 p.m. nursing assistant (NA)-G and NA-H were observed using a EZ-Stand (lift used to transfer) and transferred R164 into bed. NA-G and NA-H made no attempts to check or change R164's incontinent brief and left the room. At 1:15 p.m. NA-G stated R164 was last checked, changed for incontinence at 10:00 a.m. (three hours ago) and should be toileted every two to three hours, which was not completed. NA-G stated R164 had fallen asleep just after they laid him down and she did not want to wake him to change his pad since this would agitate him. During observation 3/12/14, at 4:15 p.m. R164's incontinent product was changed, which was over 6 hours since he was last checked, registered nurse (RN)-B and NA-D removed R164's incontinent brief which had a small amount of stool. R164 had a stage one reddened area on his coccyx which RN-B measured as 1 cm (centimeter) by 1.3 cm. During interview 3/13/14 at 4:00 p.m. the director of nursing (DON) stated R164 should be toileted according to his schedule and was not aware he "becomes agitated," when they change his incontinent product.	F 315	six weeks or until substantial compliance is achieved, whichever is later. Corrective action and/or education will be conducted as indicated by the Clinical Manager. All audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance QA&A Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure falls were thoroughly re-assessed and interventions were implemented to help decrease the risk of falls for 1 of 3 residents (R106) reviewed for falls. Findings include: R106's admission progress note, dated 2/7/14, identified that R106 had a diagnoses that included dementia and adult failure to thrive. The resident's admission Minimum Data Set (MDS), dated 2/14/14, identified R106 was moderately cognitively impaired, severe visually impaired and received hospice care. The MDS identified R106 had no falls in the last month, or 2-6 months prior to admission; however the physician order's signed 2/25/14, identified a fall history. R106 was observed continuously on 3/12/14, from 7:07 a.m. until 12:50 p.m. in a low bed with bilateral grab bars. The bed was against the wall, she had a mat on the floor on her left side, a personal alarm was attached to the back of her gown, and secured to the head board. A call light	F 323	A new bowel and bladder assessment and fall risk assessment was completed for R106 to investigate potential fall risk factors. Her care plan was updated to include toileting assistance every two hours and PRN. Further PVR testing is in progress and assessment will be revised as necessary based on those results. Random toileting/ repositioning audits are in progress to identify concerns related to compliance. Corrective action and/or education will be conducted as indicated by the Unit Manager. Hospice and facility care plans were reviewed for all clients receiving hospice care to ensure integrated care plans were in place and all relevant notifications have been made to hospice staff. A Hospice Collaboration of Care policy and procedure was developed to address protocols for collaboration with hospice staff and integration of care. Updated contact information was placed in the medical records to instruct staff to contact hospice staff and the primary MD/NP with all hospice client updates. Clients	4/22/14

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 43 was within her reach. R106 requested, and received assist to the bathroom at 7:20 a.m., and at 7:29 a.m. R106 sat up on the edge of the bed, her feet on the mat, personal alarm was attached and not sounding. She needed to frequently use the bathroom with assistance at 7:34 a.m., 8:36 a.m., 10:12 a.m., and 11:08 a.m. R106's Fall's Care Area Assessment (CAA), dated 2/14/14, identified R106 had risk factors of incontinence, visual and hearing impairment, delirium, agitation, cognitive impairment, depression, dementia, and pain. The analysis of the risk factors indicated R106 was "At risk for falls due to visual impairment, weakness, impaired balance and gait. Last fall in 2011 in which client suffered a closed fracture of pubis. Client still has difficulty with ambulation and physical mobility from this fx [fracture]." R106's Urinary Incontinence CAA, dated 2/14/14, identified the resident required extensive assistance and was frequently incontinent. Risk factors included modifiable factors of delirium, pain, and restricted mobility with urinary urgency and need for assistance in toileting. R106's Interdisciplinary Care Plan (ID-CP) dated 2/25/14, identified R106 was at risk for falls r/t [related to] history of falls and a decline in status. Under, "other," included, "2/20 & 2/21 -attempts self tx [transfer] fall/got self/out of bed, no injury." The ID-CP directed staff to "offer opportunity to toilet, respond to requests promptly, observe for unsafe actions, keep call light within reach as able and remind client to utilize, make sure foot wear is appropriate, establish a routine, provide adequate opportunity for rest, observe during	F 323	receiving hospice care were also identified on the nursing assistant care sheets. Falls continue to be discussed daily by the Interdisciplinary Team (IDT) and an Interdisciplinary Post-Fall Assessment Tool has been added to enhance the root cause analysis process and the identification of relevant interventions. Nursing staff will receive training related to hospice care protocols and on the revised Hospice Communication policy and procedure by 4/22/2014. Hospice and facility care plans were reviewed for all clients receiving hospice care to ensure integrated care plans were in place and all relevant notifications have been made to hospice staff. Hospice Collaboration of Care audits will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Audits will be submitted to the Director of Nursing upon completion. Interdisciplinary Post-Fall Assessment Tools will be completed during the daily falls review and maintained with the fall report. Falls data and the Hospice Collaboration of Care audits will be submitted to the will be reported to the Quality Assessment and Assurance QA&A Committee at least quarterly. The Director of Nursing and Administrator will be responsible for compliance.	

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cares for bruises, bumps, skin tears, etc, tabs alarm when in w/c [wheel chair] and bed, sensor alarm to wheel chair and bed, fall mats(s) per order by bed, Envolve [sic] family as needed." R106's Unit 1, Team Sheet, updated 3/5/14, identified R106 utilized safety equipment of "floor mat," and "tabs sensor bed."

Review of the progress notes indicated R106's had a fall 2/21/14, at 10:56 p.m. that R106 was sitting on the floor mat with her back facing the room door. R106 was assisted into the wheelchair and brought to the evening meal. The intervention identified in the progress notes was to place a sensor on the bed so when R106 either sat up in bed or tried to get out of bed the alarm would sound.

R106's progress note, dated 2/22/14, at 11:00 p.m. identified R106 had fallen and was on the floor, with her feet facing the window. R106 stated she was trying to go to the bathroom, and the gray floor mat was very wet.

R106's progress note, dated 2/23/14, at 5:00 p.m. identified R106 was found sitting on the toilet. The note indicated that R106 was an assist of two with transfers. No injuries were noted. "At HS (hours of sleep) tab and sensor alarm applied to clients bed for safety." Every 30 minutes safety checks were implemented. A review of R106's 30 Minute Safety Checks, identified that the checks were documented from 2/24/14, at 11:00 p.m. through 2/28/14 at 2:30 p.m. (four days).

R106's progress note, dated 2/24/14, at 9:09 a.m. included, the IDT (interdisciplinary team) met to discuss recent falls out of bed on 2/21/14 at 4:50

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F 323	Continued From page 45 p.m. at which time a sensor pad was added to safety equipment. The fall on 2/22/14 at 11:00 p.m. identified that the "Toileting plan to be evaluated." There was no evidence in the medical record from 2/24/14 through 3/13/14, the toileting plan for R106 had been re-evaluated to determine if the plan was appropriate to help prevent potential falls. R106's progress note, dated 3/1/14, at 2:00 a.m., identified, "Staff heard personal alarm sounding off, went immediately to clients room and saw client sitting on floor matt, with bed in low position, lights were on at her bedside. Client facing the doorway. Client attempted a self-transfer and was trying to go to the bathroom..." An Incident Report, dated 3/1/14, indicated "Revised Interventions: (make sure to update care plan)" were to "{monitor, observe client q30 (every 30 minutes), speak with onsite psychology." A review of the 30 Minute Safety Checks, identified that the checks were documented from 3/1/14, at 11:00 p.m. through 2:30 p.m. and undated on the same form 3:00 p.m. through 10:30 p.m. R106's progress note, dated 3/3/14, at 9:05 a.m., identified the "IDT met to discuss recent fall from bed. Client stated she was attempting to go to the bathroom. Client repeatedly reports she needs to use BR, even though she has just went PVR [post void residual] attempted to be completed, however client is combative with any staff intervention and will strike out. House psychologist to evaluate client as a follow-up intervention." R106's progress noted dated 3/4/3014, at 10:45	F 323		

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p.m. identified, "Client was sitting at table and was starting to stand up when fell to the floor on back. No injuries were present when lifting client with transfer belt back into wheelchair." The note also identified that "Intervention: 30 minutes checks due a fall less then 30 days ago." A Post Fall Staff Huddle Worksheet, dated 3/4/14, at 9:35 a.m., that the resident had a w/c [wheel chair] tabs [personal alarm]] and that the resident had removed it before the fall. An Incident Report, dated 3/4/14, at 9:50 a.m. indicated that the document's, "Revised Interventions: (Make sure to update care plan) Hospice here 3/5/14 to review status."

A progress noted, dated 3/5/2014 at 9:02 a.m., identified, the "IDT met to discuss fall on 3/4/14 at 9:35 a.m. Client had attempted to stand from chair, proceeding to fall to floor. No injury sustained; client continues to be agitated. Hospice to address recent falls..." A progress note, dated 3/5/14, at 11:52 a.m., indicated that the hospice registered nurse noted the fall with no injuries and reviewed this with the Hospice Medical Director and NP [nurse practitioner] along with "The pt [patient] had been c/o [complains of] chronic severe neck and back pain in the past months/weeks and wanted to lie down. She is not using prn MS [as needed morphine]" R106's pain medications were adjusted.

R106's progress note, dated 3/8/14, at 5:38 a.m. "kneeling on floor mat. client at 420am [sic]bed alarm sounding off and was found with knees on floor matt and head resting on bed, client had been anxiously/agitated this noc [night], was assisted to the bathroom @ [at] 430 am prior to this client was assisted to the bathroom @ 3 am,

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client voided and was incontin [incontinent], client cont [continues] to be asking to use the bathroom, scooting around in bed sounding off alarms writer had did a bladder scan and results showed 0, client continues to be on Q [every]1 hour safety checks, client agitated unable to do vital signs at 5am client again on floor mat this time she was sitting on buttocks."

A review of R106's document, entitled, 1 Hours Safety Checks, dated 3/8/14, identified R106 was found on the mat in her room at 4:00 a.m.; however the 5:00 a.m. check identified that R106 was in bed talking to herself, but at 6:00 a.m. R106 was sitting on the edge of her bed.

An Incident Report, signed and dated 3/10/14 (two days after the falls occurred), identified that R106 had a fall "Date: 3/8/2014 Time: "4a [a.m.] &[and] 5a [a.m.] a.m." with no injury. The document's "Revised Interventions: (Make sure to update care plan) included on Q1 [every one hour], NP, no changes, continue [with] current POC [plan of care]. The Post Fall Staff Huddle Worksheet, undated, identified the resident regularly used alarms, "tabs, bed sensor."

A progress note dated 3/10/14, at 9:14 a.m. "IDT met to discuss falls that occurred on 3/8/14 at 4:20am and 5am. They were both out of bed onto the floormat, no injuries sustained. Client had been increasingly agitated throughout NOC [night] shift, recent medication changes made by hospice in hopes to keep client more comfortable. NP and hospice to be updated regarding falls to discuss potential interventions." A hospice licensed practical nurse (LPN) progress note, dated 3/11/14, at 4:46 p.m. indicated the resident's agitation and pain were reviewed;

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however there was no indication in the note that R106's falls were reviewed by hospice for potential interventions.

During interview, on 3/13/14, at 9:25 am, the director of nursing, (DON) stated the house Psychologist did not see R106 because R106 was receiving the hospice benefit and this wouldn't be appropriate. Hospice is controlling the behaviors with medications.

When interviewed, on 3/13/14, at 11:51 am the hospice registered nurse (RN)-D, stated that the facility did not call or communicate that R106 was having falls and that hospice was not contacted regarding potential interventions. In addition, she also stated that she would like to know about R106's falls at the time they happen. In addition, the hospice RN stated that the facility's in house psychologist did see R106 and discussed this with the hospice NP. The hospice RN verified that there was no documentation of the recommendations. The hospice RN-D stated R106's frequent requests to use the toilet was not communicated to hospice and would expect that the facility communicate this information to us.

When interviewed, on 3/13/14, at 3:14 pm, the director of nursing (DON) stated that R106 was not identified on the temporary care plan as at risk for falls, because R106 did not have a fall in the past year. The DON stated that after the 2/20/14 and 2/21/2014 falls, the tabs in the wheelchair and the bed and the sensor alarm in the wheelchair and bed were added to the care plan. At 3:44 p.m. the DON stated that R106's toileting plan was not re-evaluated as recommended by the IDT on 2/24/14, as she was able to verbally request to use the toilet and there

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F 323	Continued From page 49 were no signs of a UTI (urinary tract infection). At 3:52 p.m. the DON stated that she did talk to someone from hospice about increasing the volunteer hours for R106, however the DON stated that there was no documentation in the record and there should have been. In addition, the DON stated that the falls should have been reported to Hospice the next day, depending on the day. Although R106 had five falls since admission to the facility (February 2014), there was no indication that the facility followed up on recommendations from the interdisciplinary team to help decrease R106's risk for falls. These recommendations included 1) reassessment of R106's toileting plan(2/24/2014); 2) house psychologist to evaluate R106 for fall interventions 3/3/2014); and 3) NP and hospice to be updated regarding falls to discuss potential interventions (3/10/2014). A review of the facility's Fall Risk Assessment, policy dated 3/13/2013, identified that "all Camilla Rose clients will have a Fall Risk Assessment completed on admission, RFH [unknown abbreviation], with significant change and following > [over] 3 falls in a month. R106 had three falls in March 2014; 3/1/2014. 3/4/2014, and 3/8/2014; however there was no evidence in R106's chart that a comprehensive assessment was completed to decrease R106's fall risk.	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -	F 325		4/22/14

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F 325	Continued From page 50 (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 5 residents (R104, R14), reviewed for nutrition were monitored, assessed, and had interventions put in place to ensure adequate nutritional intake. Findings include: R104 quarterly Minimum Data Set (MDS) dated 1/23/14 identified the resident had severe cognitive impairment, had no identified weight loss in the prior 6 months of the assessment, and required extensive assistance with all activities of daily living (ADL's). During observation on 3/12/14 at 9:45 a.m. R104 was laying in bed. At 10:08 a.m. nursing assistant (NA)-M came into R104's room to get the resident up for brunch. At 10:08 a.m. NA-M stated R104 only gets up for two meals, brunch and dinner. R104 does not have much of an appetite and doesn't eat the other three smaller meals. During observation on 3/12/14 at 10:50 a.m. R104 was observed in the dining room receiving assistance with the brunch meal which consisted	F 325	R104□s nutrition assessments and related progress notes were reviewed and client preferences, such as no milk and two juices at meals were carried forward from previous assessments. She is on hospice and has had a weight loss. A calorie count flow sheet was initiated for R104 on 4/11/2014 for all meals. The Registered Dietician (RD) will continue to monitor her status as a nutritional risk and determine the stop date for these calorie counts. R14□s intake is monitored for all five meals, beginning 3/20/2014. His care sheet was updated to direct staff to keep extra snacks in his room. Weight logs were reviewed by the Diet Technician to identify clients with recent weight loss that are not on risk monitoring. One client was changed to a nutritional risk status and will be monitored by the Registered Dietician as such. Food and fluid intake monitoring for all five meals was implemented 3/20/2014. Designated staff on each unit will be responsible for ensuring that all clients are offered each meal and that intake is recorded. Refusals will be reported to the	

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F 325	Continued From page 51 of egg bake and fruit. R104 was sleeping during the entire meal, and would not open her eyes or mouth to eat. R104 was brought back to her room at 11:51 a.m. The resident drank 1 and 1/2 cups of juice, but did not eat any of her meal. The Vitals report of R104's intake for 3/12/14 "lunch" indicated R104 had intake of 1-25% of the meal, and 100 cc of fluid. Review of R104's weights revealed the following: 10/27/13- 146 pounds. 12/23/13- 135 pounds. 3/3/14- 127 pounds. (most recent weight.) A Nutrition Risk Review dated 2/19/14 completed by consulting dietician (CD)-G indicated, "... current intakes at meals variable from 1-25% to 75-100%. Drinks 180-360cc per meal. Does need assistance with eating...will continue to follow at risk due to weight loss, skin issues." The Quarterly Nutrition assessment dated 3/13/14 indicated R104, "receiving a regular diet... weigh down 19.5 pounds/ 13% in 6 months which is significant... she remains on Remeron... client is followed by RDLD [registered dietician licensed dietitian] per nutritional risk tracking." This was completed by dietary technician (DT)-B. R104's care plan dated 3/7/14 indicated resident refuses supplements, had a recent weight loss trend, was at "nutritional risk", and does not drink milk. The care plan directed staff R104 needed total assistance with eating, record intake at each meal, Remeron (appetite stimulant) as ordered, and 6 oz ensure (supplement) every day. Review of R104's current physician orders dated	F 325	nurse for investigation. Nursing staff will receive training on intake monitoring, client refusals, and documentation by 4/22/2014. The Nutrition Services Director, Therapeutic Recreation Director, and the Director of Nursing met with Resident Council members 4/09/2014 and returning to a standard three meal plan was overwhelmingly approved by the clients. The Nutrition Services Director is leading a team to develop an action plan to return to a standard three meal plan by 5/5/2014. A Nutrition at Risk policy and procedure was implemented 4/9/2014 to ensure the Diet Technician (DT) identify clients with nutritional concerns. The Diet Technician (DT) will refer clients to the Registered Dietitian (RD) for assessment. The Nutrition Assessment policy and procedure was reviewed and revised to include noting dietary preferences and allergies on each assessment. The Diet Technician and Registered Dietician participated in these changes. Random weekly compliance audits of nutrition offering, documentation, and appropriate follow-up for each meal or snack will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Results of these audits will be submitted to the Director of Nursing upon completion and reported to the Quality Assessment and Assurance (QA&A) Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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F 325	Continued From page 52 3/13/14 identified the resident had been on Remeron 15 mg in the past, however, the resident was not currently taking Remeron and it was discontinued on 4/4/13, 11 months prior to the nutrition assessment completed on 3/7/14 identifying the resident was still receiving Remeron for appetite stimulant. Upon review of R104's Vitals Report identifies the residents intake for residents fluids and intake for lunch and dinner, however, the facility was on a 5 meal a day plan and only 2 of the meals were documented consistently. The January to March 2014, Vitals Report identified R104 had varying intakes documented for lunch and dinner. Lunch intake documentation ranged from 1%-100%, with an average intake of 26-50%. Dinner intake documentation ranged from 1%-100%, with an average intake of 26-50%. During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R104 was at nutritional risk related to weight loss and was being monitored and documenting the residents intakes at meals. DT-B stated she had done R104's quarterly nutritional assessment on 3/7/14 and "thought" the resident was still taking Remeron for appetite stimulant and was not aware this was discontinued almost a year ago. DT-B stated the consultant dietician assess any residents at nutritional risk monthly and makes recommendations as needed. DT-B reviewed R104's intake record and stated R104's intakes can not be determined and it appeared the resident was not getting adequate fluid or nutrition. DT-B also stated she was not aware staff was not charting the intake for all 5 meals.	F 325		

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F 325	Continued From page 53 DT-B was unable to provide a comprehensive nutritional assessment for R104 which included likes, dislikes and preferences. During interview on 3/13/14 at 3:15 p.m. consulting dietician (CD)-G stated the nutritional assessment completed on R104 was based on receiving 5 meals a day. She was not aware R104 was only receiving two meals a day. CD-G stated her assessment is based off the information the nurses provide to her and she does not always review the intakes charted in the individual resident records. CD-G verified there was no specific nutritional assessment which identified R104's likes and dislikes. She stated she did not have a lot of information on R104, however, she was aware R104 refused nutritional supplements. Although R104 was assessed to be at nutritional risk related to weight loss, the facility failed to ensure the resident had a individualized comprehensive assessment and monitoring in place to ensure adequate nutrition. R14 Annual MDS dated 1/24/14 indicated the resident had severe cognitive impairment, required extensive assistance with all ADL's except eating, had no or unknown weight loss in the previous 3 months, and it was "very important" for R14 to have snacks available. The annual Nutritional assessment completed on 1/22/14 indicated the resident was on regular diet, refused supplements and refused to be weighed. The summary identified, "...refuses supplements;	F 325		

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discontinued from [nutrition risk] due to hospice care; refuses weights...client is eating very little and often refuses meals... he will make food preferences needs known when asked."

Review of R14's care plan dated 2/3/14 indicated R14 was underweight, refused supplements, likes hot chocolate, refused to be weighed, and was on a regular diet. Staff was instructed to document R14's intake at each meal, assist resident with set up for meals and offer cheese and crackers at night.

Upon review of R14's weights from September 2013 to March 2014, only identified a weight on 9/27/13 and was 91.5 pounds. The other weekly weights were documented as "refused."

R104's current physician orders dated 3/13/14 indicated resident "to have a general snack at bedtime."

During observation on 3/10/14 at 8:05 p.m. staff was serving the night snack (the 5th meal of the 5 meal plan at the facility). Dietary staff served residents in the dayroom room yogurt, ice cream, and juice. After the residents in the dayroom were provided snacks, the dietary staff cleaned up the snack cart and left the floor. No snacks were provided or offered to R14. R14 was laying in bed and had no snacks were in his room. There was a cup of water on the residents nightstand, however, this was not within the residents reach.

During interview on 3/13/14 at 10:30 a.m. NA-D stated R14 usually eats in his room and we bring meals to his room, however, he is usually sleeping. NA-D stated lunch (brunch) and dinner

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are the only intakes documented for R104. The other three meals are served in the dayroom and/ or dining room for whatever residents are out of their rooms at that time. NA-D stated staff did not bring the other three meals to R14 as he doesn't have much of an appetite.

During observation on 3/13/14 at 2:57 p.m. R14 was laying in bed and turned his call light on. Nursing assistant (NA)-D went in to assist, and R14 asked when they were eating as he stated he hadn ' t eaten all day. The resident asked if he could have a sign in his room so he knew when he got to eat. NA-D left and brought the resident in a pack of Lorna Dune cookies and a cup of coffee. The resident drank all of the coffee and ate the entire pack of cookies. There were no snacks observed in the residents room.

During interview on 3/13/14 at 3:47 p.m. R14 stated he had not eaten all day, and finally got some cookies to eat. R14 stated he knows he had been loosing weight, however, he does not get weighed and doesn't know why. He stated he would like to be weighed to see how much he weighs. R14 stated he eats "most" meals in his bed.

Upon review of R14's Vitals Report identified the residents intake for residents fluids and intake for lunch and dinner, however, the facility was on a 5 meal a day plan and only 2 of the meals were documented consistently. The January to March 2014, Vitals Report were reviewed and identified R14 had varying intakes documented for lunch and dinner. Lunch intake documentation ranged from "none" to 100%, with an average intake of 26-50%. Dinner intake documentation ranged from "none"-100%, with an average intake of

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F 325	Continued From page 56 26-50%. During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R14 was taken off nutritional risk monitoring because he was on hospice care. DT-B reviewed R14's intake record and stated the residents intakes can not be determined and it appeared the resident was not getting adequate fluid or nutrition. DT-B also stated she was not aware staff was not charting the intake for all 5 meals and verified R14 should be brought all 5 meals to his room and should always have snacks available. DT-B was unable to provide a comprehensive nutritional assessment for R14 which included likes, dislikes and preferences. During interview on 3/13/14 at 3:15 p.m. consulting dietician (CD)-G stated the nutritional assessment completed on R14 was based off receiving 5 meals a day, and she was not aware R14 was only receiving two meals a day. CD-G stated her assessment is based off the information the nurses provide to her and she does not always review the intakes charted in the individual resident records. CD-G verified there was no specific nutritional assessment which indicated the resident likes and dislikes. She stated R14 was taken off nutritional risk monitoring related to hospice care, however, CD-G verified R14 should still be receiving fluids, snacks, and regular meals for comfort and quality of life. Review of facility policy titled Five Meal Plan dated 9/15/09 indicated, "Nutritional needs monitoring: Menus are monitored and approved by dietician to meet daily nutritional requirements of the clients. Upon admission clients are	F 325		

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F 325	Continued From page 57 monitored and approved by dietician to meet daily nutritional requirements of the clients. Upon admission clients are monitored for food and fluid intake daily for all 5 meals..."	F 325		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		4/22/14

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F 356	Continued From page 58 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the daily staff posting included the actual hours worked for nursing staff. This had the potential to affect all 71 residents currently residing in the facility and all the visitors. Findings include: During initial tour of the facility on 3/10/14 at 1:10 p.m. the daily staff posting was observed posted on the wall near the front entrance of the facility. The posting identified the actual working hours as "DAYS", "PM's" and "NOC'S"; the actual hours identifying the hours were not included. During interview on 3/13/14 at 3:20 p.m. receptionist (R)-E stated the staffing coordinator is responsible for the staff posting, however, she was not available for interview. R-E verified there was no way to determine what the actual hours worked were according to the staff posting listing "DAYS", "PM's" and "NOC'S." A policy on staff posting was requested but not provided.	F 356	The Daily Staffing Hours posting format was revised to include the actual hours worked for nursing staff and implemented 4/11/2014. The Daily staffing Hours posting policy and procedure was revised to include this new format and staff responsible for this procedure will be trained by 4/22/2014. Forms will be maintained for a minimum of 18 months in the staffing office. The Director of Nursing will review forms at least weekly for six weeks or until compliance is achieved, whichever comes first. The Director of Nursing will be responsible for compliance.	
F 368 SS=D	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the	F 368		4/22/14

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F 368	Continued From page 59 following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 2 of 5 residents (R104, R14) reviewed for nutrition, had no more then 14 hours between meals provided. Findings include: During the initial entrance conference on 3/10/14 at 1:45 p.m. director of nursing (DON) stated the facility was on a 5 meal a day plan. DON stated all residents were to receive 5 meals, breakfast (1st meal), brunch (2nd meal), afternoon snack around 2:00 p.m. (3rd meal), dinner (4th meal), and night snack (5th meal). R104 quarterly Minimum Data Set (MDS) dated 1/23/14 identified the resident had severe cognitive impairment, had no identified weight loss in the prior 6 months of the assessment, and required extensive assistance with all activities of daily living (ADL's). R104's care plan dated 3/7/14 indicated resident refuses supplements, had a recent weight loss trend, was at "nutritional risk." The care plan	F 368	R104□s nutrition assessments and related progress notes were reviewed and client preferences, such as no milk and two juices at meals were carried forward from previous assessments. She is on hospice and has had a weight loss. A calorie count flow sheet was initiated for R104 on 4/11/2014. Staff will report refusal of meals to nurse. The Registered Dietician (RD) will continue to monitor her status as a nutritional risk and determine the stop date for these calorie counts. R14□s intake is monitored for all five meals, beginning 3/20/2014. His care sheet was updated to direct staff to keep extra snacks in his room. Weight logs were reviewed by the Diet Technician to identify clients with recent weight loss that are not on risk monitoring. One client was changed to a nutritional risk status and will be monitored by the Registered Dietician as such. Food and fluid intake monitoring for all five meals was implemented 3/20/2014. Designated staff on each unit are	

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F 368	Continued From page 60 instructed staff resident required total assistance with eating and to record intake at each meal, The Quarterly Nutrition assessment dated 3/13/14 indicated R104, "receiving a regular diet... weigh down 19.5 pounds/ 13% in 6 months which is significant... client is followed by RDLD [registered dietician] per nutritional risk tracking." This was completed by dietary technician (DT)-B. A Nutrition Risk Review dated 2/19/14 completed by consulting dietician (CD)-G indicated, "... current intakes at meals variable from 1-25% to 75-100%. Drinks 180-360 cc per meal. Does need assistance with eating...will continue to follow at risk due to weight loss, skin issues." During observation on 3/10/14 at 7:45 p.m. dietary staff was serving the night snack (considered 5th meal according to the facility 5 meal plan) on the 3rd floor. There were approximately 5-7 residents in the dayroom area where the ice cream, yogurt, and juice was being served. After the residents in the dayroom were served, the dietary staff pushed the cart back into the kitchenette and left for the evening. None of the residents in their rooms were observed being offered or receiving the 5th meal. R104 was laying in bed in her room and was not offered the 5th meal. During interview on 3/12/14 at 10:08 a.m. NA-M stated R104 only gets up for two meals, brunch and dinner. NA-M stated the resident does not have much of an appetite and doesn't eat the other three meals. NA-M stated R104 does not eat breakfast, and she was currently getting the resident up to bring her to the dining room for brunch. NA-M verified R104 was not offered	F 368	responsible for ensuring that all clients are offered each meal or snack and that intake is recorded. Refusals are reported to the nurse for investigation. Nursing staff will receive training on intake monitoring, client refusals, and documentation by 4/22/2014. The Nutrition Services Director, Therapeutic Recreation Director, and the Director of Nursing met with Resident Council members 4/09/2014 and returning to a standard three meal plan was overwhelmingly approved by the clients. The Nutrition Services Director is leading a team to develop an action plan to return to a standard three meal based plan , including a substantial evening snack, to ensure sufficient nutrition is offered to each client throughout the day by 5/5/2014. A Nutrition at Risk policy and procedure was implemented 4/9/2014 to ensure the Diet Technician (DT) identify clients with nutritional concerns. The Diet Technician (DT) will refer clients to the Registered Dietitian (RD) for assessment. The Nutrition Assessment policy and procedure was reviewed and revised to include noting dietary preferences and allergies on each assessment. The Diet Technician and Registered Dietician participated in these changes. Random weekly compliance audits of nutrition offering, documentation, and appropriate follow-up for each meal or snack will be conducted at least weekly for six weeks or until substantial compliance is achieved, whichever is later. Results of these audits will be submitted to the Director of Nursing upon	

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F 368	Continued From page 61 breakfast on 3/12/14. During observation on 3/12/14 at 10:50 a.m. R104 was observed in the dining room receiving assistance with the brunch meal. Upon review of R104's Vitals Report of the residents intake indicated the facility was documenting the residents fluids and intake for lunch and dinner, however, the facility was on a 5 meal plan and only 2 of the meals were documented. R104 was observed on 3/12/14 laying in bed from 11:51 a.m. until she was assisted out of bed and brought into the dining room for brunch at 4:50 p.m. R104 was assisted eating brunch, and brought back to her room at approximately 5:40 p.m. On 3/13/14 at 10:20 a.m. R104 was assisted out of bed into her wheelchair and brought out to dining room for brunch. NA-M verified R104 had not eaten breakfast that morning and is only brought out of her room for the 2 main meals, brunch and dinner. There is approximate 16 1/2 hours between dinner and brunch the following day. During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R104 was at nutritional risk related to weight loss and staff was monitoring and documenting the residents intakes at meals. DT-B reviewed R104's intake record and verified the residents intakes can not be determined and it appeared the resident was only being served 2 meals a day which were approximately 16 hours apart. DT-B verified R104 should be offered all 5 meals and it	F 368	completion and reported to the Quality Assessment and Assurance (QA&A) Committee at least quarterly. The Director of Nursing will be responsible for compliance.	

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F 368	Continued From page 62 appeared R104 was going approximately 16 hours between meals. DT-B stated the facility was aware the time between meals were too long on the 5 meal plan due to "many" of the residents not receiving all 5 meals, however, no change had been implemented but was "being reviewed." During interview on 3/13/14 at 3:15 p.m. consulting dietician (CD)-G stated the nutritional assessment done on R104 was based off receiving 5 meals a day, and she was not aware R104 was only receiving two meals a day. CD-G verified all residents should be offered all 5 meals to receive adequate nutrition, and 16 hours is "to long" to go between meals. CD-G stated she was aware there were "concerns" with the time between meals, however, currently no changes had been implemented. R14 Annual MDS dated 1/24/14 indicated the resident had severe cognitive impairment, required extensive assistance with all ADL's except eating, had no or unknown weight loss in the previous 3 months, and the resident indicated it was "very important" to have snacks available. Review of R14's care plan dated 2/3/14 indicated resident is underweight, and was on a regular diet. Staff was instructed to document resident intakes at each meal, assist resident with set up for meals, and offer cheese and crackers at night. R104's current physician orders dated 3/13/14 indicated resident "to have a general snack at bedtime." During observation on 3/10/14 at 8:05 p.m. staff	F 368		

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was serving the night snack (the 5th meal of the 5 meal plan at the facility). Dietary staff served residents in the dayroom room yogurt, ice cream, and juice. After the residents in the dayroom were provided snacks, the dietary staff cleaned up the snack cart and left the floor. No snacks were provided or offered to R14. R14 was laying in bed and had no snacks observed in his room. There was a cup of water on the residents nightstand, however, it was not within the residents reach.

During interview on 3/13/14 at 10:30 a.m. NA-D stated R14 usually eats in his room and staff is to bring meals to his room, however, he is usually sleeping so he does not always receive the meals. NA-D stated lunch (brunch) and dinner are the only intakes monitored for R14. The other three meals are served in the dayroom and/ or dining room for residents who are in the dayroom at that time. NA-D stated staff did not bring the other three meals to R14 as he didn't have much of an appetite, however, she stated at times R14 will ask for something to eat if he is hungry.

During observation on 3/13/14 at 11:15 a.m. brunch was served in the dining room. R14 was observed in his room laying bed with the television on. R14 had no snacks or food in his room, nor was staff observed bringing or offering any food to R14.

During observation on 3/13/14 at 2:57 p.m. R14 was laying in bed and turned his call light on. Nursing assistant (NA)-D went in to assist R14 and the resident asked when they were eating as he stated he hadn't eaten all day. The resident asked if he could have a sign in his room so he knew when he "got to eat." NA-D left and brought

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the resident in a pack of Lorna Dune cookies and a cup of coffee. The resident drank all of the coffee and ate the whole pack of cookies. There were no other snacks observed in the residents room. NA-D was unsure if R14 was offered breakfast or brunch.

During interview on 3/13/14 at 3:47 p.m. R14 stated he had not eaten all day, and finally got some cookies to eat. R14 stated he does not like to get out of bed, and eats "most" meals in his bed.

Review of R14's Vitals Reports on on 3/12/14 there is no record of R14 receiving the 5th meal (bedtime snack). The intake records for 3/13/14 indicated breakfast was documented as "none" and there was no documentation regarding brunch. The last documented intake was recorded as "dinner" at 7:00 p.m. on 3/12/14; which was approximately 20 hours prior to when the resident requested staff to bring him something to eat on 3/13/14 at 2:57 p.m.

During interview on 3/13/14 at 11:40 a.m. dietary technician (DT)-B stated R14 was taken off nutritional risk monitoring because the resident was on hospice care. DT-B reviewed R14's intake record and verified it appeared the resident was not getting adequate fluid or nutrition and the resident was going for long periods of time without eating. DT-B also stated staff should be monitoring intake for all 5 meals, should be bringing all meals to R14's room, and should assure the resident always has snacks available bedside.

During interview on 3/13/14 at 3:15 p.m. consulting dietician (CD)-G stated all residents

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F 368	Continued From page 65 should be offered all 5 meals to receive adequate nutrition, and anything over 14 hours between meals is "to long." CD-G stated she was aware there were "concerns" with the time between meals, however, currently no changes had been implemented. During interview on 3/12/14 at 10:08 a.m. nursing assistant (NA)-M stated residents eat brunch (around 10:30 a.m.-11:00 a.m.) and dinner (around 5:00 p.m.) in the main dining room. Otherwise staff is instructed to provide snacks to the residents out in the dayroom but they do not serve each resident in their rooms. During interview on 3/13/14 at 5:10 p.m. the administrator stated he was aware there were problems with the five meal plan which included ensuring all residents were provided/ offered all 5 meals and some residents may be going over 14 hours between meals. The administrator stated the facility had been discussing going back to the "traditional" 3 meals a day, however, no changes had been implemented. Review of facility policy titled Five Meal Plan dated 9/15/09 indicated, "Nutritional needs monitoring: Menus are monitored and approved by dietician to meet daily nutritional requirements of the clients. Upon admission clients are monitored and approved by dietician to meet daily nutritional requirements of the clients. Upon admission clients are monitored for food and fluid intake daily for all 5 meals...clients that require assist with eating are to be assisted by NA (nursing assistant) or client dining staff when they are scheduled with each of the five daily offerings."	F 368		

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F 441	Continued From page 66	F 441		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		4/22/14

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	245353	A. BUILDING _____ B. WING _____	03/13/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 67 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure there was an infection control program in place to track, analyze, monitor, and summarize resident infections. This had the potential to effect all 71 residents currently residing in the facility. In addition, the facility failed to ensure 1 of 1 residents (R8), observed with possible infectious symptoms was isolated while displaying symptoms to prevent the spread of infection to other residents. Findings include: During interview on 3/11/14 at 1:45 p.m. director of nursing (DON) stated the facility currently had no one in charge of the facility infection control program. DON stated registered nurse (RN)-C was in charge of the infection control program in the past, however, RN-C began a different position in the facility in October, 2013. DON provided an antibiotic usage form from the facility pharmacy with varying dates from September 2013 through February 2014 which she identified as the only tracking for infections in the facility. Review of the antibiotic usage form included the residents name, floor where the resident resided, antibiotic used with the date it was dispensed, and the number of antibiotics dispensed. The form did not include what the antibiotic was prescribed for, organism, room number, symptoms, and if the infection was present prior to admission or if it was acquired at the facility.	F 441	The new Director of Nursing assumed responsibility for the Infection Control Program 4/11/2014. Verification was made that policies and procedures are in place to outline the definition of infection and appropriate isolation measures to implement with clients displaying signs of illness. Current infection control data was compiled and the Director of Nursing is monitoring infection control procedures. Verification was made that Infection Control program policies and procedures are in place to address the investigation, tracking and prevention of infections in the facility. Current Infection Control program policies and procedures address the investigation, tracking and prevention of infections in the facility. Infection Control data is collected and maintained by the Director of Nursing or designee. This data is used to investigate individual cases of infection and to prevent or manage outbreaks. Outdated forms were removed. Unit managers received additional training regarding current facility policies and procedures, including infection control surveillance responsibilities. The Medical Director will be consulted for guidance and oversight on an ongoing basis. Licensed staff will receive additional training on the Infection Control Program, including facility surveillance policies and procedures as well as intervention to prevent the spread of infection by	

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F 441	Continued From page 68 During review of the antibiotic usage form on 3/11/14 at 1:45 p.m. DON verified the facility had no infection control program which determined type of infections, trends, summary's, symptoms, or organism. DON stated the clinical managers on the resident floors are responsible for tracking resident infections, however, there are no reports or documented infections because the clinical managers "just know" who the residents are and if there are current infections. The facility policy titled Infection Control Program dated 5/2010 indicated, "The infection control program exists to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. The facility establishes a program under which it investigates, controls, and prevents infections in the facility; Decides what procedures such as isolation, should be applied to an individual resident; maintains a record of incidents and action plans related to infections...through the infection control program has systems in place to provide surveillance, investigation and monitoring to prevent, to the extent possible, the onset and the spread of infection; control outbreaks, by clustering or cohorting of residents to reduce spread of infection...elements of the [infection control program] program include: surveillance based on systemic data collection to identify infections in residents; a system for detection, investigation, and control of outbreaks of infectious disease..." R8 annual Minimum data set (MDS) dated	F 441	4/22/2014. Data is compiled and reported to the Quality Assessment and Assurance (QA&A) Committee at least quarterly on an ongoing basis. Follow-up actions required as a result of this data review will continue be identified and implemented as part of the QA&A process. The Medical Director and Director of Nursing will be responsible for compliance.	

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F 441	Continued From page 69	F 441		

12/27/13 identified the resident had severe cognitive impairment and required extensive assistance with all activities of daily living (ADL's).

During observation on 3/10/14 at 3:50 p.m. R8 was observed sitting in her wheelchair in the dayroom area. R8 was moaning, her face was red, and it appeared her forehead was damp. On 3/10/14 at 5:20 p.m. R8 was observed sitting in her wheelchair in the dining room. The resident was sleeping on and off in the wheelchair, moaning, and coughing. Nursing assistant (NA)-I was attempting to feed R8 supper, however, R8 would not swallow and the food and fluids ran out of her mouth. At 5:45 p.m. R8 was pushed in her wheelchair into the dayroom and placed next to several other residents. R8 continued to cough and moan. At 6:15 p.m. NA-I pushed R8 into her room and began to get the resident ready to lay down.

During interview on 3/10/14 at 6:15 p.m. NA-I stated R8 was not feeling well today and had a temperature earlier today. NA-I stated R8 would not eat "all day" and was usually much more talkative and awake.

Review of R8's Progress notes dated 3/10/14 identified, "not feeling well this shift. Client had large loose BM [bowel movement] before dinner and was moaning and holding her head... vital signs were 100.3 temperature...Tylenol was administered and temperature went to 98.9..."

During interview on 3/11/14 at 1:45 p.m. DON stated she was not aware of any residents having any symptoms of illness in the last week. DON was not aware of R8's temperature and illness and verified she was also the clinical manager in

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F 441	Continued From page 70 charge of the unit R8 resided on. DON verified any resident with a temperature or loose stools should be isolated to prevent the spread of infection to other residents. Although R8 had a temperature and was displaying symptoms of a possible infectious illness, the facility failed to ensure the resident was isolated from other residents to prevent the spread of infection.	F 441		
F 466 SS=C	483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure arrangements for emergency water were readily available in the event of emergency and/or disruption of water supply. This had the potential to affect all 71 residents currently residing in the facility. Findings include: The facility's emergency water supply contract with Glenwood Inglewood dated 3/9/12, did not specify the source of water provisions for storing potable water, description of a method for distributing the water, and calculations for estimating the gallons of water required daily to meet the needs of the residents and staff in the event of a disruption of the water supply. During interview 3/13/14, at 10:30 a.m. the	F 466	A contract was secured with Premium Waters, Inc. on 4/7/2014 to ensure that water is available to essential areas when there is a loss of normal water supply. The Emergency Water Supply Plan has been revised to specify the water source, method of distribution and calculations for estimating the gallons of water required to meet the needs of the facility in the event of a disruption of the normal water supply. The Maintenance Director was trained on 4/7/2014. The Maintenance Director will be responsible for compliance.	4/22/14

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F 466	Continued From page 71 maintenance director stated he called Glenwood Ingelwood in February 2014 and discovered the facility no longer had a contract with them to provide emergency water. He stated the facility did not have an estimation to determine the amount of potable and non- potable water required in the event of a disruption of their water supply. He was in the process of trying to have onsite storage of water for the residents. He was unaware of the necessary components for the emergency water supply plan to be effective in meeting the needs of the residents.	F 466		
F 501 SS=F	483.75(i) RESPONSIBILITIES OF MEDICAL DIRECTOR The facility must designate a physician to serve as medical director. The medical director is responsible for implementation of resident care policies; and the coordination of medical care in the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility medical director failed to provide guidance, oversight, and collaboration with the facility staff related to the lack of a resident infection control program. This had the potential to effect all 71 residents currently residing in the facility. Findings include: During interview on 3/11/14 at 1:45 p.m. director of nursing (DON) stated the facility currently had no one in charge of the infection control program. DON stated registered nurse (RN)-C was in	F 501	The new Director of Nursing assumed responsibility for the Infection Control Program 4/11/2014. Infection Control program policies and forms are in place to address the investigation, tracking and prevention of infections in the facility. The Medical Director will be consulted for ongoing guidance and oversight. N/A The Medical Director□s contract was reviewed and it does include all appropriate oversight responsibilities, including the Infection Control program.	4/22/14

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F 501	Continued From page 72 charge of the infection control program in the past, however, RN-C began a different position in the facility in October, 2013. DON provided an antibiotic usage form from the facility pharmacy with varying dates from September 2013 through February 2014 which she identified as the only tracking for infections in the facility. Review of the antibiotic usage form included the residents name, floor where the resident resided, antibiotic used with the date it was dispensed, and the number of antibiotics dispensed. The form did not include what the antibiotic was prescribed for, organism, room number, symptoms, and if the infection was present prior to admission or if it was acquired at the facility. During review of the antibiotic usage form on 3/11/14 at 1:45 p.m. DON verified the facility had no infection control program which determined type of infections, trends, summary's, symptoms, or organism. DON stated the clinical managers on the resident floors are responsible for tracking resident infections, however, there are no reports or documented infections because the clinical managers "just know" who the residents are and if there are current infections. DON stated resident infections were talked about at the Quality assurance (QA) meetings, however, there was no monitoring of resident infections nor was there a written summary or analysis of infections. During interview on 3/13/14 at 5:10 p.m. administrator stated infection control was talked about in the quarterly QA meetings, however, he knew it was not "talked about enough." The administrator stated he was aware the facility currently had no infection control program to track	F 501	The Administrator will be responsible for compliance.	

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F 501	Continued From page 73	F 501		

resident infections. The administrator stated a new medical director had taken over "about 2 months ago" and stated both the new and the prior medical director attended the last QA meeting in January 2014.

During interview on 3/19/14 at 1:58 p.m. facility medical director (MD) stated she was not aware the facility had no infection control program and was not made aware from the prior MD when taking over about 2 months ago. Although the administrator indicated MD attended the QA meeting in January 2014, MD stated she had not yet attended any QA meetings at the facility but had only just met privately with the administrator.

The facility policy titled Infection Control Program dated 5/2010 indicated, "The infection control program exists to assure a safe, sanitary and comfortable environment for residents and personnel. It is designed to help prevent the development and transmission of disease and infection. The facility establishes a program under which it investigates, controls, and prevents infections in the facility; Decides what procedures such as isolation, should be applied to an individual resident; maintains a record of incidents and action plans related to infections...through the infection control program has systems in place to provide surveillance, investigation and monitoring to prevent, to the extent possible, the onset and the spread of infection; control outbreaks, by clustering or cohorting of residents to reduce spread of infection...elements of the [infection control program] program include: surveillance based on systemic data collection to identify infections in residents; a system for detection, investigation, and control of outbreaks of infectious disease..."

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F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility Quality Assessment and Assurance (QA&A) committee failed to develop and implement appropriate action plans for previously identified areas of concern related the lack of a facility infection control program. This had the potential to effect all 71 residents currently residing in the facility.	F 520	The Medical Director□s attendance at the January 2014 QA&A meeting was verified. The QA&A Committee, consisting of the Medical Director, Administrator, Director of Nursing, and at least three other facility representatives, will continue to meet at least quarterly. The agenda includes data review related to the Infection Control Program and other	4/22/14

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F 520	Continued From page 75 Findings include: During interview on 3/11/14 at 1:45 p.m. director of nursing (DON) stated the facility currently had no one in charge of the infection control program. The DON stated registered nurse (RN)-C was in charge of the infection control program in the past, however, RN-C began a different position in the facility in October, 2013. DON provided an antibiotic usage form from the facility pharmacy on 3/11/14 at 1:45 p.m. with varying dates from September 2013 through February 2014 which she identified as the only tracking for infections in the facility. Review of the antibiotic usage form included the residents name, floor where the resident resided, antibiotic used with the date it was dispensed, and the number of antibiotics dispensed. The form did not include what the antibiotic was prescribed for, organism, room number, symptoms, and if the infection was present prior to admission or if it was acquired at the facility. DON verified the facility had no infection control program which determined type of infections, trends, summary's, symptoms, or organism. DON stated resident infections were talked about at the QA&A meetings, however, there was no monitoring of resident infections nor was there a written summary or analysis of infections. During interview on 3/13/14 at 5:10 p.m. administrator stated infection control was talked about in the quarterly QA&A meetings, however, he knew it was not "talked about enough." The administrator stated he was aware the facility currently had no infection control program to track resident infections, however, he was not sure when the last tracking had been done related to	F 520	key quality indicators. Existing and/or potential areas of concern are identified and plans of action are developed within the QA&A process. The QA&A Committee policy and procedures were revised. The QA&A Committee will be responsible for developing action plans to address areas of concern, such as infection control. QA&A minutes, including attendance, will be maintained in the Health Information office. The Medical Director and Director of Nursing will be responsible for compliance.	

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F 520	Continued From page 76 infection control with the residents. The administrator stated a new medical director had taken over "about 2 months ago" and stated both the new and the prior medical director attended the last QA&A meeting in January 2014. During interview on 3/19/14 at 1:58 p.m. facility medical director (MD) stated she was not aware the facility had no infection control program and was not made aware the facility had no infection control program from the prior MD when taking over as the medical director about 2 months ago. Although the administrator indicated MD attended the QA&A meeting in January 2014, MD stated she had not yet attended any QA&A meetings at the facility but had just met privately with the administrator and the prior medical director. Although the QA&A committee was aware the facility had no infection control program, they did not develop and implement appropriate action plans to ensure a infection control program was put into place.	F 520		

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K 000	INITIAL COMMENTS HE 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 VERIFAICATION 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 YOU VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Camilia Rose Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Health Care Fire Inspections STATE FIRE MARSHAL DIVISION 444 CEDAR STREET, SUITE 145 ST. PAUL, MN 55101-5145 or By E-Mail to: Marian Whitney@state.mn.us	K 000	EPOC	

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

Electronically Signed | 04/11/2014

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

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K 000	Continued From page 1 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Camilia Rose Care Center LLC was not found 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. Camilia Rose Care Center is a 3-story building with no basement. The original building was constructed in 1976 and an addition was constructed to the facility in 1993 both the original building and the addition are Type I (332) construction. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility	K 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 has a licensed capacity of 94 beds and had a census of 71 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT met.	K 000		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on review of available documentation the kitchen hood extinguishment system is not properly being maintained in accordance with MSFC(07) section 904.5.1 & NFPA 96. This deficient practice could effect all building occupants in the event of a fire under the hood. Findings include: At the conclusion of the facility tour on 3-13-14, at 10:30AM. Based on a review of available documentation, the last inspection. testing and maintenance of the kitchen hood extinguishment system was completed on 5-6-13. This procedure is required every 6 months. This deficient practice was confirmed by the Director of Maintenance (JD) at the time of exit.	K 069	1. The kitchen hood extinguishment system was cleaned and tested on 4/4/2014. 2. N/A 3. Kitchen hood extinguishment system cleaning schedule was revised to direct cleaning every six months. 4. The Dietary Manager will be responsible for monitoring compliance.	5/25/14