DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL E SURVEY AGENCY	ID: WOCL Facility ID: 00757
MEDICARE/MEDICAID PROVIDER NO. (L1) 245353 2.STATE VENDOR OR MEDICAID NO. (L2) 231243300 5. EFFECTIVE DATE CHANGE OF OWN (L9)	Э.	 NAME AND ADI (L3) CAMILIA RC (L4) 11800 XEON (L5) COON RAPI PROVIDER/SUP 01 Hospital 	DRESS OF FACILIT DSE CARE CENT BOULEVARD DS, MN	Y FER LLC	(L6) 55448 <u>02</u> (L7) 13 PTIP 22 CLIA	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
 6. DATE OF SURVEY 0 Unaccredited 0 Unaccredited 1 TJC 2 AOA 0 Other 	2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	80 (L18) 80 (L17)	B. Not in Com	ce With quirements	Vaivers:	And/Or Approved Waivers Of The 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code * Code: A*	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 80 (L37) (L38)	19 SNF (L39)	ICF (L42)	11D (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMARK 17. SURVEYOR SIGNATURE Brenda Fischer, U		Date :	ATION DATE):	(L19)	18. STATE SURVEY AGENCY AP Kate JohnsTon, Pr	ogram Specialist 05/18/2015
	PART II - TO	BE COMPLETE	D BY HCFA RE	. ,	OFFICE OR SINGLE STAT	(L20) YE AGENCY
 DETERMINATION OF ELIGIBILITY _X_ 1. Facility is Eligible to Part 2. Facility is not Eligible 	icipate (L21)		PLIANCE WITH CI ITS ACT:	VIL	 Statement of Financ Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE OF PARTICIPATION 10/13/1986 (L24)	23. LTC AGREEMI BEGINNING I (L41)		 LTC AGREEMEN ENDING DATE (L25) 		26. TERMINATION ACTION: <u>VOLUNTARY</u> 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: (L27)	 ALTERNATIVI A. Suspension of B. Rescind Susp 	of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/C. 03001		(L31)	30. REMARKS	
31. RO RECEIPT OF CMS-1539	32 (L32)	DETERMINATION C 05/21/2015	OF APPROVAL DAT	E (L33)	Posted 06/09/2015 Co	



Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245353 May 28, 2015

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

Dear Mr. Broman:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 12, 2015 the above facility is certified for or recommended 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.

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 Health Regulations Division Telephone: (651) 201-3992 Fax: (651) 215-9697 Enclosure (s) cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered May 27, 2015

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

RE: Project Number S5353024

Dear Mr. Broman:

On April 15, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 2, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 18, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on May 26, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 2, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 12, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 2, 2015, effective May 12, 2015 and therefore remedies outlined in our letter to you dated April 15, 2015, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

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

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245353	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 5/18/2015
Name	of Facility		Street Address, City, State, Zip Code	
CA	MILIA 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)	ltem		(Y5)	Date
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pref	x F0156		05/12/2015		ID Prefix	F0241		05/12/2015		ID Prefix	F0279		05/12/2015
-	# 483.10(b)(5) -	(10), 483.10(1	o)(1)		•	483.15(a)				-	483.20(d), 483.2	0(k)(1)	
LS					LSC					LSC			_
			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pref	x F0281		05/12/2015		ID Prefix	F0282		05/12/2015		ID Prefix	F0311		05/12/2015
Reg.	# 483.20(k)(3)(i)			Reg. #	483.20(k)(3)(ii)					483.25(a)(2)		
LS	C				LSC					LSC			_
			Correction					Correction					Correction
ID Pref	x F0314		Completed 05/12/2015		ID Prefix	F0315		Completed 05/12/2015		ID Prefix	F0323		Completed 05/12/2015
Reg	# 483.25(c)		-		Rea #	483.25(d)		-		Rea #	483.25(h)		
LS			•		LSC					LSC			
				1									
			Correction					Correction					Correction
ID Drof	x F0441		Completed 05/12/2015		ID Drofiv			Completed		ID Prefix			Completed
			05/12/2015					-					
Reg. LS	# 483.65				Reg. #					Reg. #			
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			Correction					Correction					Correction
			Completed					Completed					Completed
ID Pref	x		-		ID Prefix					ID Prefix			
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LS	C				LSC					LSC			_
Reviewed	Зу	Reviewed I	Зу	Dat	te:	Signature of	f Surve	vor:				Date:	
State Ager	су	BI	F/KJ	5	/27/20	-		1056	52				18/2015
Reviewed		Reviewed I		Dat		Signature of	f Surve					Date:	.,
CMS RO													
Followup	o Survey Comp	leted on:				Check f	or anv	Uncorrected	Defici	encies. Was	a Summary of	1	
	4/2/2	2015					-				to the Facility?	YES	NO

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245353	(Y2) Multiple Construction A. Building B. Wing 01 - N	AIN BUILDING 01	(Y3) Date of Revisit 5/26/2015
Name	of Facility		Street Address, City, State, Zip Code	
CA	MILIA 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).

	(Y5)	Date	(Y4)	Item		(Y5)	Date	(Y4)	ltem		(Y5)	Date
		Correction					Correction					Correction
		Completed					Completed					Completed
		05/12/2015		ID Prefix			05/12/2015		ID Prefix			05/12/2015
				-					-			
K0029				LSC	K0038				LSC	K0069		
		Correction										Correction
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10070				200					200			
		Correction					Correction					Correction
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/	Reviewed E	Зу	Da	ite:	Signature o	of Surve	yor:	1			Date:	
/	PS/	KJ	5/	27/201	5			2812	20		5	/26/2015
/	Reviewed E	Зу	Da	ite:	Signature o	of Surve					Date:	
Survey Compl	eted on:				Check	for anv	Uncorrected	Defici	encies. Was	a Summary of	1	
4/6/2	2015					-				-	YES	NO
	NFPA 101 K0029 NFPA 101 K0076	NFPA 101 K0029 NFPA 101 K0076	Correction Completed 05/12/2015 NFPA 101 K0029 Correction Completed 05/12/2015 NFPA 101 K0076 Correction Correction Correction Correction Correction Completed O5/12/2015 NFPA 101 K0076 Correction Completed Correction Completed Correction Completed Support Reviewed By PS/KJ Y Reviewed By Survey Completed on:	Correction Completed 05/12/2015 NFPA 101 K0029 Correction Completed 05/12/2015 NFPA 101 K0076 Correction Completed	Correction Correction Completed 05/12/2015 NFPA 101 Reg. # K0029 LSC Correction Completed 05/12/2015 ID Prefix NFPA 101 Reg. # K0076 ID Prefix Reg. # LSC Correction Completed OS/12/2015 ID Prefix Reg. # LSC Correction Completed ID Prefix Reg. # LSC Correction Completed ID Prefix Reg. # LSC Correction ID Prefix Reg. # LSC Correction ID Prefix Reg. # LSC Correction ID Prefix Reg. # LSC Completed ID Prefix Reg. # LSC V PS/KJ PS/KJ 5/27/2015 V PS/KJ V PS/KJ Survey Completed on:	Correction Completed 05/12/2015 ID Prefix	Correction Completed 05/12/2015 ID Prefix NFPA 101 K0023 Correction Completed 05/12/2015 Reg. # NFPA 101 K0023 Correction Completed 05/12/2015 ID Prefix	Correction Completed 06/12/2015 Correction Completed 06/12/2015 Correction Completed 06/12/2015 Correction Completed 06/12/2015 Correction Completed 06/12/2015 NFPA 101 LSC Correction Completed 06/12/2015 Correction Completed Correction Completed NFPA 101 LSC Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed UD Prefix LSC Reg.# LSC Correction Completed Correction Completed Correction Completed D Prefix Reg.# LSC Correction Completed Correction Completed V Reviewed By Date: Signature of Surveyor: 2 'Y Reviewed By Date: Signature of Surveyor: 2 'Survey Completed on: UD Prefix Signature of Surveyor: 2	Correction Completed 06/12/2015 Correction Completed 06/12/2015 Correction Completed 06/12/2015 Correction Correction Completed 06/12/2015 NFPA 101 USC K0038 Correction Completed 06/12/2015 Correction Completed Correction Completed NFPA 101 USC Correction Completed Correction Completed Correction Completed Correction Completed USC USC Correction Completed USC USC Correction Completed USC USC Correction Completed V PS/KJ 5/27/2015 2812 Y PS/KJ Date: Signature of Surveyor: Survey Completed on: Correction Education Check for any Uncorrected Deficion	Correction Correction Correction Correction NFPA 101 Correction Correction Correction Correction Correctio	Correction Completed 05/12/2015 Correction ID Prefix Correction 05/12/2015 ID Prefix Reg # ID Prefix ID Prefix Reg # ID Prefix Reg # ID Prefix Reg # ID Prefix Reg # ID Prefix ID Prefix Reg # ID Prefix Reg # ID Prefix Reg # ID Prefix ID Prefix Reg # ID Prefix ID Prefix Reg # ID Pref	Correction Completed 05/12/2015 Correction Completed 05/12/2015 Correction Completed 05/12/2015 Correction Completed 05/12/2015 ID Prefix Reg. # NFPA 101 LSC K0038 Reg. # NFPA 101 LSC K0069 K0029 Correction Completed 05/12/2015 Correction Completed 05/12/2015 Correction Completed 05/12/2015 Correction Completed MFPA 101 LSC K0038 Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Correction Completed Merg.# LSC LSC Correction Completed Correction Completed Correction Completed Merg.# LSC Signature of Surveyor: 28120 Date: 5 Merg.# LSC Signature of Surveyor: Date: Date: 5 Survey Completed on: Date: Signature

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

					ND TRANSMITTAL	ID: WOCL
MEDICARE/MEDICAID PROVIDER N (L1) 245353		3. NAME AND ADD (L3) CAMILIA RC	DRESS OF FACILIT	Υ	E SURVEY AGENCY	Facility ID: 00757 4. TYPE OF ACTION: 2 (L8)
(L2) 231243300		(L4) 11800 XEON (L5) COON RAPI			(L6) 55448	1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. O. Giv Ni in the control of the contro
5. EFFECTIVE DATE CHANGE OF OW (L9)		7. PROVIDER/SUP	05 HHA	09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 6. DATE OF SURVEY 8. ACCREDITATION STATUS: 	2/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(E10)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY I	S CERTIFIED AS:			
From (a):		X A. In Compliand	ce With		And/Or Approved Waivers Of The	e Following Requirements:
To (b):		Program Rec Compliance	*		2. Technical Personnel	6. Scope of Services Limit
12.Total Facility Beds	80 (L18)		cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural SNF) 5. Life Safety Code	 7. Medical Director 8. Patient Room Size 9. Beds/Room
13.Total Certified Beds	80 (L17)		bliance with Program nts and/or Applied V		* Code: A1*	(L12)
14. LTC CERTIFIED BED BREAKDOWN	Ī				15. FACILITY MEETS	
18 SNF 18/19 SNF 80	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMARI	KS (IF APPLICABLE S	HOW LTC CANCELL	ATION DATE):		18. STATE SURVEY AGENCY AP	PROVAL Date:
Austin Fry, 1	HFE NE II		04/29/2015			forcement Specialist 05/18/2015
		BE COMPLETEI) BY HCFA RE	(L19) CGIONAI	COFFICE OR SINGLE STAT	- (L20)
19. DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to Pa			PLIANCE WITH C TS ACT:	IVIL	 Statement of Financi Ownership/Control I Both of the Above : 	ial Solvency (HCFA-2572) interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE	23. LTC AGREEMI	ENT 24	4. LTC AGREEME	NT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION 10/13/1986	BEGINNING	DATE	ENDING DATE	2	VOLUNTARY 00 01-Merger, Closure 00	INVOLUNTARY 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimbursemen	nt 06-Fail to Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATIVI	E SANCTIONS			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER
	A. Suspension of	of Admissions:	(1.44)		04-Other Reason for withdrawar	07-Provider Status Change 00-Active
(L27)	B. Rescind Sus	pension Date:	(L44)			00-Active
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/CA	ARRIER NO.		30. REMARKS	
		03001				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	DETERMINATION O	F APPROVAL DAT	Έ	Posted 05/21/2015 Co	0.
	(L32)			(L33)	DETERMINATION APPRO	VAL



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered April 15, 2015

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

RE: Project Number S5353024

Dear Mr. Broman:

On April 2, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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, Unit Supervisor Minnesota Department of Health 3333 West Division, #212 St. Cloud, Minnesota 56301 Telephone: (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 May 12, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 12, 2015 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 2, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by October 2, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting 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) 215-0525

Feel free to contact me if you have questions.

Sincerely,

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

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0904 STATEMENT OF DEFICIENCIES (X) POTE SUPPLIES AND PLAN OF CORRECTION (X) IDENTIFICATION NUMBER: AND PLAN OF CORRECTION (X) DATE SURVEY AMD PLAN OF CORRECTION (X) DATE SURVEY AMD PLAN OF CORRECTION (X) DATE SURVEY AMD CONSTRUCTION 245353 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE TAGE SUMMARY STATEMENT OF DEFICIENCIES PREFIX The facility splan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Beculations has b	DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245353 B. WING 04/02/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11800 XEON BOULEVARD CAMILLA ROSE CARE CENTER LLC STREET ADDRESS, CITY, STATE, ZIP CODE 11800 XEON BOULEVARD (M) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION ECON RAPIDS, MN 55448 COMPLETION F 000 INITIAL COMMENTS F 000 F 000 PREFIX TAG PROVIDER'S PLAN OF CORRECTION MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 000 F 000 INITIAL COMMENTS F 000 F 000 COMPLETION DEFICIENCY COMPLETION DEFICIENCY F 000 INITIAL COMMENTS F 000 F 000 STREET ADDRESS, CITY, STATE, ZIP CODE COMPLETION DEFICIENCY Junce 100 INITIAL COMMENTS F 000 F 000 STREET ADDRESS, CITY, STATE, ZIP CODE COMPLETION DEFICIENCY	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			0	MB NO.	0938-0391
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE CAMILLA ROSE CARE CENTER LLC 1800 XEOD BOULEVARD COON RAPIDS, MN 55448 VAI ID PREFX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PR F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 000 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 156 F 156 A83.10(b)(5) - (10), 483.10(b)(1) NOTICE OF SB=D F 156 The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the F 156				` '				
CAMILIA ROSE CARE CENTER LLC 11800 XEON BOULEVARD COON RAPIDS, MN 55448 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PREFIX DECORRECTIVE ACTION SHOULD BE CORRECTION (EACH OCRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE COMPLETION CORRECTIVE ACTION SHOULD BE CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE F 000 INITIAL COMMENTS F 000 F 000 F 000 F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 156 5/12/15 Vupon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with regulations has been attained in accordance with your verification. F 156 5/12/15 SS=D RIGHTS, RULES, SERVICES, CHARGES F 156 5/12/15 5/12/15 The facility must inform the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the F 156			245353	B. WING _			04/	02/2015
CAMILIA ROSE CARE CENTER LLC 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 CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY OWNETTION DATE F 000 INITIAL COMMENTS F 000 F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 156 5/12/15 F 156 483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF SS=D F 156 F 156 5/12/15 The facility must inform the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the F 156	NAME OF F	PROVIDER OR SUPPLIER						
PREFX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETION DATE F 000 INITIAL COMMENTS F 000 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. F 000 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. F 156 F 156 RIGHTS, RULES, SERVICES, CHARGES F 156 The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the	CAMILIA	ROSE CARE CENTE	RLLC					
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notice (if any) of the State developed under		as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificat Upon receipt of an on-site revisit of you validate that substar regulations has beet your verification. 483.10(b)(5) - (10), RIGHTS, RULES, S The facility must inf and in writing in a la understands of his regulations governi responsibilities duri facility must also pr	of compliance upon the obtance. Because you are your signature is not required a first page of the CMS-2567 nic submission of the POC will tion of compliance. acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with 483.10(b)(1) NOTICE OF SERVICES, CHARGES form the resident both orally anguage that the resident or her rights and all rules and ng resident conduct and ng the stay in the facility. The ovide the resident with the	F 1	56			5/12/15
		entitled to Medicaid of admission to the resident becomes e items and services facility services und which the resident	I benefits, in writing, at the time nursing facility or, when the eligible for Medicaid of the that are included in nursing ler the State plan and for may not be charged; those					
The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers			DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	Electron	ically Signed						04/24/2015

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.

PRINTED: 05/07/2015

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245353	B. WING			04/(02/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
CAMILIA	A ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 156	and for which the re- the amount of charge inform each resider the items and servic (i)(A) and (B) of this The facility must inf at the time of admiss the resident's stay, facility and of charge including any charge under Medicare or M The facility must fur legal rights which in A description of the funds, under parage A description of the for establishing elige the right to request 1924(c) which deter non-exempt resource institutionalization a spouse an equitable cannot be considered toward the cost of the medical care in his down to Medicaid e A posting of names numbers of all perti groups such as the agency, the State life ombudsman progra advocacy network, unit; and a stateme	esident may be charged, and ges for those services; and nt when changes are made to ces specified in paragraphs (5) s section. form each resident before, or ssion, and periodically during of services available in the ges for those services, ges for services not covered by the facility's per diem rate. rnish a written description of ncludes: e manner of protecting personal raph (c) of this section; e requirements and procedures gibility for Medicaid, including an assessment under section ermines the extent of a couple's rees at the time of and attributes to the community e share of resources which red available for payment the institutionalized spouse's or her process of spending	F 1	56			

Facility ID: 00757

If continuation sheet Page 2 of 42

		AND HUMAN SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		E SURVEY IPLETED
		245353	B. WING	i		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ROSE CARE CENTE	BUC		1	1800 XEON BOULEVARD		
CAIMILIA	NUSE CARE CENTE			0	COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 156	misappropriation of facility, and non-cor directives requirem The facility must inf name, specialty, an physician responsit The facility must pre- written information, applicants for admis- information about h Medicare and Medi	resident abuse, neglect, and resident property in the mpliance with the advance		156			
FORM CMS-22	by: Based on interview facility failed to provinform residents whof their right to an elestimated costs for 3 residents (R63, a compliance with lial Findings include: R63's current Resididentified he was ac 4/24/14, where he r Review of a Notice (Centers for Medicate (CMS]-10123) signer received Medicate end on 7/10/14, due therapies. Though I	NT is not met as evidenced y and document review, the vide the required notices to no discharged from Medicare, expedited review and/or the non-covered services, for 2 of nd R49) reviewed for bility and appeal rights. dent Admission Record dmitted to the facility on remained a resident to date. of Provider Non-coverage are & Medicaid Services ed 7/8/14, identified R63 had covered services that were to a to his discharge from skilled R63 remained in the facility d, the facility was unable to	11	Fa	F156 SPECIFIC RESIDENTS AFFEC IDENTIFICATION OF OTHERS MAY BE AFFECTED: All resider pending Medicare denials were to to ensure appropriate notice was notices were reissued, using for CMS-10055. SYSTEMIC CHANGES: The fac and procedure, now titled, Issua Medicare/ Managed Care Denial Appeal Notices, was revised to it issuing the Skilled Nursing Facilit Advance Beneficiary Notice (CM form to inform residents no long for Medicare coverage of estimat for non-covered services. This be utilized for residents remainin	WHO its with eviewed given. 2 n ility policy nce of and nclude ty S-10055) er eligible ted costs form will g in	t Page 3 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	()	PLE CONSTRUCTION		E SURVEY PLETED
			A. BUILDING	G	001	
		245353				02/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 156	Continued From pa provide evidence R	-	F 150	6 facility after Medicare covera	ge ends per	
	Facility Advance Be to notify him of esti services. R63 also received a The OT (occupation Progress & Dischar and PT (physical the Discharge Summar R63 received Media treatment of muscle through 1/30/15, af The facility was una and/or his legal rep CMS-10123 to notifiending and a right to there was no indication CMS-10055 form the	sived the Skilled Nursing eneficiary Notice (CMS-10055) mated costs for non-covered skilled services from therapy. nal therapy) Therapist rge Summary signed 1/29/15, nerapy) Therapist Progress & ry signed 1/30/15, identified care covered services for e weakness from 1/13/15, ter a qualifying hospital stay. able to provide evidence R63 resentative received the form fy him of Medicare services to an appeal process. Also ation the facility gave him the hat notified him of estimated red services after Medicare		CMS guidelines. MONITOR CHANGES: The I Accounting or designee will r Medicare denial notices issue residents who will remain in t after coverage ends ensure t appropriate CMS form has be These reviews will continue f days, or until substantial com achieved, whichever is later. Discrepancies will be reporte Administrator and corrected i Audit results will be report to Assurance (QA) task force m period of 90 days, or until sub compliance is achieved, which greater. The Director of Acco responsible for compliance.	eview all ed to he facility hat the een used. or at least 90 pliance is d to the mmediately. the Quality onthly for a ostantial hever is	
	identified she was a 12/14, and was disc OT Therapist Progr signed 1/5/15, and Discharge Summar had received Medic difficulty in walking after a qualifying ho incorrect Medicare and signed on 1/5/ ⁻ that R49 and/or here the required CMS- ⁻ right to an expedite CMS-10055 form c resident and/or lega	dent Admission Record admitted to the facility on charged on 1/8/15. Review of ress & Discharge Summary PT Therapist Progress & ry signed 1/7/15, identified R49 care covered services for from 12/19/14, through 1/7/15, ospital stay. A CMS-10095 (an form) was provided to R49 15. There was no indication r legal representative received 10123 form to notify her of her d review, nor was a ompleted that notified the al representative of estimated red services after Medicare				

If continuation sheet Page 4 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			<u>IB NO.</u>	SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:				PLETED
		245353	B. WING		04/0)2/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 156	Medicare part A for On 4/2/15, at 3:07 p	0095, was not the correct m that was used by the facility. o.m. the director of nursing	F 156	3		
	liability and appeal of CMS-10095 form the residents with notic costs for services. Facility had not beer required for notificating the stated the process was not cobut had not yet device the proces was not cobut had not yet device the process wa	wed regarding the facility's rights processes and the e facility used for providing es of services ending and The DON knowledge the n using the correct forms as tion of liability and appeal he facility had identified their mpliant with the requirements, eloped or implemented the errors of the incorrect				
F 241 SS=D	for providing liability within the facility, w A policy was reques	RN)-Z, who was responsible and appeal right notices as unavailable for interview. sted, but none was provided. AND RESPECT OF	F 241			5/12/15
	manner and in an e enhances each res	omote care for residents in a nvironment that maintains or dent's dignity and respect in s or her individuality.				
	by: Based on observat review, the facility fa and cues to enhanc observation for 1 of	NT is not met as evidenced ion, interview, and document ailed to provide supervision the dignity during a dining 1 residents (R15) who was rnel corn, and diced fruit with		F241 SPECIFIC RESIDENTS AFFECTED R15 s care plan was reviewed and revised to further promote dignity wit meals by offering additional finger fo menu items. Staff will offer finger fo	th ood	

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Facility ID: 00757

If continuation sheet Page 5 of 42

	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MILLT	IPLE CONSTRUCTION	OMB NO.	0938-039 E SURVEY
	OF DEFICIENCIES	IDENTIFICATION NUMBER:		NG	. ,	PLETED
		245353	B. WING _			02/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 241	Continued From pa	age 5	F 24	11		
	Findings include:			when appropriate to pror of ability to eat independ menu was updated to re	ently. Ř15's	
	(MDS), dated 1/28/ and long term mem	hange Minimum Data Set (15, identified R15 had short hory problems, and required sistance from staff to eat.		additional finger foods. S assigned to R15 s table supervision and assistan necessary and as reside	Staff has been to provide closer nee with meals as nt allows. Staff	
	problem of cognitiv decision making re deficits. Staff were	ated 1/27/15, identified a e loss/dementia with impaired lated to memory and judgment directed to "provide cues and needed]" and to "anticipate client "		communication was prov R15's updated interventi staff will receive addition in this area as outlined b IDENTIFICATION OF O MAY BE AFFECTED: Clinical Managers and th	ons. Nursing al, related training elow. THERS WHO	
	During observation on 3/30/15 at 5:20 table in the 3rd floo residents, and had her neck which cov served a plate of fo small diced fruit bo shredded lettuce an	of the evening meal service, p.m., R15 was seated at a or dining room with two other a clothing protector around vered her shirt. She was bod consisting of kernel corn, wl, and a soft taco with nd cheese on top. A fork and on the table next to her plate.		team reviewed all long-terresidents to identify thos similar mealtime interverdignity and the highest fullevel related to eating. Correvised as necessary. SYSTEMIC CHANGES: Nutritional Services has foods available on the urappropriate as finger foo	erm care e that may need ntions to promote unctional ADL Care plans were posted lists of nit which may be	
	fingers, spilling a la floor as she attemp (NA)-D, NA-E, and did not offer assista provided utensils to corn using her finge floor. R15 opened began to eat the m	up pieces of corn using her irge amount of the corn on the oted to eat it. Nursing assistant NA-F walked by the table and ance, or cues to use the o R15 who continued to eat the ers, spilling on her lap and the the soft taco at 5:26 p.m. and eat inside using her fingers,		and also ways to modify items to be served as fin Nursing staff will continu residents at meal times, necessary and offering n including finger foods, as Nursing staff and Client (CDAs) have been made information. Nursing staf	regular menu ger foods. e to supervise assisting as neal alternatives, s appropriate. Dining Assistants e aware of this ff and CDA will	
	she ate it. At 5:27 small bowl of diced her fingers, resume her plate, and then	ser to the edge of the table as p.m. she then picked up the fruit and began to eat it using ed eating the taco meat from spilled the plate on her lap at ked her plate back up, placed		receive additional trainin supervision at meals, mo and offering assistance a if intake is less than 75% completed by May 8, 20 Staff will continue to sup	onitoring intake and/or substitutes b. Training will be 15.	

Facility ID: 00757

If continuation sheet Page 6 of 42

	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		0938-039 E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:				PLETED	
		245353	B. WING		04/02/2015		
NAME OF	PROVIDER OR SUPPLIER	·		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CAMILIA	ROSE CARE CENTE	RLLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 241	Continued From pa	-	F 241				
	fingers to eat her n soiled with a tattere and corn. At 5:37 pieces of food from her fingers. Regist approached the tat 5:44 p.m., but did r cues to her as R15 taco meat and corn The director of nur 5:47 p.m. and state cleaned up a little.' clothing protector f dining room. R15 room by RN-B at 5 she began eating. eating had been of of the meal even th corn and diced frui When interviewed dining assistant (C	on 4/1/15, at 1:25 p.m. client DA)-A stated R15 often will eat Id has been leaving more food		at meal times, assisting residents necessary. Menu item alternative including finger foods, will be offer residents consuming less than 75 as appropriate. Nursing staff and Dining Assistants will receive train identify residents on the finger foo program and offering appropriate items. Training will be completed 5/12/15. MONITOR CHANGES: Random dining room audits will b conducted at least three times we meal by Clinical Managers and/or of Nursing to ensure that resident receiving the appropriate level of supervision and/or assistance fro The Director of Nutrition Services review menus weekly to ensure s finger food items are available for meal. Concerns that may arise fro audits will be addressed as appro the auditor and/or Clinical Manag appropriate. Audit results will be by the Director of Nursing weekly reported to the Quality Assurance	es, red to all % of the Client ning to od menu by eekly per Director s are m staff. will ufficient each om these priate by ers as reviewed and		
	stated R15 should assistance or cues During interview or director of nursing during the 3/30/15	on 4/2/15, at 10:19 a.m. RN-B should have been offered with her meal. A 4/2/15, at 2:51 p.m. the (DON) who had observed R15 evening meal with food on her nel corn and diced fruit with		task force monthly for a period of or until substantial compliance is achieved, whichever is greater. T task force will determine additional alternative actions to be taken, if necessary.	90 days, ⁻ he QA		
F 279 SS=D		staff should have offered R15 her meal. k)(1) DEVELOP	F 279			5/12/15	

		AND HUMAN SERVICES			FORM	APPROVED 0.0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
		245353	B. WING		04	/02/2015
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
	ROSE CARE CENTE			11800 XEON BOULEVARD		
CAIVILIA	NOSE CARE CENTE			COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 279	Continued From pa	age 7	F 27	9		
		the results of the assessment and revise the resident's n of care.				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial atified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise §483.25 but are not provided 's exercise of rights under the right to refuse treatment th).				
	by: Based on observar review, the facility f comprehensive car resident's assessed	NT is not met as evidenced tion, interview, and document ailed to develop re plans, based on the d needs, for 2 of 3 residents ed for care planning.		F279 SPECIFIC RESIDENTS A R99 was discharged hom R15 s care plan has bee revised to include offering foods, staff offering to as as necessary, and offerin less than 75% of meal is plan interventions were c	ne 1/3/2015. en reviewed and g additional finge sist with meals ng substitute if consumed. Care	
FORM CMS-25	12/16/14, included impaired vision, sev mild mood indicato	linimum Data Set (MDS) dated he had difficulty with hearing, vere cognitive impairment, rs, rejection of cares, he had ly care and activities that were	11 F	staff as appropriate. IDENTIFICATION OF OT MAY BE AFFECTED: Medical records were rev residents to identify those	THERS WHO	at Page 8 of 42

PRINTED: 05/07/2015

ALEWENI	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT		E CONSTRUCTION	MB NO. 0938-0 (X3) DATE SURVE	
	OF CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		245353	B. WING			04/02/2015	
AME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
AMILIA	ROSE CARE CENTI	ER LLC			800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
F 279	Continued From pa	age 8	F 2	79			
	very important to h most activities of o balance, use of an including cancer a breath, oral/dental and he had skin te the following Care which were comple cognitive loss/dem communication, ur Foley catheter, psy behavioral sympto dehydration/fluid m indicated that all o addressed in R99's R99's Temporary O included check bot assistance for dres walking and wheel staff on how much needs R99 had in Care Plan also ind and a lower partial vision and commu was different than R99's electronic C included, a generic not specific to R99 which were indicat Care Plan also add dehydration risk. components comp pan for R99.	im, limited assistance with laily living (ADL's), unsteady indwelling catheter, diagnoses nd pneumonia, shortness of status had not been assessed, ars. The MDS triggered out Care Assessments (CAA) eted by the facility on 12/22/14: entia, visual function, inary incontinence/indwelling /chosocial well-being, ms, falls, activities, and naintenance. The MDS f these areas had been			have care plans in place. Care plan were developed as indicated by the interdisciplinary team. Existing care not otherwise mentioned, are being reviewed and revised as necessary later than the resident's next sched assessment period. SYSTEMIC CHANGES: Nutritional Services has posted lists foods available on the unit which m appropriate as finger food substitutiand also ways to modify regular me items to be served as finger foods. Nursing staff will continue to supervise residents at meal times, assisting a necessary and offering meal alterna including finger foods, as appropria Nursing staff and Client Dining Assi (CDAs) have been made aware of the information. Nursing staff and CDA receive additional training on reside supervision at meals, monitoring int and offering assistance and/or subs if intake is less than 75%. Training to completed by 5/12/15. MONITOR CHANGES: Random comprehensive care plan will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and current. These audits will be condu- monthly for at least 6 residents, for period of 90 days or until substantia compliance is achieved, whichever later. Audit results will be reviewed Director of Nursing weekly and repor- the Quality Assurance (QA) task for	e plans , no uled of ay be ons enu rise s atives, te. stants this s will ent take stitutes will be audits o remain icted a l is by the orted to	

Facility ID: 00757

If continuation sheet Page 9 of 42

TATEMEN	OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DAT	0938-039 E SURVEY PLETED
		245353	B. WING _	B. WING			02/2015
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	ER LLC		118 CC			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIC DATE
F 279	on how to care for loss/dementia, visu urinary incontinence psychosocial well-k falls, activities, and maintenance. When interviewed director of nursing should have a com completed within 2 had not been done been routinely com residents. She wa recently been appr hours so that care A facility Care Plan identified a residen developed, "21 d [Resident Assessm on the 14th day, B. if done earlier than plan "needs to be u clients care/conditi R15's significant cl (MDS), dated 1/28, and long term men supervision with as R15's care plan, da problem of being a greater than 25% c	ans addressed, or directed staff R99, in regards to cognitive ual function, communication, ee/indwelling Foley catheter, being, behavioral symptoms, I dehydration/fluid on 4/2/15, at 1:30 p.m. the (DON) stated each resident oprehensive care plan 1 days of admission, but this for R99. The nurses had not opleting care plans for s aware of this and had oved to add additional nursing plans could be completed. It care plan should be ays after admission in the RAI nent Instrument] is completed . 7 days after completion of RAI 14th day." Further, the care up to date and reflect the on at all times."	F 2	79	whichever is greater. The QA task will determine additional or alterna actions to be taken, if necessary.		

Facility ID: 00757

If continuation sheet Page 10 of 42

STATEMEN	OF DEFICIENCIES	KEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED	
	ST GOTTILE TION	IDENTIFICATION NOMBER.	A. BUILDIN	G	001		
		245353	B. WING		04/	02/2015	
NAME OF	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE				
CAMILIA	ROSE CARE CENTE	ER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 279	loss/dementia with related to memory were directed to "p PRN [as needed]" needs-inquire with indication in the ca much staff assistant her meals. During observation on 3/30/15 at 5:20 table and received kernel corn, small with shredded lettu and spoon were si plate. R15 began using her fingers, s corn on the floor as Nursing assistant (walked by the table or cued R15 to use continued to eat th fingers. She spilled the contents of the was finished with h When interviewed registered nurse (F feed herself often "she is a complex R15's care plan sh assistance that she During interview or stated a care plan since late 2014 the "zero" involvement	a problem of cognitive impaired decision making and judgment deficits. Staff provide cues and reminders	F 27	9			

Facility ID: 00757

If continuation sheet Page 11 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER.	A. BUILDIN	G	COMPLETED
		245353	B. WING _		04/02/2015
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 11800 XEON BOULEVARD	
CAMILIA	ROSE CARE CENTE	RLLC			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE
F 279		h assistance she required to 've had a real problem with	F 27	9	
F 281 SS=D	a purpose of, "ass optimal wellness ba Assessment." A pro- follow, and identified be identified on a re- policy added, "Ca and reflect the clien	policy, dated 8/2010, identified sist the client towards a goal of ased on the Comprehensive ocedure was listed for staff to d "Nutritional needs" should esident care plan. Further, the re plan needs to be up to date its care/condition at all times." EVICES PROVIDED MEET STANDARDS	F 28	1	5/12/15
		led or arranged by the facility onal standards of quality.			
	by: Based on interview facility failed to deve address discomfort who had been rece Findings include:	NT is not met as evidenced y and document review, the elop a temporary care plan to for 1 of 5 residents (R216) ntly admitted to the facility.		F281 SPECIFIC RESIDENTS AFFECTED: A comprehensive care plan, including and related interventions, was develop for R216 on 4/1/2015. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Medical records were reviewed for all	
	R216 admitted to the multiple skeletal fra R216's initial Pain M dated 3/24/15, iden pain/discomfort in the recent Pain Manage 3/31/15, identified F	ne facility on 3/22/15 and had		residents to identify those that may no have pain care plans in place. Pain ca plans were developed as indicated by interdisciplinary team. Existing care pl are being reviewed and revised as necessary, no later than the resident's next scheduled assessment period. SYSTEMIC CHANGES: The facility s policy and procedure for	re he ans

Facility ID: 00757

If continuation sheet Page 12 of 42

		& MEDICAID SERVICES			OMB NO.		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED	
		245353	B. WING _			02/2015	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DDE		
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 281	Continued From pa	age 12	F 28	care planning, now titled Care	Plan		
	Plan, dated 3/25/15 with pain, what was staff interventions t discomfort even the fractures. When interviewed of registered nurse (Finot been addressed then added that pain addressed on any riplan. Further, RN-1 see pain addressed RN-D further stated managed by pain minurse practitioner (updated about the since admission to changed R216's cur regime today. RN- repositioning R216 decrease her pain a A facility Care Plan identified a residen completed, "21 day [Resident Assessmithe 14th day," or, "2010/10/10/10/10/10/10/10/10/10/10/10/10/	Camilia Rose Temporary Care 5, did not identify a problem 5 R216's goal nor included any o help reduce her pain and bugh she had current on 4/1/15, at 1:45 p.m. RN-D) stated R216's pain had d in her temporary care plan, in/discomfort was rarely new residents temporary care D stated, "I would expect to d in her (R216) care plan." d R216's pain was being nedications and the certified CNP) has been consistently resident's pain/discomfort the facility. The CNP had also urrent pain management D added the facility was also every two hours to help and discomfort. ning policy, dated 8/18/10, t care plan should be 's after admission if the RAI tent Instrument] is complete on 7 days after completion of RAI 14th day." The policy did not		Development has been update provide additional details relate planning. This policy and proc outlines timelines for care plan completion, disciplines respons initiating and updating each se information on developing comprehensive, resident-center holistic care plans. MDS Coord have assumed responsibility for development and quarterly rev nursing care plans, based on in from the MDS assessments. Of Managers will be responsible for care plans are updated betweet assessment periods. All discip review care plans and revise a necessary, at least quarterly. A MDS Coordinator has been con supplement the existing MDS O until the vacant position is filled MONITOR CHANGES: Random comprehensive care p will be conducted by the Direct Nursing and/or Clinical Manage ensure care plans are in place current. These audits will be c monthly for at least 6 residents period of 90 days or until subst compliance is achieved, which	d to care edure sible for ction, and red, and dinators r initial ews of all formation Clinical or ensuring n lines will s An interim ntracted to Coordinator olan audits or of ers to and remain onducted , for a antial		
	temporary care pla	tion for completion of a n to address immediate on their admission to the		later. Audit results will be revie Director of Nursing weekly and the Quality Assurance (QA) tas monthly. The QA task force wil additional or alternative actions taken, if necessary. The Direc Nursing will be responsible for compliance.	reported to k force determine to be		

Facility ID: 00757

	OF DEFICIENCIES	KANNER STATE STREAM STREA		PLE CONSTRUCTION G	· /	E SURVEY PLETED	
		245353			04/	4/02/2015	
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		02/2010	
CAMILIA	ROSE CARE CENTE	ERLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 282 SS=D	483.20(k)(3)(ii) SE PERSONS/PER C	RVICES BY QUALIFIED ARE PLAN	F 28	2		5/12/15	
	must be provided b	ded or arranged by the facility by qualified persons in ach resident's written plan of					
	by: Based on observa review, the facility repositioning as ca (R97, R65) review In addition, the fac interventions were falls for 1 of 3 resid accidents. Findings include: R97's quarterly Min 2/26/15, identified assistance of two s and repositioning. 3/25/14, identified breakdown and list and reposition eve During constant ob a.m. until 9:50 a.m. was observed to br	NT is not met as evidenced tion, interview, and document failed to ensure timely the planned for 2 of 3 residents ed for activities of daily living. Ility failed to ensure care plan followed to reduce the risk of dents (R9) reviewed for himum Data Set (MDS) dated R97 required extensive staff to complete bed mobility R97's care plan, dated R97 was at risk for skin ted an intervention of, "Turn ry 2 hours with assist of 1." heservation on 4/1/15, from 7:00 . (2 hours and 50 minutes) R97 e laying on her back in bed. At assistant (NA)-A entered the		F282 SPECIFIC RESIDENTS AFFECT R97 expired 4/9/2015. An updated fall risk assessment we completed for R9. R9's care plan safety was reviewed and remains Staff was reminded of R9's care plan safety interventions and the expectation safety interventions are to be follow all times. Nursing staff will receive additional, related training in this a outlined below. A comprehensive skin risk assess including Braden scale and tissue tolerance testing was completed to R65 s care plan was reviewed and remains current. R65 moved to and long term care unit within the facil staff on R65 s new unit was upd her specific skin interventions, ind appropriate offloading techniques was reminded of specific intervent these residents and the expectati	vas for current. blan that wed at e area as area as sment, or R65. nd nother ity and ated on cluding . Staff tions for		
	room to see if R97 was not lowered th and left the room.	was wake, and finding she e head of the bed (HOB) down RN)-C, stated on 04/01/2015		they be followed at all times. Nur will receive additional, related trai this area as outlined below.	sing staff ning in		

Facility ID: 00757

If continuation sheet Page 14 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MU				0938-039 SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED
		245353	B. WING			04/0	02/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 14	F 2	82			
	repositioned every	two hours as directed by the			NAR care sheets, which include spe	ecific	
	care plan. RN-C, st	tated after reviewing the night			care plan interventions for safety an	nd skin,	
		hat the prior shift did not			were reviewed for accuracy, especi		
		97 was last repositioned. The locumented was on the relief			it relates to skin and safety interven and were revised as necessary. NA		
		efore at 10:45 p.m., 11 hours			turning and repositioning audits wer		
	and 5 minutes prior				initiated to identify immediate and s		
		-			staff training needs, and compliance		
	During an interview	/ on 4/01/15, at 10:05 a.m.,			issues. Concerns that may arise fro		
		as unaware when R97 had			these audits will be addressed as		
		hile nothing was reported to			appropriate by the auditor and/or Cl		
		shift. NA-A then assisted R97 and examined her coccyx with			Managers. Nursing staff will receive additional, related training in this are		
	no redness noted.				outlined below. SYSTEMIC CHANGES:	ea as	
	During interview or	n 04/01/2015, at 1:31 p.m.			Facility policies and procedures rela	ated to	
		RN)-B stated the facility had			safety and skin/wound interventions		
	started a new shift	reporting sheet, so that			reviewed and remain current. Nurs	ing	
		dents' need, such as last			staff will receive additional training of		
		be followed, but this had not			care, prevention of pressure ulcers,		
		r R97. Further RN-B stated every two			appropriate techniques for assisting residents with pressure reduction by		
	hours as care plan				5/12/2015. Nursing staff will also re		
	nours as oure plan				additional training on safety related		
					falls, proper use of equipment to as		
		S, dated 1/19/15, identified			residents with mobility, and following		
		nition, required extensive			individualized safety interventions a		
		d mobility and transfers, and			times. This training will be provided	l by	
		breakdown. R65's care plan, tified she was at risk for skin			5/12/2015.		
		ted an intervention of, "Turn			MONITOR CHANGES:		
		y hour as res. [resident]			Clinical Managers and/or Director o	f	
	allows."				Nursing will conduct 4 random mon		
					audits per unit/per shift for a minimu		
		servation starting on 4/1/15, at			36 audits per month, to ensure		
		lying in bed positioned slightly			compliance with repositioning and		
		ees) on her left side. R65 d, in the same position until			pressure reduction interventions. A random monthly audits per unit/per		
	remained in her De		1		rangom monuny addits per utili/Der	ວເມເ	

Facility ID: 00757

If continuation sheet Page 15 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · /	SURVEY
id plan (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	·	COM	PLETED
		245353	B. WING		04/	02/2015
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
AMILIA	ROSE CARE CENTE	ER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETI DATE
F 282	or 3 inches) pulled NA-H completed R exercises, howeve R65 in the bed, and R65 then remained she was assisted t have her incontine R65 was not off loa adequately to allow for 1 hour and 37 r When interviewed stated she thought repositioned every tries to follow a res it as closely as I ca at 12:12 p.m. NA-H to be repositioned did not off load R65 exercises earlier th During interview or stated R65 was at should be reposition her plan of care, "H hour." When interviewed DON stated a care and the expectatio staff. R9's quarterly MDS R9 had moderately	d and slightly (approximately 2 the draw sheet towards her. 165's range of motion r did not off load or reposition d left R65's room at 8:00 a.m d in bed until 8:38 a.m. when o roll onto her right side to nce product removed by NA-I. aded or repositioned v tissue perfusion to her coccyx ninutes. on 4/1/15, at 9:11 a.m. NA-I R65 should be offered two hours, and that she always idents care plan, "I try to follow an." During interview on 4/1/15, I stated she thought R65 was every 2 hours, and verified she 5's during her range of motion	F 282		antial ver is ved by the at least ask force s will be nonthly nined as	

If continuation sheet Page 16 of 42

		AND HUMAN SERVICES			FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245353	B. WING		04/(02/2015
NAME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAMILIA	ROSE CARE CENTE	RLLC		1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	uge 16	F 282			
	prevent falls, amon of 1 to 2 persons) w	g which included "A1-2 (assist vith all transfers and mobility," resident in bathroom alone or				
	NA-G entered R9's and begin routine m R9 into the bathroo transfer onto the toi to help a co-worker some linens" to rem bathroom alone at 8 minutes later), NA-G bed linens and proc NA-G was out of R9 9:04 a.m. (9 minute until 9:07 a.m. (3 m	on 4/1/2015, at 8:44 a.m. room to assist him out of bed, norning cares. NA-G assisted om, and provided assistance to ilet. NA-G stated she needed r "for a little bit and bring back nake his bed, and left R9 in the 8:55 a.m. At 9:04 a.m., (9 G returned to R9's room with ceeded to make his bed. 9's room from 8:55 a.m. to es); however, from 9:04 a.m. hinutes), NA-G was in R9's ent with him in the bathroom.				
	During the entire tw the bathroom, he re and made no attem or otherwise move	velve minutes R9 was alone in emained seated on the toilet, npts to stand up, self transfer, out from the room. Upon oom, NA-G assisted R9 to get				
	NA-G verified she le bathroom" when sh co-worker, and also made his bed. NA- "he could have som	on 4/1/2015 at 9:13 a.m., eft "[R9] alone in the be briefly helped out a b left him alone while she G said she left R9 alone so he privacy." Further, NA-G 19] had a recent fall, and he transfer.				
	registered nurse (R for falls, and had a	r on 4/2/2015 at 1:36 p.m., RN)-B stated "[R9] was at risk history of "self transferring." A r R9's fall prevention had				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION		E SURVEY	
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	COM	PLETED	
		245353	B. WING _		04/	02/2015	
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
AMILIA	ROSE CARE CENTE	RLLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETIC DATE	
F 282 F 311 SS=D	recently been added leave him unattendo said the new interver identified on the aid not been completed When interviewed of director of nursing ("expect" a resident" 483.25(a)(2) TREAT IMPROVE/MAINTATATATATATATATATATATATATATATATATATAT	d to the care plan, "To not ed in the bathroom." RN-B ention should have been le's care sheets, but that it had d, "it should have added." on 4/2/15, at 2:23 p.m. the DON) stated she would s care plan be followed. TMENT/SERVICES TO	F 28			5/12/15	
	by: Based on observat review, the facility fa and cues for eating required staff assist Findings include: R15's significant ch (MDS), dated 1/28/ and long term mem supervision with ass R15's care plan, da problem of being at greater than 25% o directed to monitor weekly weights and plan also identified	NT is not met as evidenced ion, interview, and document ailed to provide supervision to 1 of 4 residents (R15) who tance with eating. ange Minimum Data Set 15, identified R15 had short ory problems, and required sistance from staff to eat. ted 1/27/15, identified a nutritional risk and "leaving f food uneaten." Staff were and record intake of food, offer substitutes. The care a problem of cognitive impaired decision making		F311 SPECIFIC RESIDENTS AFFECTE R15 s care plan was reviewed an revised to further promote dignity of meals by offering additional finger menu items. Staff will offer finger when appropriate to promote high of ability to eat independently. R1 menu was updated to reflect offer additional finger foods. Staff has I assigned to R15 s table to provid supervision and assistance with m necessary, and as resident allows communication was provided rega R15's updated interventions. Nurs staff will receive additional, related in this area as outlined below. IDENTIFICATION OF OTHERS W MAY BE AFFECTED:	d with foods est level 5's ng been e closer eals as . Staff urding sing l training		

Facility ID: 00757

If continuation sheet Page 18 of 42

		& MEDICAID SERVICES			OMB NO.		
	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		E SURVEY PLETED	
245353			B. WING _		04/0	04/02/2015	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	E, ZIP CODE		
				11800 XEON BOULEVARD COON RAPIDS, MN 5544	8		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIC DATE	
F 311	Continued From pa	ge 18	F 3	11			
	related to memory a were directed to "pr PRN [as needed]" a needs-inquire with a During observation on 3/30/15 at 5:20 p table in the 3rd floo residents, and had her neck which cov served a plate of fo small diced fruit boy shredded lettuce ar spoon were sitting of R15 began to pick of fingers, spilling a la floor as she attemp (NA)-D, NA-E, and did not offer assista provided utensils to corn using her finge floor. R15 opened began to eat the me pulling the plate clo she ate it. At 5:27 p small bowl of diced her fingers, resume her plate, and then 5:30 p.m R15 picl it on the table, and fingers to eat her m soiled with a tattere and corn. At 5:37 p pieces of food from her fingers. Registr approached the tab 5:44 p.m., but did n	and judgment deficits. Staff rovide cues and reminders and to "anticipate client." of the evening meal service, o.m., R15 was seated at a r dining room with two other a clothing protector around ered her shirt. She was od consisting of kernel corn, wl, and a soft taco with nd cheese on top. A fork and on the table next to her plate. up pieces of corn using her rge amount of the corn on the ted to eat it. Nursing assistant NA-F walked by the table and ance, or cues to use the R15 who continued to eat the ers, spilling on her lap and the the soft taco at 5:26 p.m. and eat inside using her fingers, ser to the edge of the table as o.m. she then picked up the fruit and began to eat it using ed eating the taco meat from spilled the plate on her lap at ked her plate back up, placed continued to eat using her neal. Her clothing was now of soft taco shell, taco meat, o.m. R15 began picking up her lap and eating them with		Clinical Managers and team reviewed reside weights and food inta those that may need a interventions to prome and fluid intake. Care residents were review necessary. SYSTEMIC CHANGE Services has posted I available on the unit v appropriate as finger and also ways to mod items to be served as Nursing staff will cont residents at meal time necessary and offerin including finger foods Nursing staff and Clie (CDAs) have been ma information. Nursing receive additional trai supervision at meals, and offering assistand if intake is less than 7 completed by May 8, MONITOR CHANGES Random dining room conducted at least thm meal by Clinical Mana of Nursing to ensure to receiving the appropri supervision and/or as The Director of Nutriti review menus weekly finger food items are meal. Concerns that r audits will be address	nts, including routine ke logs, to identify additional mealtime be adequate food e plans for identified red and revised as S: Nutritional ists of foods which may be food substitutions lify regular menu finger foods. inue to supervise es, assisting as g meal alternatives, , as appropriate. nt Dining Assistants ade aware of this staff and CDA will ning on resident monitoring intake be and/or substitutes 5%. Training will be 2015. S: audits will be ee times weekly per agers and/or Director hat residents are iate level of sistance from staff. on Services will to ensure sufficient available for each may arise from these		

Facility ID: 00757

If continuation sheet Page 19 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		0938-039 E SURVEY		
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:			· · ·	PLETED		
		245353	B. WING		04/02/2015			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	DDE			
CAMILIA ROSE CARE CENTER LLC				11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE		
F 311	Continued From pa	age 19	F 311	1				
	The director of nursing (DON) approached R15 at 5:47 p.m. and stated she would "help get her cleaned up a little." The DON removed the soiled clothing protector from R15's lap, and left the dining room. R15 was removed from the dining room by RN-B at 5:55 p.m., or 35 minutes after she began eating. No assistance or cues for eating had been offered to R15 during the course of the meal. When interviewed on 4/1/15, at 1:25 p.m. client dining assistant (CDA)-A stated R15 often will eat with her fingers, and has been leaving more food on the floor "a lot more lately." R15 struggles to eat smaller items, and during clean up, staff will			appropriate. Audit results will be by the Director of Nursing week reported to the Quality Assurance task force monthly for a period of or until substantial compliance is achieved, whichever is greater. task force will determine additional ternative actions to be taken, is necessary.	ly and ce (QA) of 90 days, s The QA nal or			
	floor when she is fi they [nurses] could During interview or stated staff should and offer assistance	e peas and corn left on the nished eating adding, "Maybe take a look at her that way." n 4/2/15, at 10:06 a.m. NA-B provide R15 with cues to eat, ce if she is seen to be						
		on 4/2/15, at 10:19 a.m. RN-B should have been offered						
	director of nursing	n 4/2/15, at 2:51 p.m. the (DON) stated staff should have ance, or at least provided cues to eat her meal.						
F 314 SS=D	requested, but non 483.25(c) TREATM		F 314	4		5/12/15		

If continuation sheet Page 20 of 42

		& MEDICAID SERVICES					0938-039
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245353	B. WING			04/0	2/2015
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 314	Based on the comp resident, the facility who enters the facil does not develop priindividual's clinical of they were unavoida pressure sores rece services to promote prevent new sores f This REQUIREMEN by: Based on observat review, the facility fa repositioning to red formation for 2 of 3 reviewed for pressu Findings include: R97's quarterly Min 2/26/15, identified F ulcers, and required staff for bed mobility Pressure Ulcers Ca dated 6/07/14, indic mechanical lift to tra A2 [assist of 2] staff During constant obs a.m until 9:50 a.m. was observed to be 9:24 a.m., nursing a room to see if R97 she was not, lowere and left the room.	rehensive assessment of a must ensure that a resident ity without pressure sores ressure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and e healing, prevent infection and from developing. NT is not met as evidenced ion, interview, and document ailed to complete timely uce the risk of pressure ulcer residents (R97, R65) are ulcers. imum Data Set (MDS) dated 897 had no current pressure d extensive assistance of two y and repositioning. R97's are Area Assessment (CAA), ated " assist of 2 with ansfer; turns side to side with	F 3	14	F314 SPECIFIC RESIDENTS AFFECTED R97 expired 4/9/2015. A comprehensive skin risk assessm including Braden scale and tissue tolerance testing was completed for R65 s care plan was reviewed and remains current. R65 moved to ano long term care unit within the facility staff on R65 s new unit was update her specific skin interventions, includ appropriate offloading techniques. S was reminded of specific interventio R65 and the expectation that they be followed at all times. Notices have b posted for nursing staff regarding complete offloading for at least 1 mi Nursing staff will receive additional, related training in this area as outline below. IDENTIFICATION OF OTHERS WH MAY BE AFFECTED: NAR care sheets, which include spe care plan interventions for safety and were reviewed for accuracy, especia it relates to skin and safety intervent	ent, R65. other and ed on ding Staff ns for e Deen nute. ed HO ecific d skin, ally as	

Facility ID: 00757

If continuation sheet Page 21 of 42

			()(0)			OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
245353		B. WING			04/02/2015		
NAME OF PROVIDER OR SUPPLIER				STREET	ADDRESS, CITY, STATE, ZIP CODE		
				11800 X COON			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 314	at 9:50 a.m., that R repositioned every care plan. RN-C, st shift report sheet th document when RS last time this was d shift the evening be and 5 minutes ago. During interview on stated that the nigh when R97 has last R97 to the side to e with no redness no Review of R97's Ca Tissue Tolerance a identified an area o Points and that after redness noted over	Continued From page 21 at 9:50 a.m., that R97 should of been repositioned every two hours as directed by the care plan. RN-C, stated after reviewing the night shift report sheet that the prior shift did not document when R97 was last repositioned. The last time this was documented was on the relief shift the evening before at 10:45 p.m., 11 hours and 5 minutes ago. During interview on 4/01/15 at 10:05 a.m., NA-A stated that the night shift had not informed her of when R97 has last been turned. NA-A then turned R97 to the side to examine the resident's coccyx, with no redness noted. Review of R97's Camilia Rose Care Center Tissue Tolerance assessment, dated 03/07/14, identified an area of Bed Evaluation of Pressure Points and that after lying for 2 hours, "was redness noted over bony prominence." The facility checked "no." The Intervention section of		turr initi train Cor auc the Nur rela beld SYS Fac staf pre pro inte MO Clir Nur	d were revised as necessary. hing and repositioning audits were to identify immediate specining needs and compliance is necerns that may arise from the dits will be addressed as appro- auditor and/or Clinical Managers auditor and remain current. Numerical managers per offloading, and following of perventions by 5/12/2015. NITOR CHANGES: hical Managers and/or Directors rsing will conduct 4 random me dits per unit/per shift for a mini- dits	vere ecific staff sues. ese opriate by jers. al, tlined related to ons were ursing care, cluding care plan r of onthly	
	intervention plan", was no indication of be repositioned. The (not dated) Bra- used to determine p R97 had a score of the development of In review of R97's of of 3/25/14), the fac at risk for skin irrita decreased mobility and bladder, and po (PVD). The intervent	which was left blank. There if how frequent R97 needed to aden Scale score form, (a form pressure ulcer risk) identified 13 (13-14 moderate risk) for		36 a con pre- will unti whi revi des the the tasl be o Nur	audits per unit per shift for a finit audits per month, to ensure npliance with repositioning an ssure reduction interventions. continue for a period of 90 da il substantial compliance is ac chever is later. Audit results iewed by the Director of Nursi signee at least weekly and rep QA task force monthly. Res se audits will be reviewed by t k force monthly and further ac determined as necessary. Dir rsing will be responsible for npliance.	d Audits ays, or hieved, will be ng or orted to ults of he QA tions will	

If continuation sheet Page 22 of 42

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245353	B. WING			04/	02/2015
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC		-	800 XEON BOULEVARD DON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ıge 22	F 31	14			
	registered nurse (R started a new shift information on resid repositioning could done. RN-B stated	n 04/01/2015 at 1:31 p.m., a RN)B stated the facility had reporting sheet, so that dents' need, such as last be followed, and this was not that R97 should have been two hours as assessed and					
	Care Protocol (date facility would be util Braden Scale, Skin Tolerance Observa Breakdown Observ indicated: "The con develop and impler	, entitled: Skin and Wound ed 4/24/14) indicated that the lizing tools such as: the n Risk Assessment, Tissue titions and weekly Skin vations. This document further npleted tools will be used to ment and individualized plan of escribed interventions, unitoring systems.					
	R65 had intact cog assistance with bec was at risk for skin assessment, dated "open area on cocc of, "Staff to continu R65's care plan, da at risk for skin brea	OS, dated 1/19/15, identified nition, required extensive d mobility and transfers, and breakdown. R65's Skin 1/29/15, identified R65 had an cyx", and listed an intervention ie to offer hourly repositioning." ated 1/19/15, identified she was akdown, and listed an rn and reposition every hour as vs."					
	6:51 a.m. R65 was (less than 15 degre	pservation starting on 4/1/15, at lying in bed positioned slightly bes) on her left side, without or positioning device. R65					

Facility ID: 00757

If continuation sheet Page 23 of 42

STATEMEN	OF DEFICIENCIES	KIN PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	CMB NO. 0938-039 (X3) DATE SURVEY COMPLETED			
			A. BUILDING					
	IAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/02/2015			
CAMILIA ROSE CARE CENTER LLC				11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETIO DATE		
F 314	7:45 a.m. when NA the head of the bed or 3 inches) pulled having her lay com then completed R6 however did not off R65's room at 8:00 bed without being r hour and 37 minute her to roll onto her cares. R65 was ob area on her coccyx the site. When interviewed stated she thought repositioned every tries to follow a res it as closely as I ca at 12:12 p.m. NA-H to be repositioned stated she did not area during her rar that morning. During interview or stated R65 admitte (full thickness skin necrosis of subcuta on her coccyx, whi to remain at risk fo Further, R65 shoul off-loaded from her directed by her car	d, in the same position until A-H entered the room lowered d and slightly (approximately 2 R65's draw sheet towards her pletely on her back. NA-H 5's range of motion exercises, f load or reposition her, and left 0 a.m R65 then remained in repositioned until 8:38 a.m. 1 es later, when NA-I. assisted right side during morning served to have a small open d, with minor redness around on 4/1/15, at 9:11 a.m. NA-I R65 should be offered two hours, and that she always idents care plan, "I try to follow m." During interview on 4/1/15, d stated she thought R65 was every 2 hours, and further off load R65's from her coccyx nge of motion exercises earlier n 4/1/15, at 2:42 p.m. RN-B ed to the facility with a stage III loss involving damage to, or aneous tissue) pressure ulcer ch has improved but continues r pressure ulcer development. d have been completely r coccyx every one hour as	F 31					

If continuation sheet Page 24 of 42

		AND HUMAN SERVICES		FC	TED: 05/07/201 DRM APPROVE NO. 0938-039		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3) DATE SURVEY COMPLETED		
		245353	B. WING		04/02/2015		
NAME OF F	PROVIDER OR SUPPLIER	L	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RLLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE		
F 314	Continued From pa	ige 24	F 314				
F 315 SS=D	dated 4/24/14, iden appropriate care ar skin [sp] breakdown the individualized c identified, "Nursing includetoileting ar plan" 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the fa resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of treatment and servi	HETER, PREVENT UTI, ER ent's comprehensive cility must ensure that a s the facility without an is not catheterized unless the ondition demonstrates that necessary; and a resident of bladder receives appropriate ices to prevent urinary tract store as much normal bladder	F 315		5/12/15		
	by: Based on observat review, the facility f assess and implem urinary incontinence reviewed and who Findings include: R1's admission Mir 12/18/14, identified cognitively impaired	NT is not met as evidenced tion, interview, and document ailed to comprehensively tent interventions to reduce e for 1 of 3 residents (R1) was incontinent of urine. himum Data Set (MDS), dated R1 was moderately d, required extensive assist of was occasionally incontinent		F 315 SPECIFIC RESIDENTS AFFECTED: R1 s bowel and bladder care plan wa updated to reflect current status. R1 toileting plan indicates reminders to request assistance to toilet as needed staff to approach and offer toileting at least q2 hours while up, and assist to to on each night rounds and upon request IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Clinical Managers, additional nursing s	s , oilet st.		

Facility ID: 00757

If continuation sheet Page 25 of 42

		& MEDICAID SERVICES					0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· /	E SURVEY PLETED	
		245353	B. WING _			04/0)2/2015	
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	[PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 315	Continued From pa	age 25	F 31	15				
	of urine, however d R1's quarterly MDS had a change and of urine, but did not R1's care plan date of urinary incontine "Assist to toilet Q [e [night] rounds and During observation a.m., nursing assis incontinent product During an interview NA-B stated she ty and if R1 is sleepin frequently be incon Review of R1's Boy Collection (a form u incontinence over 7 12/12/14-12/14/14, incontinent episode Bowel and Bladder thru 1/31/15, identif 32 opportunities du left blank. During t continent 27 out of the night was contin with 3 shifts being I voided 12 times on continent during the voiding pattern of b evening and day sh The facility had not data to determine a	bid not have a toileting plan. S, dated 3/19/15, identified she was now frequently incontinent t have a toileting plan in place. ed 1/2/15 identified a problem nt and staff were directed to every] 2 hours, with NOC PRN [as needed]." of care on 4/01/15 at 7:55 tant (NA)-B removed R1's which was soiled with urine. o on 04/02/15 at 1:53 p.m., pically works on the day shift g when she gets here, she will tinent in the morning. wel and Bladder 72-Hour Data used to monitor urinary		0	and the interdisciplinary team review residents to identify those with rece increased incontinence, as demons by the last MDS assessment, staff reports, or other indications. Comprehensive bowel and bladder assessments were initiated for 11 residents that may benefit from furt review. Care plans will be reviewed revised as indicated, based on assessment results. SYSTEMIC CHANGES: The MDS Coordinators have assum responsibility for following the MDS process through to completion, culminating in an accurate, individu care plan. Clinical Managers will be responsible for ensuring care plans updated between assessment period interim MDS Coordinator has been contracted to supplement the existin MDS Coordinator until the vacant p is filled. MONITOR CHANGES: Random comprehensive care plan will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and current. These audits will be condu- monthly for at least 2 residents per for a minimum of 6 per month. Aud continue for a period of 90 days or substantial compliance is achieved, whichever is later. Audit results will reviewed by the Director of Nursing weekly and reported to the Quality	nt strated her d and ned alized e are ods. An ng osition audits o remain icted unit, dits will until be		
	Review of the Poin	t of Care Bowel/Bladder om 2/28/15 through 3/21/15			Assurance (QA) task force monthly QA task force will determine additio alternative actions to be taken, if			

Facility ID: 00757

If continuation sheet Page 26 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MUUTI	PLE CONSTRUCTION		. 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				/PLETED
		245353	B. WING _		04	/02/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 315	opportunities during opportunities for th continent 0 of 9 op Review of R1's qua dated 3/18/15, ider incontinence, impa appropriate for toile to her dementia. Ev data from 2/28/15 t	continent 10 out of 22 g the day shift; 20 out of 22 e evening shift, and was portunities for the night shift. arterly Bladder Observation, ntified R1 had urge and stress ired mobility, and was not eting program or retraining due ven though the point click care to 3/21/15 identifies a pattern	F 31	5 necessary. The Director of Nu be responsible for compliance.	rsing will	
	day shift hours, wh December 2014 Bo Collection sheet, w twice. When interviewed registered nurse (F protocol for resider collection done and would do a deeper	inent during the evening and ich was a change from the owel and Bladder 72-Hour Data here she was only incontinent on 4/02/2015, at 10:03 RN)-B stated the facility ht bladder assessment is 3 day hually, and "as a practice we investigation." Further, RN-B e to verbalize her need for as inconsistent.				
	stated R1's Bladde been completed up not been. Further, have reviewed R1's and put her on a m	n 04/02/15, at 2:04 p.m., RN-B r Observation should have oon admission, however it had RN-B stated the facility should s incontinence more closely ore individualized toileing it some of her incontinent				
	occasionally to frec could verbalize her failed to assess for	ntinence went from quently incontinent, and R1 need for toileting. The facility patterns and the cause of pontinence and implement a				

		AND HUMAN SERVICES & MEDICAID SERVICES			F	FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE	E SURVEY PLETED
		245353	B. WING			04/(02/2015
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 315 F 323 SS=D	plan to help reduce A facility Guidelines Bowel Assessment identified it, "Directs able to maintain the toileting function an individualized toileti full assessment is t admission, quarterly significant change of Bladder and Bowel and Bladder analys 483.25(h) FREE OF HAZARDS/SUPER The facility must en environment remain as is possible; and	her incontinence episodes. for Client's Bladder and policy, dated 3/13/15, s staff to ensure clients are bir highest practicable level of d to develop and ng plan of care." Further, "A o be completed upon y, annually and with a of condition using a 72 hour Data collection sheet, Bowel is and summary of data." F ACCIDENT	F3				5/12/15
	by: Based on observat review, the facility fa assess and implem the risk of falls for 1 reviewed for accide In addition, the facil four-wheeled walke device, which the m recommended for u	NT is not met as evidenced ion, interview and document ailed to comprehensively ented interventions to reduce of 3 residents (R9, R1) nts hazards during the survey. ity failed to ensure a seated r was used as a transportation hanufacturer had not use for 1 of 4 residents (R69) ch a device during the survey.			F323 SPECIFIC RESIDENTS AFFECTED: A comprehensive fall risk assessmen was completed for R1. R1's care pla was reviewed and additional minor interventions were implemented. NA care sheets were updated to include current safety interventions. An updated fall risk assessment was completed for R9. R9's care plan for safety was reviewed and remains cur	nt an AR s r	

Facility ID: 00757

If continuation sheet Page 28 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE		<u>//B_NO.</u> (X3) DATE	SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:					PLETED	
		245353	B. WING _			04/0)2/2015	
NAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RLLC			800 XEON BOULEVARD OON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 323	Continued From pa	ge 28	F 32	23				
	Finding include:	-			Staff was reminded of R9's care pla	เท		
					interventions and the expectation th			
	FALLS RISK	identified on the physician's			safety interventions are to be follow	ed at		
		identified on the physician's 2015, included arthritis,			all times. Nursing staff will receive additional, related training in this are	-2 26		
		ve heart failure, and obesity.			outlined below.	54 45		
		num Data Set (MDS), dated			Regarding R69 being transported u	sing a		
		d R9 had moderately impaired			walker, staff received reminders that			
		that he needed extensive,			residents are never to be transporte			
		for transferring, and toileting.			while seated on a walker seat, show			
		ment (CAA) for falls, dated R9 was at high risk for falls,			chair, or any other device not intend that type of use. Nursing staff will re-			
		sk score, and a history of falls,			additional, related training in this are			
		hip fracture. The CAA further			outlined below.	ou uo		
		factors, increasing R9's fall						
		of anti-depressant and			NOTIFICATION OF OTHERS WHO) MAY		
		medications, incontinence,			BE AFFECTED:			
		, as well as cognition			The QA Committee Chair analyzed			
	impairment.				falls data from Jan 1-March 31, 201 reports were discussed at the QA	5 and		
	R9's care plan (CP)), updated 3/30/2015,			Committee meeting on 4/21/15. Th	e		
		that R9 would not have any			analysis compared overall falls data			
		while at the nursing home, and			day of the week, time of day, and u			
		call light for assistance,			The fall/incident report log was ente			
		ferring. The CP listed			into an electronic spreadsheet, allow			
		ions to prevent falls, among			managers to sort information quickl			
		to "A1-2 (assist of 1 to 2 Insfers and mobility," and "Do			Information includes name, room, d time, type of incident, and also track			
		n bathroom alone or			reports from initial IDT review through			
	unattended."				completion.	3.		
					Entries were entered into the spread			
		on 4/1/2015 at 8:44 a.m.,			retrospectively from Jan 1, 2015 an			
		NA)-G entered R9's room to			continuing through present date and			
		ed, and begin routine morning shoes over R9's socks and			sorted to identify any patterns of sporesidents. Incident reports and	ecilic		
		him to sit upright on the side			investigative reports were reviewed	for		
		with a transfer belt around his			identified residents to ensure interve			
	waist, assisted him	to stand, pivot, then sit into			addressed all root causes. Care pla			
		A-A pushed R9 into the			were reviewed and revisions were			

Facility ID: 00757

If continuation sheet Page 29 of 42

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	· · ·	SURVEY	
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	BUILDING			PLETED	
		245353	B. WING			04/0)2/2015	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE	
F 323	Continued From pa	ae 29	F 3	23				
	transfer onto the to to help a co-worker some linens" to ren at 8:55 a.m., exited minutes later), NA- clean bed linens an a.m., NA-G remove shirt out of the close bathroom, asking F wanted to wear. NA R9's room and site minutes); however, (3 minutes) NA-G v present with him in entire twelve minute bathroom, he rema made no attempts to otherwise move out	a provided him assistance to ilet. NA-G told R9 she needed "for a little bit and bring back hake his bed and left the room R9's room. At 9:04 a.m., (9 G returned to R9's room with d made R9's bed. At 9:07 ed two pairs of pants and a et, then re-entered the R9 which pair of pants he A-G was completely out of from 8:55 a.m. to 9:04 a.m. (9 from 9:04 a.m. until 9:07 a.m. vas in R9's room, but was not the bathroom. During the es R9 was alone in the ined seated on the toilet, and to stand up, self transfer, or t from the room. Upon return A-G assisted R9 to complete the day.			completed as indicated. SYSTEMIC CHANGES: The facility policy and procedure fo investigations, titled IDT Incident Re Process, was updated and revised include the use of the electronic incomport report log. Clinical Managers will se log by name, print data specific to the resident being investigated, and att the post-fall investigation form. This information will be used as part of the cause investigation and analysis. Company Managers have been updated on the policy and procedure revisions and process was implemented 4/24/207 Nursing staff will receive additional training on safety related to falls, pri- use of equipment to assist residented mobility, and following individualized safety interventions at all times. Tri- will be provided by 5/12/2015.	eview to cident ort the he ach to is he root Clinical ne the 15. roper s with d		
	NA-G acknowledge bathroom" when sh also left him alone v NA-G said she left some privacy." NA had a recent fall, ar transfer. A review of nursing had two recent falls 3/21/2015. An inter 3/18/2015, for the r identified "res [res straighten/rearrang Nursing departmen	on 4/1/2015 at 9:13 a.m., ed she left "[R9] alone in the le helped out a co-worker, and while she made his bed. R9 alone so "he could have -G stated she was aware [R9] nd that he was known to self progress notes indicated R9 in the facility: on 3/16/15 and rdisciplinary note (IDT) dated eview of R9's fall on 3/16 sident] fell while attempting to e items on bedside table. t assisted with reorganization ole. Considered an isolated			MONITOR CHANGES: Clinical Managers and/or the Direct Nursing will conduct 4 random mor audits per unit/per shift, for a minim 36 audits per month, to ensure compliance with safety intervention Random comprehensive care plan will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and current. These audits will include investigating whether appropriate s interventions were identified and implemented after a fall or other into These audits will be conducted mon for at least 6 residents, for a period days or until substantial compliance	nthly num of s. audits o remain afety cident. nthly of 90		

Facility ID: 00757

If continuation sheet Page 30 of 42

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	(X3) DAT	
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245353	B. WING		04/	02/2015
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 323	continue to observe behavior/mobility." which reviewed R9 "res. attempted to subsequently fell be hospitalized with L Returned to facility toileting assistance wake hours except [therapeutic recrea w/NOC [with night] per request. Staff changes in behavio During an interview registered nurse (F for falls, based on I assessment from J due to his being un since R9's latest fa "[R9] did not walk a program to maintai they initiated having "every 30 minutes, assistance," and th before he goes." F had "a history of se increased his fall ri intervention for R9' added to the care p him unattended in t the new interventio care sheets, but "th	alls > [in the last] 60 days. Will e for changes in An IDT note dated 4/1/2015, 's fall on 3/21/15, indicated o transfer self to toilet and ack on floorRes. was [left] rib fractures, #9,10,11. on 3/23/2015. Staff to offer e Q [every] 30 minutes during twhen participating in TR tion] programming or dining, rounds and PRN [as needed] will continue to observe for or and pain ongoing." o on 4/2/2015 at 1:36 p.m., RN)-B stated "[R9] was at risk his "latest quarterly January, and that he 'triggered' isteady." RN-B also stated that and he was on a restorative in strength." RN-B also said g staff check on him every and offer him toileting hat "we are trying to catch him RN said she was very aware R9 elf transferring," which sk. RN also said a new 's fall prevention was just olan, and that was "not to leave the bathroom." RN-B said she in was not part of the aide's hat it should have added." The eets were not updated. RN-B	F 32:	achieved, whichever is later. Aud will be reviewed by the Director of weekly and reported to the Qualit Assurance (QA) task force month QA task force will determine addital alternative actions to be taken, if necessary. The Director of Nurs be responsible for compliance.	of Nursing ty hly. The itional or	

Facility ID: 00757

If continuation sheet Page 31 of 42

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245353	B. WING	i		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CAMILIA	ROSE CARE CENTE	RLLC			11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	leaving R9 unattend present in a resider balance between puresident." The DOI would "expect" a re A facility policy regannee provided. R1's admission Min 12/18/14, indicated was moderately cog extensive assist of occasionally incontriated in the lass with a fracture and without injury. R1's indicated she had the admission with no i incontinent of urine R1's care plan date at risk for falls and a history of falls. The "Provide toileting as toileting plan." During observation a.m. nursing assist assist R1 onto the the incontinence and less he gathered clothi returned to the bath stated she (R1) has attempting to take the R1's falls care area	ded in the bathroom, but be nt's room, "There had to be a rivacy and safety for this N added, however, that she esident's care plan be followed. arding falls was requested, but himum Data Set (MDS) dated I she admitted on 12/14, and gnitively impaired needed one with transfers and was inent of urine and did not have e MDS further indicated she st month prior to admission fallen once since admission quarterly MDS dated 3/19/15, wo or more falls since injury, and was frequently		323			

If continuation sheet Page 32 of 42

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245353	B. WING			04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 323	incontinence, histor hospitalized and se identified she had fa to self transfer to th Observation dated fallen in the last 30 that she was at high with current plan of history of falls befor her admission a fac risk assessment un admission to the fac Review of R1's Pos indicated the follow R1 had a fall 12/12/ found on floor near alarm was added. R1 had fall 12/22/14 floor next to bed aft tab alarm in room, fa R1 had a fall 1/14/15 staff to bring to nurs change. R1 fall 1/26/15 at 83 floor in bathroom at use the restroom. R1 had fall 3/11/15, on floor in bathroom Review of the falls i occurred while R1 wa attempting to self tr indicated four of the	y of falls at home and was nt to the facility. The CAA allen at the facility attempting e toilet. A Fall Risk 3/15/15, indicated she had days, had loss of balance and n risk for falls and to continue care. Although R1 had a re admission and falls since sility had not completed a fall til 3/15/15, three months after cility. t Incident Investigations ing: '14, at 9:00 p.m. resident was the foot of her bed and a tab 4, at 8:02 p.m. was found on er apparent self transfer no	F 3	23			

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245353	B. WING	ì		04/(02/2015
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	A ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	occurred between 3 was no indication the falls to determine if though six falls occur attempting to self the During interview 4/2 she was aware that stated she did not of Observation upon a she stated "I missed had a 72 hour blade admission (a test to incontinence) and a was decided due to indicated and that a to say they should he incontinence closer established a indivi- prevent some her in transfers. The facilities Incide 11/12/14, indicated be reviewed by the Team members will process, root cause of appropriate internation Although R1 had fa to self transfer to the comprehensively as if there was patternation	3:00 p.m. and 3:30 p.m. There he facility had analyzed R1's there was a pattern, even surred while in the bathroom or ransfer. 2/15, at 2:04 p.m. RN-B stated t R1 had multiple falls and complete a Fall Risk admission and should have ed it". RN-B then stated R1 der study completed upon o determine a pattern of according to the assessment it o her dementia no plan was another . RN-B then went on have looked at her r and maybe they could have dualized toileting plan to ncontinence and falls from self ent Review Process dated "Incident/Accident reports will interdisciplinary Team (IDT), I participate in the investigative e analysis, and determination ventions. allen multiple times attempting he toilet the facility failed ssess these falls to determine in related to her urinary mplement interventions to help	F	323			

Facility ID: 00757

If continuation sheet Page 34 of 42

		AND HUMAN SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245353	B. WING			04/(02/2015
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 323	Continued From pa TRANSPORTATION R69's diagnoses, a orders dated 3/26/2 disease, paralysis, degeneration. The (MDS) dated 1/16/2 moderate cognitive extensive assistance locomotion, and util The Care Area Asso daily living (ADLs), R69 had a decline i and hospital stay, w and functional decli R69 was participati she was at risk for fu updated 3/1/15 ider and directed staff "C not to ambulate/tran assist of one person walker]. During observation R69 had a gait belt just outside her roo handle bar grips of walker (FWW), and standing next to he FWW, and NA-C pu seated looking forw room, past the nurs Cafe. Once in the o stand, transfer into belt after R69 was s	ige 34	F3	323			

If continuation sheet Page 35 of 42

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245353	B. WING	i		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE				1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	In an interview on 3 nursing assistant (N from her room to br use the [four wheel sometime request ther, but has asked pushed. NA-C state four-wheeled walke time." NA-C said R assist" to walk. Review of the Nova information guide, " 2014, indicated "Se Do no ambulate or seated." Further th is a walking aid only transportation device During an interview registered nurse (R policy to transport r walker, and that pra RN-B also stated (F updated, to include transportation, and re-education was n stated, "This is not residents that way." In an interview on 4 director of nursing (should be transport walker. The DON s should not have be A facility policy rega	A/31/2015 at 11:21 a.m., NA)-C stated she pushed R69 reakfast in the Cafe. "[R69] will led] walker to walk," and to use a wheel chair to push to sit in the walker and be ed "Today I pushed her in the er," and "I don't do that all the R69 usually "needed stand by a Medical Products brand "Nova Go! Mobility," dated eat is for stationary sitting only. use as a transport chair while he guide had a warning: "This y, and is not to be used as a ce." o on 4/1/2015 at 12:56 p.m., RN)-B stated it was not facility residents using a four-wheeled actice "was not condoned." R69's) care sheet could be a reminder of appropriate d that some "education and heeded for the staff. RN-B our policy to transport " 4/2/2015 at 2:23 p.m., the (DON) stated no residents ted using a four-wheeled said "This is not safe, and	F3	323			

If continuation sheet Page 36 of 42

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DAT	E SURVEY PLETED
		245353	B. WING			04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441 SS=F		I CONTROL, PREVENT	F4	441			5/12/15
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a comfortable environment and development and transmission ction.					
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr should be applied to	tablish an Infection Control ch it - ntrols, and prevents infections rocedures, such as isolation, o an individual resident; and ord of incidents and corrective					
	determines that a reprevent the spread isolate the resident. (2) The facility musicommunicable dise from direct contact direct contact will the (3) The facility music hands after each di hand washing is incorportessional practice (c) Linens Personnel must har	ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which licated by accepted					

Facility ID: 00757

If continuation sheet Page 37 of 42

CENTER STATEMENT AND PLAN C		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245353 R LLC		9ING S 1	Fi OMB	ORM / <u>3 NO.</u> 3) DATE COMF	05/07/2015 APPROVED 0938-0391 SURVEY PLETED 02/2015
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 441	by: Based on observat review, the facility f implement an infec included tracking, t infections to reduce other residents in th potential to affect a staff in the facility. I ensure proper disim monitor for 1 of 1 re have their blood glu of the survey. Findings include: LACK OF ANALYS CONTROL PROGE Review of the Mont December 2014, Ja 2015 had categorie residents name, un culture, antibiotic, o and isolated type. T Monthly Infection C The December 201 indicated they had influenza A and two on the second floor the rooms were in t when the symptom analysis or summa control practices. The January 2015	NT is not met as evidenced tion, interview and document ailed to develop and tion control program that rending and analysis of the risk of transmission to he facility. This had the II 75 residents, visitors and n addition, the facility failed to ifection of a blood glucose esidents (R75) observed to ucose tested during the course IS IN THE INFECTION RAM: thly Infection Control Log for anuary 2015 and February es on the sheet that identified it, room number, infection, classification, date resolved The following were noted in the	F 4	141	F441 SPECIFIC RESIDENTS AFFECTED: IDENTIFICATION OF OTHERS WHC MAY BE AFFECTED: All residents have the potential to be affected. Notices were posted to remind staff of proper glucose meter disinfection practices. The supplemental staffing agency TMA received individual trainir on the facility policy and procedure on glucose meter disinfection. SYSTEMIC CHANGES: The facility policy and procedure, Infec Control Surveillance, which includes trending and analysis of infection cont data has been reviewed and remains current. Data for 1st quarter was reviewed and analyzed by the Director Nursing. The analysis report, includin incidence and prevalence of infections within the time period, was submitted the QA Committee and discussed on 4/21/2015. Infection control data anal and will be conducted monthly by the Director of Nursing or designee. Infect control analysis with summary will be submitted to the QA Committee quarter The facility policy and procedure, Cleaning and Disinfecting Blood Gluco Meters was reviewed and remains current. This policy and procedure wa immediately included in the agency sta orientation materials for all appropriate	o f ng ction trol or of ng s to lysis ction ction eerly. cose as	

Facility ID: 00757

If continuation sheet Page 38 of 42

PRINTED: 05/07/2015 FORM APPROVED

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G	CON	IPLETED
		245353	B. WING _		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE	
CAMILIA	ROSE CARE CENTE	ER LLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 38	F 44	1		
	the date of onset 1	ures from 99-100 degrees with /29/15, the log did not indicate nism, antibiotic or the date		supplemental staff. This p procedure	policy and	
	resolved.			MONITOR CHANGES: The QA Committee Chair		
	indicated they had	5 Monthly Infection Control Log two resident with c-diff colitis which is a bacteria that		infection control data and submitted quarterly. Data and discussed to determi	a will be reviewed ne if appropriate	
	or colon that can b	d irritation of the large intestine e passed from person to sident listing did not identify the		and timely actions are be prevent the spread of infe facility.		
	date of onset, if wh listing did not ident	ien it resolved. The second ify a onset day, the start date d if the symptoms had resolved		Clinical Managers and/or Nursing will conduct 2 rar audits per unit/per shift, c	ndom monthly	
	and when. Another was on ceftin (antil did not indicate the	resident listing indicated he piotic) for four days the listing type of infection, date of liture and if it had resolved.		shift, for a minimum of 12 month, to ensure complia disinfection of glucose m continue for a period of 9	2 audits per ince with proper eters. Audits will	
	During interview or	n 4/1/15, at 1:16 p.m., the		substantial compliance is whichever is later. Audit	achieved, results will be	
	control logs were d in January of 2015	(DON) stated the infection lone by the floor staff beginning . She would then take the		reviewed by the Director designee at least weekly the QA task force monthly	and reported to y. Results of	
	sheet reports from check them. She s	get it together with spread lab and pharmacy and cross tated, "We didn't want to do		these audits will be review task force monthly and fu be determined as necess	ary. Director of	
	they were trying to (Matrix is the electronic detection)	licated", at this time because get information into Matrix ronic medical record system). In regard to tracking,		Nursing will be responsib compliance.		
	trending and analy stated that they loc (Quality Assurance	sis of infections, the DON k at the information at QA b but they do more with the				
	was requested and	way. A summary of the analysis I not received.				
		v of 4/2/15, at 10:20 a.m., the e Clinical Managers are				

If continuation sheet Page 39 of 42

		AND HUMAN SERVICES				FORM	05/07/2015 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY PLETED
		245353	B. WING			04/(02/2015
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	A ROSE CARE CENTE	RLLC			800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	independently. She admit diagnosis, att hospital acquired at be listed on a conce During an interview registered nurse (R change in resident they make sure the and that infection of stated that the DON and trending of infe A policy labeled Infe dated 2010 states: identify possible clu organisms, or incre timely manner. The elements of surveill standardized definit symptoms of infect such as surveys an walking rounds thro of resident populati processes or outco statistical analysis of outbreak and feedb caregivers so they resident's physical BLOOD GLUCOSE R75 was observed trained medical ass glucose check. The on and wiped R75's pad. TMA-A pierce exposing blood, and	e stated that they look at the tempt to look at the "bug" if nd that the symptoms should ern form. (on 4/2/15 at 2:14 p.m., RN)-B stated that if there is a condition she alerts floor staff, ey have supplies that they need ontrol logs are completed. She N was in charge of tracking	F 4	.41			

If continuation sheet Page 40 of 42

		AND HUMAN SERVICES				FORM	: 05/07/2015 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245353	B. WING			04/	02/2015
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	removed the test st the strip in a sharps strip from a bottle, a Glucometer. TMA-, on R75's right hand then applied it to the disposed of lancet a container, removed Glucometer in a dra be used for other re- her hands after rem During interview on stated she was una own Glucometer. T an outside agency a facility a few times. cleaning of the Gluc use bleach wipes at During interview on director of nursing (shared Glucometer formal education or been completed, bu randomly as needed A facility Cleaning a policy, dated 2010, facility Glucometer recommendation. An undated McKess Glucometer manufa "the meters must disinfected after eve and disinfecting the	blood sugar). TMA-A then rip out of the Glucometer, put a container, removed a new and inserted it into the A proceeded to pierce a finger I exposing more blood, and e test strip. TMA-A then and test strip in a sharps the gloves and placed the awer of the medication cart to esidents. TMA-A did not wash noving her gloves. 4/1/15, at 1:00 p.m. TMA-A tware if each resident had their TMA-A stated she worked for and had only been to the Further, TMA-A stated cometer, "I think they [staff] t the end of the shift." 04/02/15, at 3:16 p.m. the (DON) stated the facility used for all the residents. No in cleaning of Glucometer had at she would speak to staff d. and Disinfecting Blood Glucose directed staff to sanitize the	F 4	141			

If continuation sheet Page 41 of 42

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES	1				0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245353	B. WING			04/	02/2015
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
	ROSE CARE CENTE	BIIC			1800 XEON BOULEVARD		
				0	COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa pathogens."		F 4		DEFICIENCY)		

Facility ID: 00757

PRINTED: 05/07/2015

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5	263023	FORM	APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
		245353	B. WING			04	/06/2015
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROIN DEFICIENCY)	D BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	S	ĸ	000			
:	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM USED AS VERIFICA UPON RECEIPT O ONSITE REVISIT C CONDUCTED TO V SUBSTANTIAL COI REGULATIONS HA ACCORDANCE WI A Life Safety Code S Minnesota Departm time of this survey C found not in substar requirements for pa Medicare/Medicaid 483.70(a), Life Safe	MPLIANCE WITH THE S BEEN ATTAINED IN TH YOU VERIFICATION. Survey was conducted by the ent of Public Safety. At the Camilia Rose Care Center was ntial compliance with the rticipation in					
	Chapter 19 Existing PLEASE RETURN	THE PLAN OF R THE FIRE SAFETY spections HAL DIVISION ET, SUITE 145			EPOC		
	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE 04/24/2015

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.

PRINTED: 04/27/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/27/2015 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` '		E CONSTRUCTION 01 - MAIN BUILDING 01		E SURVEY IPLETED
		245353	B. WING	-		04/	06/2015
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			1800 XEON BOULEVARD OON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
K 000		tate.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE	K	000			
	to correct the defici	-					2
	3. The name and/or responsible for corr	oposed, completion date. r title of the person rection and monitoring to ence of the deficiency.					
	with no basement. constructed in 1976 constructed to the f building and the add	Center is a 3-story building The original building was and an addition was acility in 1993 both the original dition are Type I (332) fore, the nursing home was uilding.					
	facility has a comple smoke detection in open to the corridor automatic fire depa	sprinkler protected. The ete fire alarm system with the corridors and spaces , that is monitored for rtment notification. The facility acity of 80 beds and had a time of the survey.					
K 029 SS=F	483.70(a) is NOT N	nditions of 42 CFR, Subpart IET as evidenced by: FETY CODE STANDARD	ĸ)29			5/12/15
30-F	fire-rated doors) or	construction (with ¾ hour an approved automatic fire m in accordance with 8.4.1					

Facility ID: 00757

If continuation sheet Page 2 of 6

		AND HUMAN SERVICES			0		APPROVED 0938-0391
STATEMENT	S FOR MEDICARE OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION 11 - MAIN BUILDING 01	(X3) DATE	
		245353	B, WING	-		04/0	06/2015
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RLLC			800 XEON BOULEVARD DON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 029	and/or 19.3.5.4 pro the approved autor option is used, the other spaces by sm doors. Doors are s field-applied protect	tects hazardous areas. When natic fire extinguishing system areas are separated from noke resisting partitions and self-closing and non-rated or tive plates that do not exceed bottom of the door are	КО	29	2		
	Based on observa hazardous areas at accordance with NI 19.3.2.1. This defic residents. Findings include: During facility tour I PM on 04/06/2015, kitchen is not prope dining room or corr This deficient pract	s not met as evidenced by: tion and interview, the re not maintained in FPA 101-2000, Section cient practice could affect the between 9:45 AM and 12:15 observation revealed that the erly separated from either the idor system. tice was verified by the tor at the time of the			 K29 A. The double doors separating the dining room from the corridor have equipped with: 1. Door closers for both leafs 2. A crash bar on the inactive leaf to latches into the top of the door frame. B. 1. The latching system was instead by Blaine Lock and Safe 4-23-2015 2. The closers were installed by maintenance 4-17-2015. 3. Magnetic door holders with eme alarm release will be installed for b leafs 4-27-2015 by Blaine Lock and hard will be inspected monthly on an interchecklist to be completed by the maintenance department. 	been hat ne. the of the stalled 5. rgency oth ad Safe. dware	
K 038 SS=F		FETY CODE STANDARD	ко	38			5/12/15
	EXIT access is arrai	nged so that exits are readily			12		
							of Dago 3 of 6

Event ID: WOCL21

Facility ID: 00757

If continuation sheet Page 3 of 6

PRINTED: 04/27/2015

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X3) MULTIPLE CONSTRUCTION (X3) D/ BUILDING 01 - MAIN BUILDING 01	
		245353	B. WING		4/06/2015
AME OF F	PROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
	ROSE CARE CENTE	BUC	1	1800 XEON BOULEVARD	
	RUSE CARE CENTE		C	COON RAPIDS, MN 55448	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE
K 038	Continued From pa accessible at all tim 7.1. 19.2.1	ge 3 nes in accordance with section	K 038		
	Based on observation facility failed to provide the providence with the	s not met as evidenced by: tion and staff interview, the vide means of egress in e following requirements of ection 7.2.1.5.4. The deficient of the residents.		K38 A. 1. An exterior inspection of the exterior walkway system was completed 4-17-2015. And a determination of 10 slab sections neede corrective action.	d
	on 04/06/2015, obs of the exterior walk creating an uneven way. This deficient pract	veen 9:45 AM and 12:15 PM ervation revealed that several ways have heaved or subsided walking path to the public ice was verified by the tor at the time of the		2. Camilia Rose Care centre has contracted with Minnesota Concrete lifting (612-790-8880) to (a)raise and correct 8 slab sections (b)rip out and replace 2 slab sections. B. 1. Minnesota Concrete Liftir has scheduled to complete work for this project on 5-6-2015. C. 1. Louis Burns, Director of Maintenance will do monthly exterior)g
	inspection.			facility inspections to ensure the integrity of the exterior walkways.	/
K 069 SS=F		FETY CODE STANDARD	K 069		5/12/15
		re protected in accordance 2.6, NFPA 96			
	Based on record re facility's kitchen coor maintained in acco	s not met as evidenced by: eview and interview, the oking equipment has not been rdance with Sec. 9.2.3 and cient practice could affect the		K69 A. Camilia Rose Care Center LLC. Has contracted with HOODZ International (7 -753-3903) to complete UL-300A inspection and testing for the 2nd floor	

Facility ID: 00757

If continuation sheet Page 4 of 6

PRINTED: 04/27/2015 FORM APPROVED OMB NO 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A, BUILDING 01 - MAIN BUILDING 01 245353 B. WING 04/06/2015 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 11800 XEON BOULEVARD CAMILIA ROSE CARE CENTER LLC COON RAPIDS, MN 55448 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 069 K 069 Continued From page 4 kitchen Denlar hood. B. Inspection and testing will be Findings include: completed 4-27-2015. C. Louis Burns, Maintenance Director On facility tour between 9:45 AM and 12:15 PM will set a bi-annual inspection / testing on 04/06/2015, record review revealed that there schedule with HOODZ International on 4is not any documentation of the semi-annual testing of the second floor UL-300A hood system. 27-2015 to ensure proper compliance. This deficient practice was verified by the Maintenance Director at the time of the inspection. 5/12/15 K 076 K 076 NFPA 101 LIFE SAFETY CODE STANDARD SS=F Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, the facility K76 A. 1. A Policy and Procedure has been failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice created for the Storage and use of oxygen tanks while inside Camilia Rose Care could affect the residents. Center LLC. 2. E cylinder racks have placed in the Findings include: oxygen storage room and empty tank During facility tour on between 9:45 AM and room.

FORM CMS-2567(02-99) Previous Versions Obsolete

Facility ID: 00757

If continuation sheet Page 5 of 6

PRINTED: 04/27/2015

		AND HUMAN SERVICES & MEDICAID SERVICES				: 04/27/201 APPROVE . 0938-039
TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DAT COM	E SURVEY
		245353	B. WING		04/	/06/2015
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE	
CAMILIA	ROSE CARE CENTE	RLLC		11800 XEON BOULEVARD COON RAPIDS, MN 55448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
K 076	that: 1. There are (2) E-(resident room 213 - oxygen tank, 2. There is a 41L lic in the linen room ac room on the first flo 3. There are severa the oxygen storage secured. These deficient pra	/2015, observation revealed Cylinders being stored in next to the resident's 41L liquid quid oxygen tank being stored djacent to the oxygen storage	K 07			

Facility ID: 00757

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted April 15, 2015

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

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5353024

Dear Mr. Broman:

The above facility was surveyed on March 30, 2015 through April 2, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

Camilia Rose Care Center Llc April 15, 2015 Page 2

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

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

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

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

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

Please feel free to call me with any questions.

Sincerely,

ate Comston

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

Minnesc	ta Department of He	alth				
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00757	B. WING		04/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULEV PIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the defic herein are not corrected shall with a schedule of f the Minnesota Depa Determination of wh corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm. The Sta delineated on the a	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf te licensing orders are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE		(X6) DATE 04/24/15

STATE FORM

If continuation sheet 1 of 44

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED	
		00757	B. WING		04/02/2015		
	PROVIDER OR SUPPLIER				04/	02/2015	
	PROVIDER OR SUPPLIER		DRESS, CITY, S				
AMILIA	ROSE CARE CENTE	RILC	APIDS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC\	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE	
2 000	Continued From pa	ige 1	2 000				
	you electronically. is necessary for Sta enter the word "corr text. You must then State licensure proo completion date, th corrected prior to e Minnesota Departm On 3/30/15 to 4/2/1 Department's staff, the following correct Please indicate in y correction that you and identify the dat Minnesota Departm the State Licensing federal software. Ta assigned to Minnes Nursing Homes. Th appears in the far le Tag." The state stat listed in the "Summ column and replace the correction order the findings which a statute after the stat as evidence by." Fo are the Suggested Time period for Cor PLEASE DISREGA FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE THIS WILL APPEA THERE IS NO REC PLAN OF CORREC	5, surveyors of this visited the above provider and ction orders are issued. rour electronic plan of have reviewed these orders, e when they will be completed. nent of Health is documenting Correction Orders using ag numbers have been sota state statutes/rules for he assigned tag number eff column entitled "ID Prefix atute/rule out of compliance is hary Statement of Deficiencies" es the "To Comply" portion of r. This column also includes are in violation of the state tement, "This Rule is not met blowing the surveyors findings Method of Correction and rrection. NRD THE HEADING OF THE					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY
		00757	B. WING		04/02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULE APIDS, MN 3		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)	(X5) COMPLET DATE
2 560	Continued From pa	ige 2	2 560		
2 560	MN Rule 4658.040 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		5/12/15
	objectives and time long- and short-terr and mental and psy identified in the con assessment. The of must include the im- required by Minnes subdivision 14, para This MN Requirem by: Based on observati review, the facility f comprehensive car resident's assessed (R99, R15) reviewe	ent is not met as evidenced ion, interview, and document		Corrected.	
	12/16/14, included impaired vision, sev mild mood indicator preferences for dai very important to hi most activities of da balance, use of an including cancer ar breath, oral/dental s and he had skin tea the following Care (which were comple cognitive loss/deme	inimum Data Set (MDS) dated he had difficulty with hearing, vere cognitive impairment, rs, rejection of cares, he had ly care and activities that were m, limited assistance with aily living (ADL's), unsteady indwelling catheter, diagnoses of pneumonia, shortness of status had not been assessed ars. The MDS triggered out Care Assessments (CAA) ted by the facility on 12/22/14: entia, visual function, nary incontinence/indwelling			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	Continued From pa	age 3	2 560			
	behavioral symptom dehydration/fluid m	chosocial well-being, ms, falls, activities, and aintenance. The MDS these areas had been s care plan.				
	included check box assistance for dres walking and wheeli staff on how much needs R99 had in t Care Plan also indi and a lower partial vision and commun	Care Plan dated 12/9/14, tes indicating that R99 needed ssing, grooming, transferring, ng. However, it failed to direct assistance, or any special these areas. The Temporary cated R99 had his own teeth was missing, his hearing, nication were normal, which the MDS information.				
	included, a generic not specific to R99 which were indicate Care Plan also ado dehydration risk. T	are Plan dated 12/19/14, a activities care plan that was 's interests and preference ed on the MDS. The electronic dressed nutrition, but not a These were the only two leted on the electronic care				
	identified care plan CAA, neither R99's electronic Care Pla on how to care for loss/dementia, visu urinary incontinenc	MDS dated 12/16/14, ning was completed for each s Temporary Care Plan or ins addressed, or directed staf R99, in regards to cognitive ual function, communication, e/indwelling Foley catheter, being, behavioral symptoms, dehydration/fluid	f			
	director of nursing	on 4/2/15, at 1:30 p.m. the (DON) stated each resident prehensive care plan				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BLIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 560	completed within 2 had not been done been routinely com residents. She was recently been appro- hours so that care A facility Care Plan identified a residen developed, "21 d [Resident Assessm on the 14th day, B. if done earlier than plan "needs to be u clients care/condition R15's significant ch (MDS), dated 1/28/ and long term men supervision with as R15's care plan, da problem of being a greater than 25% of directed to provide	1 days of admission, but this for R99. The nurses had not pleting care plans for s aware of this and had oved to add additional nursing plans could be completed. s policy, dated 8/2010, t care plan should be ays after admission in the RAI nent Instrument] is completed 7 days after completion of RAI 14th day." Further, the care up to date and reflect the on at all times."	2 560			
	weekly weights and plan also identified loss/dementia with related to memory were directed to "p PRN [as needed]" needs-inquire with indication in the ca	d offer substitutes. The care a problem of cognitive impaired decision making and judgment deficits. Staff rovide cues and reminders				
		of the evening meal service, p.m., R15 was seated at a				

	ota Department of He		T			
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _			E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	A ROSE CARE CENTE	RIIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 560	table and received a kernel corn, small c with shredded lettur and spoon were sitt plate. R15 began to using her fingers, si corn on the floor as Nursing assistant (f walked by the table or cued R15 to use continued to eat the fingers. She spilled the contents of the was finished with he When interviewed of registered nurse (R feed herself often v "she is a complex p R15's care plan sho assistance that she During interview on stated a care plan " since late 2014 the "zero" involvement process. Further, F identified how much eat her meals, "We the flow [of the care A facility Care Plan a purpose of, "ass optimal wellness ba Assessment." A pro follow, and identified be identified on a re policy added, "Ca	a plate of food consisting of liced fruit bowl, and a soft taco ce and cheese on top. A fork ting on the table next to her o pick up pieces of kernel corn pilling a large amount of the she attempted to eat it. NA)-D, NA-E, and NA-F and did not offer assistance, the provided utensils. R15 e corn, and diced fruit with her the taco, and began eating taco with her fingers until she er meal at 5:47 p.m. on 4/2/15, at 10:19 a.m. N)-B stated R15's ability to aries from day to day adding, person." Further, RN-B stated ould have identified the level of required for eating. 4/2/15, at 2:51 p.m. the DON drives resident care," and facility's MDS nurse had with the care planning R15's care plan should have n assistance she required to 've had a real problem with		DEFICIENCY		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/201	
AME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
AMILIA	ROSE CARE CENTE	BIIC	EON BOULE\ APIDS, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLE DATE
2 560	Continued From pa	ige 6	2 560			
	The director of nurs inservice staff rega	THOD OF CORRECTION: sing, or designee, could rding development of the and then audit to ensure				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 565	MN Rule 4658.040 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			5/12/15
		omprehensive plan of care I personnel involved in the t.				
	by: Based on observative review, the facility for the facility of the facility for the faci	ent is not met as evidenced ion, interview, and document ailed to ensure timely re planned for 2 of 3 residents ed for activities of daily living. lity failed to ensure care plan followed to reduce the risk of ents (R9) reviewed for		Corrected.		
	2/26/15, identified F assistance of two s and repositioning. 3/25/14, identified F	imum Data Set (MDS) dated R97 required extensive taff to complete bed mobility R97's care plan, dated R97 was at risk for skin ed an intervention of, "Turn				

STATEMEN	Dita Department of He NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00757	B. WING		04/	04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	age 7	2 565				
	and reposition ever	ry 2 hours with assist of 1."					
	a.m. until 9:50 a.m. was observed to be 9:24 a.m., nursing room to see if R97	eservation on 4/1/15, from 7:00 . (2 hours and 50 minutes) R9 e laying on her back in bed. At assistant (NA)-A entered the was wake, and finding she e head of the bed (HOB) dowr	7				
	at 9:50 a.m., that F repositioned every care plan. RN-C, si shift report sheet th document when RS last time this was d	two hours as directed by the tated after reviewing the night nat the prior shift did not 97 was last repositioned. The locumented was on the relief efore at 10:45 p.m., 11 hours					
	NA-A, stated she w last been turned, w her from the night s	v on 4/01/15, at 10:05 a.m., vas unaware when R97 had vhile nothing was reported to shift. NA-A then assisted R97 and examined her coccyx with					
	registered nurse (F started a new shift information on resi repositioning could been completed for	n 04/01/2015, at 1:31 p.m. RN)-B stated the facility had reporting sheet, so that dents' need, such as last be followed, but this had not r R97. Further RN-B stated een repositioned every two ned.					
	R65 had intact cog assistance with be	DS, dated 1/19/15, identified nition, required extensive d mobility and transfers, and breakdown. R65's care plan,					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00/3/		B. WING	B. WING		02/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	Continued From pa	age 8	2 565			
	breakdown, and lis	ntified she was at risk for skin ted an intervention of, "Turn ry hour as res. [resident]				
	6:51 a.m. R65 was (less than 15 degre remained in her be 7:45 a.m. when NA the head of the bed or 3 inches) pulled NA-H completed R exercises, however R65 in the bed, and R65 then remained she was assisted to have her incontinen R65 was not off loa	servation starting on 4/1/15, at lying in bed positioned slightly bes) on her left side. R65 d, in the same position until A-H entered the room lowered d and slightly (approximately 2 the draw sheet towards her. 65's range of motion r did not off load or reposition d left R65's room at 8:00 a.m d in bed until 8:38 a.m. when o roll onto her right side to nce product removed by NA-I. aded or repositioned r tissue perfusion to her coccyx ninutes.				
	stated she thought repositioned every tries to follow a res it as closely as I ca at 12:12 p.m. NA-H to be repositioned of	on 4/1/15, at 9:11 a.m. NA-I R65 should be offered two hours, and that she always idents care plan, "I try to follow n." During interview on 4/1/15, I stated she thought R65 was every 2 hours, and verified she 5's during her range of motion at morning.				
	stated R65 was at should be repositio	n 4/1/15, at 2:42 p.m. RN-B risk for pressure ulcers, and ned every hour according to ler care plan states every				
		on 4/2/15, at 2:51 p.m. the plan "drives resident care,"				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 565	Continued From pa	age 9	2 565			
	and the expectation staff.	n is they are followed by the				
	R9 had moderately required extensive, transferring, and to 3/30/2015, identifie fall-related injures a prevent falls, amon of 1 to 2 persons) v and "Do not leave r unattended."	5, dated 1/20/2015, identified impaired cognition, and physical assistance for ileting. R9's care plan, dated d the goal of not having any and listed interventions to g which included "A1-2 (assist with all transfers and mobility," resident in bathroom alone or				
	NA-G entered R9's and begin routine n R9 into the bathroo transfer onto the to to help a co-worker some linens" to ren bathroom alone at minutes later), NA- bed linens and proo NA-G was out of R 9:04 a.m. (9 minute until 9:07 a.m. (3 m room, but not prese During the entire tw the bathroom, he re and made no attern or otherwise move	on 4/1/2015, at 8:44 a.m. room to assist him out of bed, norning cares. NA-G assisted om, and provided assistance to ilet. NA-G stated she needed "for a little bit and bring back nake his bed, and left R9 in the 8:55 a.m. At 9:04 a.m., (9 G returned to R9's room with ceeded to make his bed. 9's room from 8:55 a.m. to es); however, from 9:04 a.m. hinutes), NA-G was in R9's ent with him in the bathroom. velve minutes R9 was alone in emained seated on the toilet, nots to stand up, self transfer, out from the room. Upon hom, NA-G assisted R9 to get <i>X</i> .	•			
	NA-G verified she I bathroom" when sh co-worker, and also	on 4/1/2015 at 9:13 a.m., eft "[R9] alone in the briefly helped out a b left him alone while she G said she left R9 alone so				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RILC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 565	stated she knew [R was known to self t During an interview registered nurse (F for falls, and had a new intervention fo recently been adde leave him unattend said the new interve identified on the aid not been completed When interviewed of director of nursing	ne privacy." Further, NA-G 9] had a recent fall, and he				
2 830	director of nursing, staff regarding the plan, and then audi TIME PERIOD FOI (21) days. MN Rule 4658.052 Proper Nursing Car Subpart 1. Care in receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nurs of bed as much as	THOD OF CORRECTION: The or designee, could inservice purpose of a resident care t to ensure compliance. R CORRECTION: Twenty-one O Subp. 1 Adequate and re; General general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the	2 830			5/12/15

Minnesc	ta Department of He	alth			1 01 101	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00757	B. WING		04/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	ON BOULE APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From par resident must remain prefers to remain in This MN Requirement by: Based on observation review, the facility for assess and implement the risk of falls for for reviewed for accide In addition, the facili four-wheeled walked device, which the more recommended for use observed to use su Finding include: FALLS RISK R9's diagnoses, as orders dated 2/22/2 dementia, congestin The quarterly Minim	ge 11 in in bed or the resident	2 830			
	physical assistance A care area assess 8/8/2014, indicated due to a high fall-ris one resulting with a identified additional risk, including: use	that he needed extensive, for transferring, and toileting. ment (CAA) for falls, dated R9 was at high risk for falls, sk score, and a history of falls, hip fracture. The CAA further factors, increasing R9's fall of anti-depressant and medications, incontinence,				
	hearing impairment impairment. R9's care plan (CP)	, as well as cognition , updated 3/30/2015,				
Vinnesota D STATE FORI	epartment of Health VI		6899 V	NOCL11	If continuatio	n sheet 12 of 44

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	identified the goal, t fall-related injuries of R9 would use their instead of self trans numerous intervent which directed staff persons) with all tra not leave resident in unattended." During observation nursing assistant (N assist him out of be cares. After putting feet, then assisting of the bed, NA-G, w waist, assisted him the wheel chair. NA bathroom, and then transfer onto the toi to help a co-worker some linens" to rem at 8:55 a.m., exited minutes later), NA-G clean bed linens an a.m., NA-G remove shirt out of the close bathroom, asking F wanted to wear. NA R9's room and site minutes); however, (3 minutes) NA-G w present with him in entire twelve minutes bathroom, he rema made no attempts to otherwise move out	hat R9 would not have any while at the nursing home, and call light for assistance, aferring. The CP listed ions to prevent falls, among to "A1-2 (assist of 1 to 2 insfers and mobility," and "Do n bathroom alone or on 4/1/2015 at 8:44 a.m., IA)-G entered R9's room to id, and begin routine morning shoes over R9's socks and him to sit upright on the side <i>vi</i> th a transfer belt around his to stand, pivot, then sit into A-A pushed R9 into the provided him assistance to let. NA-G told R9 she needed "for a little bit and bring back nake his bed and left the room R9's room. At 9:04 a.m., (9 G returned to R9's room with d made R9's bed. At 9:07 d two pairs of pants and a et, then re-entered the 19 which pair of pants he A-G was completely out of from 8:55 a.m. to 9:04 a.m. (9 from 9:04 a.m. until 9:07 a.m. vas in R9's room, but was not the bathroom. During the es R9 was alone in the ined seated on the toilet, and o stand up, self transfer, or from the room. Upon return A-G assisted R9 to complete				

B. WING STREET ADDRESS, CITY, S' 11800 XEON BOULEVA COON RAPIDS, MN 55 DIES ID PREFIX TAG	TATE, ZIP CODE	04/02/2015
11800 XEON BOULEVA COON RAPIDS, MN CIES BY FULL WATION)	TATE, ZIP CODE ARD 5448 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
COON RAPIDS, MN 55 DIES ID BY FULL PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
CIES ID BY FULL PREFIX MATION) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	
0.000	DEFICIENCY)	COMPLET DATE
2 830		
13 a.m., one in the worker, and s bed. Duld have aware [R9] own to self dicated R9 3/16/15 and IDT) dated on 3/16 tempting to le table. rganization n isolated 00 days. Will d 4/1/2015, ndicated ilet and . was #9,10,11. tiff to offer ites during g in TR or dining, as needed] serve for g." 36 p.m., was at risk re 'triggered' o stated that		
	s bed. buld have aware [R9] win to self dicated R9 3/16/15 and IDT) dated on 3/16 tempting to e table. rganization isolated 0 days. Will 4 4/1/2015, indicated ilet and was #9,10,11. tif to offer tes during in TR or dining, as needed] serve for g." 36 p.m., was at risk re 'triggered'	s bed. build have aware [R9] wrn to self dicated R9 3/16/15 and IDT) dated on 3/16 tempting to e table. rganization n isolated 0 days. Will 4/1/2015, ndicated ilet and was #9,10,11. iff to offer tes during i n TR or dining, as needed] serve for g." 36 p.m., was at risk r e 'triggered' o stated that he hospital, storative

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED		
		00757	B. WING		04/	02/2015		
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE				
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BI				TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	they initiated having "every 30 minutes, assistance," and th before he goes." F had "a history of se increased his fall ri intervention for R9' added to the care p him unattended in f the new interventio care sheets, but "th nurse aide care she said "I get to own th In an interview on 4 director of nursing leaving R9 unatten present in a resider balance between p resident." The DO would "expect" a resident balance between p resident." The DO would "expect" a resident hat fallen in the lass with a fracture and without injury. R1's indicated she had to	g staff check on him every and offer him toileting hat "we are trying to catch him RN said she was very aware RS elf transferring," which sk. RN also said a new 's fall prevention was just blan, and that was "not to leave the bathroom." RN-B said she on was not part of the aide's hat it should have added." The eets were not updated. RN-B						
procoto D	incontinent of urine R1's care plan date							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
AMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE
2 830	Continued From pa	age 15	2 830			
		he care plan directed staff to ssistance per individualized				
	a.m. nursing assist assist R1 onto the incontinence and le she gathered cloth returned to the bat stated she (R1) ha	and interview 4/1/15, at 7:55 cant (NA)-B was observed to toilet removed her soiled eft R1 alone on the toilet while ing from the closet and hroom to assist R1. NA-B s had several falls from herself to the bathroom.				
	12/23/14, indicated incontinence, histo hospitalized and se identified she had f to self transfer to th Observation dated fallen in the last 30 that she was at hig with current plan of history of falls befo her admission a far	a assessment (CAA) dated I she had memory impairment, ry of falls at home and was ent to the facility. The CAA fallen at the facility attempting he toilet. A Fall Risk 3/15/15, indicated she had days, had loss of balance and h risk for falls and to continue f care. Although R1 had a re admission and falls since cility had not completed a fall htil 3/15/15, three months after icility.				
	indicated the follow R1 had a fall 12/12 found on floor near alarm was added. R1 had fall 12/22/1 floor next to bed af tab alarm in room, R1 had a fall 1/14/ self transfer to toile	4/14, at 9:00 p.m. resident was the foot of her bed and a tab 4, at 8:02 p.m. was found on ter apparent self transfer no tab alarm added. 15, at 3:30 p.m. attempted to et tab alarm did not work ded to wheelchair and bed.				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 16	2 830			
	staff to bring to nur change. R1 fall 1/26/15 at 8 floor in bathroom a use the restroom. R1 had fall 3/11/15 on floor in bathroor Review of the falls occurred while R1 attempting to self tu indicated four of th p.m. to 9:00 p.m. a occurred between a was no indication tu falls to determine it though six falls occu attempting to self tu	neelchair brakes broke and reses station during shift 2:00 p.m. resident found on and stated she was going to , at 8:20 p.m. resident found m between sink and toilet. indicated four of the six falls was in the bathroom ransfer. The review also e falls occurred between 8:00 and the remainder two falls 3:00 p.m. and 3:30 p.m. There he facility had analyzed R1's f there was a pattern, even curred while in the bathroom or ransfer. 2/15, at 2:04 p.m. RN-B stated t R1 had multiple falls and				
	stated she did not of Observation upon a she stated "I misse had a 72 hour blad admission (a test to incontinence) and a was decided due to indicated and that a to say they should incontinence close established a indivi prevent some her i transfers.	complete a Fall Risk admission and should have ed it". RN-B then stated R1 der study completed upon o determine a pattern of according to the assessment it o her dementia no plan was another . RN-B then went on have looked at her r and maybe they could have idualized toileting plan to ncontinence and falls from sel				
	11/12/14, indicated be reviewed by the	ent Review Process dated I "Incident/Accident reports will I interdisciplinary Team (IDT), Il participate in the investigative				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	age 17	2 830			
	process, root cause of appropriate inter	e analysis, and determination ventions.				
	to self transfer to th comprehensively a if there was pattern	allen multiple times attempting ne toilet the facility failed ssess these falls to determine n related to her urinary mplement interventions to help				
	FOUR WHEELED TRANSPORTATIO					
	orders dated 3/26/2 disease, paralysis, degeneration. The (MDS) dated 1/16/2 moderate cognitive extensive assistant	as identified on the physician's 2015, included Parkinson's generalized pain and macular admission Minimum Data Set 2015, identified R69 had impairment, and required ce of one person for lized a wheel chair and walker				
	daily living (ADLs), R69 had a decline and hospital stay, v and functional decl R69 was participati she was at risk for updated 3/1/15 ide and directed staff " not to ambulate/tra	essment (CAA) for activities of dated 1/16/2015, indicated in ADLs related to pneumonia which resulted in weakness ine. The CAA also indicated ing in skilled rehab, and further falls. R69's care plan (CP) las ntified she was at risk for falls, Give resident verbal reminders nsfer without SBA 1 [stand-by m] and 4WW [four-wheeled	t			
	R69 had a gait belt	on 3/31/2015 at 10:07 a.m., around her waist standing om door. Her hands on the				

	Ita Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
IAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	ATE, ZIP CODE		
		11800 XE	ON BOULEVA	RD		
AMILIA	ROSE CARE CENTE	COON R	APIDS, MN 55	448		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	nge 18	2 830			
	handle bar grips of walker (FWW), and standing next to he FWW, and NA-C p seated looking forw room, past the nurs Cafe. Once in the stand, transfer into belt after R69 was remained parked no breakfast. In an interview on 3 nursing assistant (N from her room to be use the [four wheel sometime request ther, but has asked pushed. NA-C state four-wheeled walked time." NA-C said F	a Nova brand, four-wheeled d nursing assistant (NA)-C was r. R69 sat on the seat of the roceeded to pushed R69, who vard in the FWW from her sing station, and into the Rose cafe, NA-C assisted R69 to a chair and removed the gait seated in the chair. The FWW ext to R69 as she ate B/31/2015 at 11:21 a.m., NA)-C stated she pushed R69 reakfast in the Cafe. "[R69] will ed] walker to walk," and to use a wheel chair to push to sit in the walker and be ed "Today I pushed her in the er," and "I don't do that all the R69 usually "needed stand by				
	information guide, ' 2014, indicated "Se Do no ambulate or seated." Further th is a walking aid only transportation device During an interview registered nurse (R policy to transport r walker, and that pra RN-B also stated (F updated, to include	y on 4/1/2015 at 12:56 p.m., RN)-B stated it was not facility residents using a four-wheeled actice "was not condoned." R69's) care sheet could be a reminder of appropriate that some "education and				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE		EON BOULEVA RAPIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE	(X5) COMPLET DATE
2 830	Continued From pa	age 19	2 830			
	residents that way.	n				
	director of nursing should be transport walker. The DON s should not have be A facility policy rega	4/2/2015 at 2:23 p.m., the (DON) stated no residents ted using a four-wheeled said "This is not safe, and en done." arding safe resident requested, but none was				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9			
	The director of nurs and revice policies falls, and accident l could provide staff of resident related t The director of nurs	THOD OF CORRECTION: sing or designee, could review and procedures related to hazzard assessments. They education related to the care to falls and accident hazzards sing or designee could develo ure appropriate care is				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			5/12/15
	comprehensive res of nursing services	sores. Based on the ident assessment, the directo must coordinate the jursing care plan which	r			
	without pressure s pressure sores unle	o enters the nursing home ores does not develop ess the individual's clinical rates, and a physician				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	EON BOULE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 20	2 900			
	authenticates, that	they were unavoidable; and				
	receives necessar	who has pressure sores y treatment and services to revent infection, and prevent veloping.				
	by: Based on observat review, the facility f repositioning to red	ent is not met as evidenced ion, interview, and document failed to complete timely luce the risk of pressure ulcer residents (R97, R65) ure ulcers.		Corrected.		
	Findings include:					
	Findings include: R97's quarterly Minimum Data Se 2/26/15, identified R97 had no cu ulcers, and required extensive as staff for bed mobility and reposition Pressure Ulcers Care Area Assess dated 6/07/14, indicated " assist of mechanical lift to transfer; turns s A2 [assist of 2] staff."	R97 had no current pressure d extensive assistance of two ty and repositioning. R97's are Area Assessment (CAA), cated " assist of 2 with ansfer; turns side to side with				
	a.m until 9:50 a.m. was observed to be 9:24 a.m., nursing room to see if R97	servation on 4/1/15, from 7:00 (2 hours and 50 minutes), R9 e laying on her back in bed. At assistant (NA)A entered the was wake, and finding that ed the head of the bed (HOB)	7			
	at 9:50 a.m., that R repositioned every care plan. RN-C, st	RN)-C, stated on 04/01/2015 197 should of been two hours as directed by the tated after reviewing the night nat the prior shift did not				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			02/2013
-	ROSE CARE CENTE	11800 XI	EON BOULEVA			
		COON R	APIDS, MN 55	5448		1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 900	Continued From pa	age 21	2 900			
	last time this was c	97 was last repositioned. The documented was on the relief efore at 10:45 p.m., 11 hours				
	stated that the nigh when R97 has last	n 4/01/15 at 10:05 a.m., NA-A ht shift had not informed her of been turned. NA-A then turned examine the resident's coccyx, hted.	k			
	Review of R97's C Tissue Tolerance a identified an area Points and that aft redness noted ove facility checked "no this document ider intervention plan",	amilia Rose Care Center assessment, dated 03/07/14, of Bed Evaluation of Pressure er lying for 2 hours, "was r bony prominence." The b." The Intervention section of atified to "Select the which was left blank. There of how frequent R97 needed to				
	used to determine	aden Scale score form, (a form pressure ulcer risk) identified f 13 (13-14 moderate risk) for f pressure ulcers.				
	of 3/25/14), the fac at risk for skin irrita decreased mobility and bladder, and p (PVD). The interve	care plan (problem start date ility identified the resident was ation/breakdown related to r, incontinence of both bowel eripheral vascular disease ntions directed staff that R97 and reposition every 2 hours				
	registered nurse (F	n 04/01/2015 at 1:31 p.m., a RN)B stated the facility had reporting sheet, so that				

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 900	repositioning could done. RN-B stated repositioned every is care planned. The facility's policy, Care Protocol (date facility would be util Braden Scale, Skin Tolerance Observat Breakdown Observ indicated: "The corr develop and implen care" and further de treatments and mod R65's quarterly MD R65 had intact cog assistance with bec was at risk for skin assessment, dated "open area on cocc of, "Staff to continue R65's care plan, da at risk for skin brea intervention of, "Tur res. [resident] allow During constant obs 6:51 a.m. R65 was (less than 15 degre the use of a pillow of remained in her beo 7:45 a.m. when NA	dents' need, such as last be followed, and this was not that R97 should have been two hours as assessed and entitled: Skin and Wound ed 4/24/14) indicated that the lizing tools such as: the Risk Assessment, Tissue tions and weekly Skin rations. This document further npleted tools will be used to nent and individualized plan of escribed interventions, nitoring systems. S, dated 1/19/15, identified nition, required extensive d mobility and transfers, and breakdown. R65's Skin 1/29/15, identified R65 had ar eyx", and listed an intervention e to offer hourly repositioning.' ited 1/19/15, identified she was kdown, and listed an rn and reposition every hour as		DEFICIEN	ΟΥ)	

STATEMEN	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
	 2 900 Continued From page 23 R65's room at 8:00 a.m R65 then remained in bed without being repositioned until 8:38 a.m. 1 hour and 37 minutes later, when NA-I. assisted her to roll onto her right side during morning cares. R65 was observed to have a small open area on her coccyx, with minor redness around the site. When interviewed on 4/1/15, at 9:11 a.m. NA-I stated she thought R65 should be offered repositioned every two hours, and that she always trian to follow. 					
	it as closely as I ca at 12:12 p.m. NA-H to be repositioned stated she did not area during her ran that morning.	idents care plan, "I try to follow in." During interview on 4/1/15 I stated she thought R65 was every 2 hours, and further off load R65's from her coccyx inge of motion exercises earlier	,			
	stated R65 admitte (full thickness skin necrosis of subcuta on her coccyx, whi to remain at risk fo Further, R65 shoul	n 4/1/15, at 2:42 p.m. RN-B ed to the facility with a stage III loss involving damage to, or aneous tissue) pressure ulcer ch has improved but continues r pressure ulcer development. d have been completely r coccyx every one hour as e plan.				
		on 4/2/15, at 2:51 p.m. the lent's care plan should be				
nnosota D	dated 4/24/14, ider appropriate care an skin [sp] breakdow the individualized of identified, "Nursing	Wound Care Protocol policy, ntified, "Staff will provide and services to reduce the risk n or other wounds according to care plan." Further, the policy interventions may nd repositioning per care				

Minneso	ta Department of He	alth			_	
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00757	B. WING		0.4/0	
		00757			04/0	2/2015
NAME OF F	PROVIDER OR SUPPLIER					
CAMILIA	ROSE CARE CENTE	RIIC	ON BOULEV APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 24	2 900			
	plan"					
	SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding helping resident to complete timely repositioning to prevent pressure ulcers, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one					
	11ME PERIOD FOF (21) days.	CORRECTION: Twenty-one				
2 910	MN Rule 4658.0528 Incontinence	5 Subp. 5 A.B Rehab -	2 910			5/12/15
	have a continuous prevent unnecessary use of comprehensive restrictions home must ensure A. a resident without an indwelling unless the resident that catheterization B. a resident what receives appropriate prevent urinary traces.	nce. A nursing home must brogram of bowel and bladder luce incontinence and the catheters. Based on the ident assessment, a nursing that: ho enters a nursing home g catheter is not catheterized s clinical condition indicates was necessary; and ho is incontinent of bladder e treatment and services to t infections and to restore as er function as possible.				
	by: Based on observati review, the facility fa assess and implem	ent is not met as evidenced on, interview, and document ailed to comprehensively ent interventions to reduce e for 1 of 3 residents (R1)		Corrected.		

STATE FORM

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BLIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 25	2 910			
	reviewed and who	was incontinent of urine.				
	Findings include:					
	12/18/14, identified cognitively impaired one with transfers, of urine, however d R1's quarterly MDS had a change and of urine, but did not R1's care plan date of urinary incontine "Assist to toilet Q [e [night] rounds and I During observation a.m., nursing assiss incontinent product During an interview NA-B stated she ty and if R1 is sleepin	himum Data Set (MDS), dated R1 was moderately d, required extensive assist of was occasionally incontinent lid not have a toileting plan. S, dated 3/19/15, identified she was now frequently incontinent t have a toileting plan in place. ed 1/2/15 identified a problem ent and staff were directed to every] 2 hours, with NOC PRN [as needed]." of care on 4/01/15 at 7:55 tant (NA)-B removed R1's t which was soiled with urine. of 04/02/15 at 1:53 p.m., pically works on the day shift ig when she gets here, she will tinent in the morning.				
	Collection (a form u incontinence over 7 12/12/14-12/14/14, incontinent episode Bowel and Bladder thru 1/31/15, identif 32 opportunities du left blank. During t continent 27 out of the night was contin with 3 shifts being I voided 12 times on	wel and Bladder 72-Hour Data used to monitor urinary 72 hours), dated identified R1 had two es for the period. An additional collection sheet dated 1/28 fied R1 was continent 13 out of uring the day shift with 14 shifts he evening shift R1 was 32 opportunities, and during nent 20 out of 32 opportunities left blank. During this time R1 the toilet/bedpan and was ese times. Although R1 had a				

	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	evening and day sh The facility had not data to determine a to help improve R1 Review of the Point Category Report fro identified R1, was of opportunities during opportunities for the continent 0 of 9 opp Review of R1's qua dated 3/18/15, iden incontinence, impai appropriate for toile to her dementia. Ev data from 2/28/15 t of being more conti day shift hours, whi December 2014 Bo Collection sheet, w twice. When interviewed or registered nurse (R protocol for residen collection done ann would do a deeper stated R1 was able toileting but this wa During interview on stated R1's Bladdel been completed up not been. Further, F have reviewed R1's and put her on a m	hifts, and voided on the toilet. completed an analysis of the a specific toileting plan for R1 's bladder continence. t of Care Bowel/Bladder om 2/28/15 through 3/21/15 continent 10 out of 22 g the day shift; 20 out of 22 e evening shift, and was cortunities for the night shift. Arterly Bladder Observation, tified R1 had urge and stress ired mobility, and was not eting program or retraining due ven though the point click care o 3/21/15 identifies a pattern inent during the evening and ich was a change from the owel and Bladder 72-Hour Data here she was only incontinent on 4/02/2015, at 10:03 N)-B stated the facility it bladder assessment is 3 day mually, and "as a practice we investigation." Further, RN-B to verbalize her need for	2 910	DEFICIENC		

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00757	B. WING		04/02/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 910	Continued From pa	age 27	2 910			
	occasionally to free could verbalize her failed to assess for R1's increased inco- plan to help reduce A facility Guidelines Bowel Assessment identified it, "Direct able to maintain the toileting function ar individualized toilet full assessment is a admission, quarter significant change Bladder and Bowel	ntinence went from quently incontinent, and R1 need for toileting. The facility patterns and the cause of ontinence and implement a e her incontinence episodes. s for Client's Bladder and t policy, dated 3/13/15, s staff to ensure clients are eir highest practicable level of nd to develop and ing plan of care." Further, "A to be completed upon ly, annually and with a of condition using a 72 hour Data collection sheet, Bowel sis and summary of data."				
	The director of nurs inservice staff rega residents with incon ensure compliance	THOD OF CORRECTION: sing, or designee, could rding the assessment of ntinence, and then audit to a. R CORRECTION: Twenty-one				
2 915	. , -	5 Subp. 6 A Rehab - ADLs	2 915			5/12/15
	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities	of daily living. Based on the ident assessment, a nursing				

STATE FORM

If continuation sheet 28 of 44

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED 04/02/2015	
		00757	B. WING			
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE ((X5) COMPLET DATE
2 915	Continued From part the resident's condi- part, activities of daresident's ability to: (1) bathe, dress (2) transfer and (3) use the toil (4) eat; and (5) use speech functional communant by: Based on observation review, the facility fr and cues for eating required staff assiss Findings include: R15's significant chr (MDS), dated 1/28/ and long term mem supervision with as R15's care plan, date	age 28 ition. For purposes of this ally living includes the ss, and groom; id ambulate; let; h, language, or other ication systems; and ent is not met as evidenced ion, interview, and document alled to provide supervision to 1 of 4 residents (R15) who	2 915			
	directed to monitor weekly weights and plan also identified loss/dementia with related to memory					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING	B. WING		02/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
		11800 XE	EON BOULEVA	ARD		
SAMILIA	ROSE CARE CENTE	COON R	APIDS, MN 55	5448		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T		COMPLE DATE
IAG			IAG	DEFICIENC		
2 915	Continued From po	20	2 915			
2915	Continued From pa	ige 29	2 915			
		of the evening meal service,				
		p.m., R15 was seated at a				
		or dining room with two other				
		a clothing protector around				
		ered her shirt. She was				
		od consisting of kernel corn,				
		wl, and a soft taco with				
		nd cheese on top. A fork and				
		on the table next to her plate.				
		up pieces of corn using her				
		rge amount of the corn on the				
		ted to eat it. Nursing assistan NA-F walked by the table and				
		ance, or cues to use the				
		R15 who continued to eat the				
		ers, spilling on her lap and the	,			
		the soft taco at 5:26 p.m. and				
		eat inside using her fingers,				
		eser to the edge of the table as				
		p.m. she then picked up the				
		fruit and began to eat it using				
		ed eating the taco meat from				
	her plate, and then	spilled the plate on her lap at				
	5:30 p.m. R15 pic	ked her plate back up, placed				
	it on the table, and	continued to eat using her				
		neal. Her clothing was now				
		ed soft taco shell, taco meat,				
		p.m. R15 began picking up				
		her lap and eating them with				
	her fingers. Regist					
		ble where R15 was seated at				
		ot offer eating assistance or				
		continued to eat pieces of				
		from her lap with her fingers.				
		sing (DON) approached R15 a	L			
		ed she would "help get her				
		The DON removed the soiled				
		rom R15's lap, and left the				
		was removed from the dining				
	I TOOTTI DY TIN-D al D	:55 p.m., or 35 minutes after				1

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00757	B. WING		04/	04/02/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, ST	TATE, ZIP CODE			
CAMILIA	ROSE CARE CENTE	RILC	ON BOULEVA APIDS, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
2 915	Continued From pa	ge 30	2 915				
	she began eating. No assistance or cues for eating had been offered to R15 during the course of the meal.						
	dining assistant (CI with her fingers, an on the floor "a lot m eat smaller items, a often find items like floor when she is fin	on 4/1/15, at 1:25 p.m. client DA)-A stated R15 often will eat d has been leaving more food nore lately." R15 struggles to and during clean up, staff will e peas and corn left on the nished eating adding, "Maybe take a look at her that way."					
	stated staff should	4/2/15, at 10:06 a.m. NA-B provide R15 with cues to eat, e if she is seen to be meals.					
		on 4/2/15, at 10:19 a.m. RN-B should have been offered with her meal.					
	director of nursing	4/2/15, at 2:51 p.m. the (DON) stated staff should have ince, or at least provided cues to eat her meal.					
	A facility policy on r requested, but non	neal assistance was e was provided.					
	The director of nurs inservice staff rega	HOD OF CORRECTION: sing, or designee, could rding how to assist residents supervision, and then audit to					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					

	ta Department of He	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) DATE SURVEY COMPLETED
		00757	B. WING		04/02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, S	STATE, ZIP CODE	
CAMILIA	ROSE CARE CENTE	RIIC	ON BOULEV		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
21390	Continued From pa	ge 31	21390		
21390	MN Rule 4658.0800	0 Subp. 4 A-I Infection Control	21390		5/12/15
	control program mu procedures which p A. surveillance collection to identify residents; B. a system for control of outbreaks C. isolation and reduce risk of trans D. in-service ed prevention and con E. a resident he immunization progr defined in part 465 procedures of resid the prevention and F. the developr employee health po practices, including defined in part 4658 G. a system for products which affe disinfectants, antise incontinence produce I. methods for a	ealth program including an am, a tuberculosis program as 8.0810, and policies and lent care practices to assist in treatment of infections; ment and implementation of plicies and infection control a tuberculosis program as 3.0815; r reviewing antibiotic use; r review and evaluation of set infection control, such as eptics, gloves, and			

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA RAPIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21390	Continued From pa	age 32	21390			
	other residents in the facility. This had the potential to affect all 75 residents, visitors and staff in the facility. In addition, the facility failed to ensure proper disinfection of a blood glucose monitor for 1 of 1 residents (R75) observed to have their blood glucose tested during the course of the survey. Findings include: LACK OF ANALYSIS IN THE INFECTION CONTROL PROGRAM:					
	December 2014, Ja 2015 had categorie residents name, ur culture, antibiotic, d	thly Infection Control Log for anuary 2015 and February es on the sheet that identified hit, room number, infection, classification, date resolved The following were noted in th Control Logs form:	e			
	indicated they had influenza A and two on the second floor the rooms were in when the symptom	14 Infection Control Data five confirmed cases of o of the suspected cases were r. There was no indication if the same proximity, or if and is resolved. There was no ry regarding the infection	;			
	indicated under typ elevated temperatu the date of onset 1	Monthly Infection Control Log be they had five residents with ures from 99-100 degrees with /29/15, the log did not indicate nism, antibiotic or the date	1			
	indicated they had	5 Monthly Infection Control Log two resident with c-diff e colitis which is a bacteria tha	-			

STATEMEN	Dita Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00757	B. WING		04/02/2015	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BLIC	ON BOULEVA			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21390	Continued From pa	age 33	21390			
	or colon that can be person) the first res date of onset, if wh listing did not identi of the antibiotic and and when. Another was on ceftin (antik did not indicate the onset, organism/cu During interview on Director of Nursing control logs were d in January of 2015. information, try to g sheet reports from check them. She si anything too compl they were trying to (Matrix is the electr used by the facility) trending and analys stated that they loo (Quality Assurance information right aw was requested and During an interview DON stated that the tracking the infectio independently. She admit diagnosis, at hospital acquired a	or of 4/2/15, at 10:20 a.m., the e Clinical Managers are ons on their units e stated that they look at the tempt to look at the "bug" if nd that the symptoms should ern form.				
	registered nurse (F change in resident	y on 4/2/15 at 2:14 p.m., RN)-B stated that if there is a condition she alerts floor staff, by have supplies that they need				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00757	B. WING		04/	02/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULEVA APIDS, MN 55			
(X4) ID	SUMMARY STA			PROVIDER'S PLAN OF	COBBECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
21390	Continued From pa	ige 34	21390			
	and that infection control logs are completed. She stated that the DON was in charge of tracking and trending of infections. A policy labeled Infection Control Surveillance dated 2010 states: The intent of Surveillance is to identify possible clusters, changes in prevalent organisms, or increases in rate of infection in a timely manner. The policy describes the essential elements of surveillance to include the following: standardized definitions and listings of the symptoms of infections, use of surveillance tools such as surveys and data collection templates, walking rounds through out facility, identification of resident populations at risk, identification of the processes or outcomes selected for surveillance, statistical analysis of data that can uncover and outbreak and feedback of results to the primary caregivers so they can continually assess the resident's physical condition for signs of infection. BLOOD GLUCOSE MONITOR DISINFECTION:					
	trained medical ass glucose check. The on and wiped R75's pad. TMA-A pierce exposing blood, and was inserted into the (machine to check removed the test st the strip in a sharps strip from a bottle, a Glucometer. TMA- on R75's right hand then applied it to th	on 4/1/15, at 12:56 p.m. with sistant (TMA)-A doing a blood e TMA-A had a pair of gloves s finger with an alcohol prep ed R75's finger with a lancet d applied it to the test strip that he McKesson Glucometer blood sugar). TMA-A then trip out of the Glucometer, put s container, removed a new and inserted it into the A proceeded to pierce a finger d exposing more blood, and e test strip. TMA-A then and test strip in a sharps				
	container, removed	and test strip in a sharps I the gloves and placed the awer of the medication cart to				

ND PLAN OF CORRECTION IDENTIFICATION NUMBER:				(X3) DATE SURVE COMPLETED	
	00757	B. WING		04/02/201	
PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
ROSE CARE CENTE	BIIC				
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
Continued From pa	age 35	21390			
stated she was una own Glucometer. an outside agency facility a few times. cleaning of the Glu	aware if each resident had thei TMA-A stated she worked for and had only been to the Further, TMA-A stated cometer, "I think they [staff]	r			
director of nursing shared Glucometer formal education of been completed, bu	(DON) stated the facility used r for all the residents. No n cleaning of Glucometer had ut she would speak to staff				
policy, dated 2010,	directed staff to sanitize the	÷			
Glucometer manufa "the meters must disinfected after ev and disinfecting the	acturer's manual, identified, be properly cleaned and ery use", and, "cleaning Meter after each use to				
The director of nurs review/revise polici infection control su collection/analysis,	sing, or designee, could es and procedures for rveillance and data then inservice staff and audit				
	OF CORRECTION PROVIDER OR SUPPLIER ROSE CARE CENTER SUMMARY STA (EACH DEFICIENC) REGULATORY OR L Continued From para be used for other re- her hands after rem During interview or stated she was una own Glucometer. an outside agency facility a few times. cleaning of the Glu use bleach wipes a During interview or director of nursing shared Glucometer formal education or been completed, bu randomly as needed A facility Cleaning a policy, dated 2010, facility Glucometer recommendation. An undated McKess Glucometer manuf "the meters must disinfected after eva and disinfecting the prevent the transm pathogens."	OF CORRECTION IDENTIFICATION NUMBER: 00757 00757 PROVIDER OR SUPPLIER STREET A ROSE CARE CENTER LLC 11800 XI COON R SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 be used for other residents. TMA-A did not wash her hands after removing her gloves. During interview on 4/1/15, at 1:00 p.m. TMA-A stated she was unaware if each resident had thei own Glucometer. TMA-A stated she worked for an outside agency and had only been to the facility a few times. Further, TMA-A stated cleaning of the Glucometer, "I think they [staff] use bleach wipes at the end of the shift." During interview on 04/02/15, at 3:16 p.m. the director of nursing (DON) stated the facility used shared Glucometer for all the residents. No formal education on cleaning of Glucometer had been completed, but she would speak to staff randomly as needed. A facility Cleaning and Disinfecting Blood Glucose policy, dated 2010, directed staff to sanitize the facility Glucometer per manufacturers recommendation. An undated McKesson brand TRUE result Glucometer manufacturer's manual, identified, "the meters must be properly cleaned and disinfected after every use", and, "cleaning and disinfecting the Meter after each use to prevent the transmission of blood-borne	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00757 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STANDARD ROSE CARE CENTER LLC 11800 XEON BOULEV/ COON RAPIDS, MN 55 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG Continued From page 35 21390 be used for other residents. TMA-A did not wash her hands after removing her gloves. 21390 During interview on 4/1/15, at 1:00 p.m. TMA-A stated she was unaware if each resident had their own Glucometer. TMA-A stated she worked for an outside agency and had only been to the facility a few times. Further, TMA-A stated cleaning of the Glucometer, "I think they [staff] use bleach wipes at the end of the shift." During interview on 04/02/15, at 3:16 p.m. the director of nursing (DON) stated the facility used shared Glucometer for all the residents. No formal education on cleaning of Glucometer had been completed, but she would speak to staff randomly as needed. A facility Cleaning and Disinfecting Blood Glucose policy, dated 2010, directed staff to sanitize the facility Glucometer per manufacturers recommendation. An undated McKesson brand TRUE result Glucometer manufacturers' manual, identified, "the meters must be properly cleaned and disinfected after every use", and, "cleaning and disinfecting the Meter after each use to prevent the transmission of blood-borne pathogens." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review/rev	OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: 00757 B. WING *ROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROSE CARE CENTER LLC 11800 XEON BOULEVARD COON RAPIDS, MN 55448 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROVIDER'S PLAN OF (EACH DEFICIENCY WIST BE PRECEDED BY FULL TAG Continued From page 35 21390 be used for other residents. TMA-A did not wash her hands after removing her gloves. 21390 During interview on 4/1/15, at 1:00 p.m. TMA-A stated she was unaware if each resident had their own Glucometer. 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SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review/revise policies and procedures for infection control surveillance and data c	OF CORRECTION IDENTIFICATION NUMBER: A BUILDING: COM 00757 B. WING 04// PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ROSE CARE CENTER LLC 11800 XEON BOULEVARD CONTINUER OF DEFICIENCY MUST BE PRECEDED BY FULL ID REQUEATORY OR LSC IDENTIFYING INFORMATION) ID PRECEDUATORY OR LSC IDENTIFYING INFORMATION) ID PRECEDUATORY OR LSC IDENTIFYING INFORMATION) PRECEDUATORY OR LSC IDENTIFYING INFORMATION) Continued From page 35 21390 be used for other residents. TMA-A did not wash her hands after removing her gloves. Choise HEFFENDED TO THE APPROPRIATE DEFIDIENCY) During interview on 4/1/15, at 1:00 p.m. TMA-A stated cleaning of the Glucometer, TMA-A stated de worked for an outside agency and had only been to the facility a few times. Further, TMA-A stated de contenter, TMA-B stated cleaning of the Glucometer for all the residents. No formal education on cleaning of Glucometer had been completed, but she would speak to staff randomly as needed. An undated McKesson brand TRUE result Glucose policy, dtated fare every use. ", and ", .cleaning and disinfecting Blood Glucose policy, dtated fare every use.", and ", .cleaning and disinfecting the Meter after each use to prevent the transmission of blood-borne pathogens." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee,

	IT OF DEFICIENCIES OF CORRECTION	ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SU COMPLE	
		00757	B. WING		04/02/2015	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
AMILIA	ROSE CARE CENTE	BIIC	EON BOULEV APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLET DATE
21390	Continued From pa	ige 36	21390			
	(21) days.					
21426	MN St. Statute 144 Prevention And Cor	A.04 Subd. 3 Tuberculosis ntrol	21426		5	6/12/15
	maintain a compreh infection control pro- current tuberculosis issued by the Unite Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volu Health shall provide regarding implement	e provider must establish and hensive tuberculosis ogram according to the most s infection control guidelines d States Centers for Disease tion (CDC), Division of hation, as published in CDC's ality Weekly Report (MMWR). include a tuberculosis an that covers all paid and contractors, students, inteers. The Department of te technical assistance intation of the guidelines.	t			
	by: Based on interview facility failed to ens screenings were co (R69, R67, R209, F during the Quality In	ent is not met as evidenced , and document review, the ure tuberculosis (TB) symptom ompleted for 5 of 5 residents R198, and R95) reviewed ndicator Survey (QIS).	1	Corrected.		
	Findings include:					
	During review of R6	69, R67, R209, R198, and				

STATE FORM

WOCL11

If continuation sheet 37 of 44

					(X3) DATE SURVE COMPLETED	
		00757	B. WING		04/	02/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BLIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21426	Continued From pa	age 37	21426			
	screenings (a tool u	ord, no TB symptom used to determine if active TB present) were identified.				
	registered nurse (F stopped completing residents approxim facility no longer ha	a 3/31/15, at 1:08 p.m. RN)-A stated the facility g a symptom screening on new ately 8 months prior when the ad a shortage of tuberculin injected under the skin to test).				
	director of nursing educated regarding R198, and R95 sho	on 3/31/14, at 2:04 p.m. the (DON) stated staff had been g TB, and R69, R67, R209, buld have had a TB symptom ed upon their admission to the				
	dated 10/10/11, ide an effective Tuberc includes early dete screening for infect treatment of person However, the policy	sis Exposure Control Plan, entified a policy of, "To institute culosis (TB) Control Plan that ction of latent TB infection, tious TB diseaseand ns with non-infectious TB." y did not identify if a symptom e completed for residents the facility.				
	director of nursing, policy and procedu	THOD OF CORRECTION: The or designee, could review TB re to ensure symptom npleted, then inservice staff liance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		00757	B. WING		04/02/201	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	ige 38	21800			
21800			21800			5/12/15
	00 Continued From page 38		5	Corrected.		

STATEMEN	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Multiple A. Building:			E SURVEY PLETED
		00757	B. WING		04/02/201	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BLIC	ON BOULEV APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21800	Continued From pa	age 39	21800			
nnesota D	estimated costs for 3 residents (R63, a compliance with lia Findings include: R63's current Resid identified he was a 4/24/14, where he Review of a Notice (Centers for Medica [CMS]-10123) sign received Medicare end on 7/10/14, du therapies. Though after services ende provide evidence F representative rece Facility Advance Be to notify him of esti services. R63 also received The OT (occupatio Progress & Discha and PT (physical th Discharge Summa R63 received Medi treatment of muscl through 1/30/15, af The facility was una and/or his legal rep CMS-10123 to noti ending and a right there was no indica CMS-10055 form th costs for non-cover ended. R49's current Resid identified she was a	expedited review and/or the r non-covered services, for 2 of and R49) reviewed for bility and appeal rights. dent Admission Record dmitted to the facility on remained a resident to date. of Provider Non-coverage are & Medicaid Services ed 7/8/14, identified R63 had covered services that were to e to his discharge from skilled R63 remained in the facility ed, the facility was unable to R63 and/or his legal eived the Skilled Nursing eneficiary Notice (CMS-10055) mated costs for non-covered skilled services from therapy. nal therapy) Therapist rge Summary signed 1/29/15, herapy) Therapist Progress & ry signed 1/30/15, identified care covered services for e weakness from 1/13/15, fter a qualifying hospital stay. able to provide evidence R63 oresentative received the form fy him of Medicare services to an appeal process. Also ation the facility gave him the hat notified him of estimated red services after Medicare				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
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NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, S	TATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULEVA APIDS, MN 55			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21800	Continued From pa	ige 40	21800			
	signed 1/5/15, and Discharge Summar had received Medic difficulty in walking after a qualifying ho incorrect Medicare and signed on 1/5/- that R49 and/or her the required CMS-1 right to an expedite CMS-10055 form c resident and/or lega costs for non-cover ended. The CMS-1 Medicare part A for On 4/2/15, at 3:07 p (DON) was intervie liability and appeal CMS-10095 form th residents with notic costs for services. facility had not been required for notifica- rights. She stated th process was not co but had not yet dev systems to remedy forms. Registered nurse (If for providing liability within the facility, w A policy was reques	ress & Discharge Summary PT Therapist Progress & ry signed 1/7/15, identified R49 care covered services for from 12/19/14, through 1/7/15, ospital stay. A CMS-10095 (an form) was provided to R49 15. There was no indication r legal representative received 10123 form to notify her of her d review, nor was a ompleted that notified the al representative of estimated red services after Medicare 0095, was not the correct m that was used by the facility. com. the director of nursing wed regarding the facility's rights processes and the ne facility used for providing res of services ending and The DON knowledge the n using the correct forms as tion of liability and appeal he facility had identified their ompliant with the requirements, eloped or implemented the errors of the incorrect RN)-Z, who was responsible y and appeal right notices ras unavailable for interview. sted, but none was provided. THOD OF CORRECTION: The				
	staff regarding provinotice(s), and audit	or designee, could inservice viding correct Medicare liability to ensure compliance.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00757	B. WING		04/02/2015
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
CAMILIA	ROSE CARE CENTE	RIIC	EON BOULE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
21800	Continued From pa	ge 41	21800		
	(21) days.				
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		5/12/15
	residents have the courtesy and respe	us treatment. Patients and right to be treated with ct for their individuality by rsons providing service in a			
	by: Based on observative review, the facility f and cues to enhance observation for 1 of	ent is not met as evidenced ion, interview, and document ailed to provide supervision ce dignity during a dining i 1 residents (R15) who was rnel corn, and diced fruit with		Corrected.	
	Findings include:				
	(MDS), dated 1/28/ and long term mem	ange Minimum Data Set 15, identified R15 had short hory problems, and required sistance from staff to eat.			
	problem of cognitiv decision making re deficits. Staff were	ted 1/27/15, identified a e loss/dementia with impaired lated to memory and judgmen directed to "provide cues and needed]" and to "anticipate client."	t		
	on 3/30/15 at 5:20 table in the 3rd floo	of the evening meal service, p.m., R15 was seated at a r dining room with two other a clothing protector around			

STATEME	Dta Department of He NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
	00757		B. WING		04/	02/2015
	PROVIDER OR SUPPLIER		DRESS, CITY, ST		04/02/2015	
	I NOVIDEN ON SOFT EIEN					
CAMILIA	ROSE CARE CENTE	BLIC	APIDS, MN 55			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21805	Continued From pa	age 42	21805			
	served a plate of for small diced fruit bor shredded lettuce ar spoon were sitting of R15 began to pick of fingers, spilling a la floor as she attemp (NA)-D, NA-E, and did not offer assista provided utensils to corn using her finge floor. R15 opened began to eat the mo- pulling the plate clo she ate it. At 5:27 p small bowl of diced her fingers, resume her plate, and then 5:30 p.m R15 pic it on the table, and fingers to eat her m soiled with a tattere and corn. At 5:37 p pieces of food from her fingers. Regist approached the tab 5:44 p.m., but did n cues to her as R15 taco meat and corn The director of nurs 5:47 p.m. and state cleaned up a little." clothing protector fr dining room. R15 v room by RN-B at 5: she began eating. eating had been off	ble where R15 was seated at not offer eating assistance or continued to eat pieces of from her lap with her fingers. sing (DON) approached R15 at ed she would "help get her The DON removed the soiled rom R15's lap, and left the was removed from the dining :55 p.m., or 35 minutes after No assistance or cues for fered to R15 during the course nough R15 was eating, kernel				

Minnesc	ta Department of He	alth				
-	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	SURVEY LETED
		00757	B. WING		04/0	2/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
CAMILIA	ROSE CARE CENTE	BIIC	ON BOULEV APIDS, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21805	Continued From pa	ge 43	21805			
	When interviewed of dining assistant (CI with her fingers, an on the floor "a lot m When interviewed of stated R15 should a assistance or cues During interview on director of nursing of during the 3/30/15 of lap, and eating kerr her fingers stated s assistance during her SUGGESTED MET director of nursing of review/revise policie the provision of dig Employees could b policies. A system consistent implement be developed, with being brought to the Committee for review	on 4/1/15, at 1:25 p.m. client DA)-A stated R15 often will eat d has been leaving more food lore lately." on 4/2/15, at 10:19 a.m. RN-B should have been offered with her meal. 4/2/15, at 2:51 p.m. the (DON) who had observed R15 evening meal with food on her hel corn and diced fruit with taff should have offered R15 her meal. THOD OF CORRECTION: The or designee, could es and procedures related to nified care and services. e re-educated on these for evaluating and monitoring intation of these policies could the results of these audits e facility's Quality Assurance				
Minnesota D	epartment of Health					