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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WOCL
Facility ID: 00757

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/18/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)
01 Hospital; 02 SNF/NF/Dual; 03 SNF/NF/Distinct; 04 SNF; 05 HHA; 06 PRTF; 07 X-Ray; 08 OPT/SP; 09 ESRD; 10 NF; 11 ICF/IID; 12 RHC; 13 PTIP; 14 CORF; 15 ASC; 16 HOSPICE; 22 CLIA

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

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

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

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

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
____1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE — Date :
Brenda Fischer, Unit Supervisor — 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 05/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **03001** (L31)

30. REMARKS
Posted 06/09/2015 Co.

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **05/21/2015** (L33)

DETERMINATION APPROVAL

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

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

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245353	A. Building B. Wing	5/18/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	**05/12/2015**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	**05/12/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	**05/12/2015**
ID Prefix **F0281** Reg. # **483.20(k)(3)(i)** LSC	**05/12/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**05/12/2015**	ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	**05/12/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	**05/12/2015**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	**05/12/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	**05/12/2015**
ID Prefix **F0441** Reg. # **483.65** LSC	**05/12/2015**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	5/27/2015	10562	5/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 4/2/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit
245353	01 - MAIN BUILDING 01	5/26/2015

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0029	05/12/2015	ID Prefix Reg. # NFPA 101 LSC K0038	05/12/2015	ID Prefix Reg. # NFPA 101 LSC K0069	05/12/2015
ID Prefix Reg. # NFPA 101 LSC K0076	05/12/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/KJ	5/27/2015	28120	5/26/2015
CMS RO				

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
4/6/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: WOCL
Facility ID: 00757

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

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

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

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/02/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10. THE FACILITY IS CERTIFIED AS:

X A. In Compliance With Program Requirements Compliance Based On:
X 1. Acceptable POC

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

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Austin Fry, HFE NE II 04/29/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 05/18/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

Posted 05/21/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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**
>
> **<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the**

attached deficiencies.

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

DEPARTMENT CONTACT

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

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

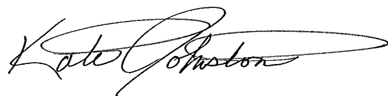
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING ______ B. WING ______	04/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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 notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. 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	F 156		5/12/15

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

Electronically 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.

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	245353	A. BUILDING ______ B. WING ______	04/02/2015

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

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F 156	Continued From page 1	F 156		

and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.

The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification

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F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notices to inform residents who discharged from Medicare, of their right to an expedited review and/or the estimated costs for non-covered services, for 2 of 3 residents (R63, and R49) reviewed for compliance with liability and appeal rights. Findings include: R63's current Resident Admission Record identified he was admitted to the facility on 4/24/14, where he remained a resident to date. Review of a Notice of Provider Non-coverage (Centers for Medicare & Medicaid Services [CMS]-10123) signed 7/8/14, identified R63 had received Medicare covered services that were to end on 7/10/14, due to his discharge from skilled therapies. Though R63 remained in the facility after services ended, the facility was unable to	F 156	F156 SPECIFIC RESIDENTS AFFECTED: N/A IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: All residents with pending Medicare denials were reviewed to ensure appropriate notice was given. 2 notices were reissued, using form CMS-10055. SYSTEMIC CHANGES: The facility policy and procedure, now titled, Issuance of Medicare/ Managed Care Denial and Appeal Notices, was revised to include issuing the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) form to inform residents no longer eligible for Medicare coverage of estimated costs for non-covered services. This form will be utilized for residents remaining in	

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F 156	Continued From page 3 provide evidence R63 and/or his legal representative received the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) to notify him of estimated costs for non-covered services. R63 also received skilled services from therapy. The OT (occupational therapy) Therapist Progress & Discharge Summary signed 1/29/15, and PT (physical therapy) Therapist Progress & Discharge Summary signed 1/30/15, identified R63 received Medicare covered services for treatment of muscle weakness from 1/13/15, through 1/30/15, after a qualifying hospital stay. The facility was unable to provide evidence R63 and/or his legal representative received the form CMS-10123 to notify him of Medicare services ending and a right to an appeal process. Also there was no indication the facility gave him the CMS-10055 form that notified him of estimated costs for non-covered services after Medicare ended. R49's current Resident Admission Record identified she was admitted to the facility on 12/14, and was discharged on 1/8/15. Review of OT Therapist Progress & Discharge Summary signed 1/5/15, and PT Therapist Progress & Discharge Summary signed 1/7/15, identified R49 had received Medicare covered services for difficulty in walking from 12/19/14, through 1/7/15, after a qualifying hospital stay. A CMS-10095 (an incorrect Medicare form) was provided to R49 and signed on 1/5/15. There was no indication that R49 and/or her legal representative received the required CMS-10123 form to notify her of her right to an expedited review, nor was a CMS-10055 form completed that notified the resident and/or legal representative of estimated costs for non-covered services after Medicare	F 156	facility after Medicare coverage ends per CMS guidelines. MONITOR CHANGES: The Director of Accounting or designee will review all Medicare denial notices issued to residents who will remain in the facility after coverage ends ensure that the appropriate CMS form has been used. These reviews will continue for at least 90 days, or until substantial compliance is achieved, whichever is later. Discrepancies will be reported to the Administrator and corrected immediately. Audit results will be report to the Quality Assurance (QA) task force monthly for a period of 90 days, or until substantial compliance is achieved, whichever is greater. The Director of Accounting will be responsible for compliance.	

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F 156	Continued From page 4 ended. The CMS-10095, was not the correct Medicare part A form that was used by the facility. On 4/2/15, at 3:07 p.m. the director of nursing (DON) was interviewed regarding the facility's liability and appeal rights processes and the CMS-10095 form the facility used for providing residents with notices of services ending and costs for services. The DON knowledge the facility had not been using the correct forms as required for notification of liability and appeal rights. She stated the facility had identified their process was not compliant with the requirements, but had not yet developed or implemented systems to remedy the errors of the incorrect forms. Registered nurse (RN)-Z, who was responsible for providing liability and appeal right notices within the facility, was unavailable for interview. A policy was requested, but none was provided.	F 156		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision and cues to enhance dignity during a dining observation for 1 of 1 residents (R15) who was observed eating kernel corn, and diced fruit with her fingers.	F 241	F241 SPECIFIC RESIDENTS AFFECTED: R15 s care plan was reviewed and revised to further promote dignity with meals by offering additional finger food menu items. Staff will offer finger foods	5/12/15

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F 241	Continued From page 5 Findings include: R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assistance from staff to eat. R15's care plan, dated 1/27/15, identified a problem of cognitive loss/dementia with impaired decision making related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client." During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a table in the 3rd floor dining room with two other residents, and had a clothing protector around her neck which covered her shirt. She was served a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cues to use the provided utensils to R15 who continued to eat the corn using her fingers, spilling on her lap and the floor. R15 opened the soft taco at 5:26 p.m. and began to eat the meat inside using her fingers, pulling the plate closer to the edge of the table as she ate it. At 5:27 p.m. she then picked up the small bowl of diced fruit and began to eat it using her fingers, resumed eating the taco meat from her plate, and then spilled the plate on her lap at 5:30 p.m.. R15 picked her plate back up, placed	F 241	when appropriate to promote highest level of ability to eat independently. R15's menu was updated to reflect offering additional finger foods. Staff has been assigned to R15 s table to provide closer supervision and assistance with meals as necessary and as resident allows. Staff communication was provided regarding R15's updated interventions. Nursing staff will receive additional, related training in this area as outlined below. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Clinical Managers and the interdisciplinary team reviewed all long-term care residents to identify those that may need similar mealtime interventions to promote dignity and the highest functional ADL level related to eating. Care plans were revised as necessary. SYSTEMIC CHANGES: Nutritional Services has posted lists of foods available on the unit which may be appropriate as finger food substitutions and also ways to modify regular menu items to be served as finger foods. Nursing staff will continue to supervise residents at meal times, assisting as necessary and offering meal alternatives, including finger foods, as appropriate. Nursing staff and Client Dining Assistants (CDAs) have been made aware of this information. Nursing staff and CDA will receive additional training on resident supervision at meals, monitoring intake and offering assistance and/or substitutes if intake is less than 75%. Training will be completed by May 8, 2015. Staff will continue to supervise residents	

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F 241	Continued From page 6 it on the table, and continued to eat using her fingers to eat her meal. Her clothing was now soiled with a tattered soft taco shell, taco meat, and corn. At 5:37 p.m. R15 began picking up pieces of food from her lap and eating them with her fingers. Registered Nurse (RN)-B approached the table where R15 was seated at 5:44 p.m., but did not offer eating assistance or cues to her as R15 continued to eat pieces of taco meat and corn from her lap with her fingers. 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 even though R15 was eating, kernel corn and diced fruit with her fingers. 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." When interviewed on 4/2/15, at 10:19 a.m. RN-B stated R15 should should have been offered assistance or cues with her meal. During interview on 4/2/15, at 2:51 p.m. the director of nursing (DON) who had observed R15 during the 3/30/15 evening meal with food on her lap, and eating kernel corn and diced fruit with her fingers stated staff should have offered R15 assistance during her meal.	F 241	at meal times, assisting residents as necessary. Menu item alternatives, including finger foods, will be offered to all residents consuming less than 75% of the as appropriate. Nursing staff and Client Dining Assistants will receive training to identify residents on the finger food program and offering appropriate menu items. Training will be completed by 5/12/15. MONITOR CHANGES: Random dining room audits will be conducted at least three times weekly per meal by Clinical Managers and/or Director of Nursing to ensure that residents are receiving the appropriate level of supervision and/or assistance from staff. The Director of Nutrition Services will review menus weekly to ensure sufficient finger food items are available for each meal. Concerns that may arise from these audits will be addressed as appropriate by the auditor and/or Clinical Managers as appropriate. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly for a period of 90 days, or until substantial compliance is achieved, whichever is greater. The QA task force will determine additional or alternative actions to be taken, if necessary.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 7 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop comprehensive care plans, based on the resident's assessed needs, for 2 of 3 residents (R99, R15) reviewed for care planning. Findings include: R99's Admission Minimum Data Set (MDS) dated 12/16/14, included he had difficulty with hearing, impaired vision, severe cognitive impairment, mild mood indicators, rejection of cares, he had preferences for daily care and activities that were	F 279	F279 SPECIFIC RESIDENTS AFFECTED: R99 was discharged home 1/3/2015. R15 s care plan has been reviewed and revised to include offering additional finger foods, staff offering to assist with meals as necessary, and offering substitute if less than 75% of meal is consumed. Care plan interventions were communicated to staff as appropriate. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Medical records were reviewed for all residents to identify those that may not	

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F 279	Continued From page 8 very important to him, limited assistance with most activities of daily living (ADL's), unsteady balance, use of an indwelling catheter, diagnoses including cancer and pneumonia, shortness of breath, oral/dental status had not been assessed, and he had skin tears. The MDS triggered out the following Care Care Assessments (CAA) which were completed by the facility on 12/22/14: cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling Foley catheter, psychosocial well-being, behavioral symptoms, falls, activities, and dehydration/fluid maintenance. The MDS indicated that all of these areas had been addressed in R99's care plan. R99's Temporary Care Plan dated 12/9/14, included check boxes indicating that R99 needed assistance for dressing, grooming, transferring, walking and wheeling. However, it failed to direct staff on how much assistance, or any special needs R99 had in these areas. The Temporary Care Plan also indicated R99 had his own teeth and a lower partial was missing, his hearing, vision and communication were normal, which was different than the MDS information. R99's electronic Care Plan dated 12/19/14, included, a generic activities care plan that was not specific to R99's interests and preference which were indicated on the MDS. The electronic Care Plan also addressed nutrition, but not a dehydration risk. These were the only two components completed on the electronic care pan for R99. Even though R99's MDS dated 12/16/14, identified care planning was completed for each CAA, neither R99's Temporary Care Plan or	F 279	have care plans in place. Care plans were developed as indicated by the interdisciplinary team. Existing care plans not otherwise mentioned, are being reviewed and revised as necessary, no later than the resident's next scheduled assessment period. SYSTEMIC CHANGES: Nutritional Services has posted lists of foods available on the unit which may be appropriate as finger food substitutions and also ways to modify regular menu items to be served as finger foods. Nursing staff will continue to supervise residents at meal times, assisting as necessary and offering meal alternatives, including finger foods, as appropriate. Nursing staff and Client Dining Assistants (CDAs) have been made aware of this information. Nursing staff and CDAs will receive additional training on resident supervision at meals, monitoring intake and offering assistance and/or substitutes if intake is less than 75%. Training will be completed by 5/12/15. MONITOR CHANGES: Random comprehensive care plan audits will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and remain current. These audits will be conducted monthly for at least 6 residents, for a period of 90 days or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly for a period of 90 days, or until substantial compliance is achieved,	

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F 279	Continued From page 9 electronic Care Plans addressed, or directed staff on how to care for R99, in regards to cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling Foley catheter, psychosocial well-being, behavioral symptoms, falls, activities, and dehydration/fluid maintenance. When interviewed on 4/2/15, at 1:30 p.m. the director of nursing (DON) stated each resident should have a comprehensive care plan completed within 21 days of admission, but this had not been done for R99. The nurses had not been routinely completing care plans for residents. She was aware of this and had recently been approved to add additional nursing hours so that care plans could be completed. A facility Care Plans policy, dated 8/2010, identified a resident care plan should be developed, "...21 days after admission in the RAI [Resident Assessment Instrument] is completed on the 14th day, B. 7 days after completion of RAI if done earlier than 14th day." Further, the care plan "needs to be up to date and reflect the clients care/condition at all times." R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assist of one to eat. R15's care plan, dated 1/27/15, identified a problem of being at nutritional risk and "leaving greater than 25% of food uneaten." Staff were directed to provide 6 ounces chocolate milk, regular diet, monitor and record intake of food, weekly weights and offer substitutes. The care	F 279	whichever is greater. The QA task force will determine additional or alternative actions to be taken, if necessary.	

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F 279	Continued From page 10 plan also identified a problem of cognitive loss/dementia with impaired decision making related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client." There was no indication in the care plan that identified how much staff assistance was required for R15 to eat her meals. During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a table and received a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of kernel corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cued R15 to use the provided utensils. R15 continued to eat the corn, and diced fruit with her fingers. She spilled the taco, and began eating the contents of the taco with her fingers until she was finished with her meal at 5:47 p.m. When interviewed on 4/2/15, at 10:19 a.m. registered nurse (RN)-B stated R15's ability to feed herself often varies from day to day adding, "she is a complex person." Further, RN-B stated R15's care plan should have identified the level of assistance that she required for eating. During interview on 4/2/15, at 2:51 p.m. the DON stated a care plan "drives resident care," and since late 2014 the facility's MDS nurse had "zero" involvement with the care planning process. Further, R15's care plan should have	F 279		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	Continued From page 11 identified how much assistance she required to eat her meals, "We've had a real problem with the flow [of the care plans]." A facility Care Plan policy, dated 8/2010, identified a purpose of, "...assist the client towards a goal of optimal wellness based on the Comprehensive Assessment." A procedure was listed for staff to follow, and identified "Nutritional needs" should be identified on a resident care plan. Further, the policy added, "...Care plan needs to be up to date and reflect the clients care/condition at all times."	F 279		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a temporary care plan to address discomfort for 1 of 5 residents (R216) who had been recently admitted to the facility. Findings include: R216's progress note, dated 3/25/15, identified R216 admitted to the facility on 3/22/15 and had multiple skeletal fractures. R216's initial Pain Management assessment, dated 3/24/15, identified R216 frequently had pain/discomfort in the last five days. R216's most recent Pain Management assessment, dated 3/31/15, identified R216 continued to have frequent pain/discomfort in the last five days.	F 281	F281 SPECIFIC RESIDENTS AFFECTED: A comprehensive care plan, including pain and related interventions, was developed for R216 on 4/1/2015. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Medical records were reviewed for all residents to identify those that may not have pain care plans in place. Pain care plans were developed as indicated by the interdisciplinary team. Existing care plans 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	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING ______ B. WING ______	04/02/2015

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F 281	Continued From page 12 Review of R216's Camilia Rose Temporary Care Plan, dated 3/25/15, did not identify a problem with pain, what was R216's goal nor included any staff interventions to help reduce her pain and discomfort even though she had current fractures. When interviewed on 4/1/15, at 1:45 p.m. registered nurse (RN-D) stated R216's pain had not been addressed in her temporary care plan, then added that pain/discomfort was rarely addressed on any new residents temporary care plan. Further, RN-D stated, "I would expect to see pain addressed in her (R216) care plan." RN-D further stated R216's pain was being managed by pain medications and the certified nurse practitioner (CNP) has been consistently updated about the resident's pain/discomfort since admission to the facility. The CNP had also changed R216's current pain management regime today. RN-D added the facility was also repositioning R216 every two hours to help decrease her pain and discomfort. A facility Care Planning policy, dated 8/18/10, identified a resident care plan should be completed, "21 days after admission if the RAI [Resident Assessment Instrument] is complete on the 14th day," or, "7 days after completion of RAI if done earlier than 14th day." The policy did not identify any instruction for completion of a temporary care plan to address immediate resident needs upon their admission to the facility.	F 281	care planning, now titled Care Plan Development has been updated to provide additional details related to care planning. This policy and procedure outlines timelines for care plan completion, disciplines responsible for initiating and updating each section, and information on developing comprehensive, resident-centered, and holistic care plans. MDS Coordinators have assumed responsibility for initial development and quarterly reviews of all nursing care plans, based on information from the MDS assessments. Clinical Managers will be responsible for ensuring care plans are updated between assessment periods. All disciplines will review care plans and revise as necessary, at least quarterly. An interim MDS Coordinator has been contracted to supplement the existing MDS Coordinator until the vacant position is filled. MONITOR CHANGES: Random comprehensive care plan audits will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and remain current. These audits will be conducted monthly for at least 6 residents, for a period of 90 days or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly. The QA task force will determine additional or alternative actions to be taken, if necessary. The Director of Nursing will be responsible for compliance.	

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F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning as care planned for 2 of 3 residents (R97, R65) reviewed for activities of daily living. In addition, the facility failed to ensure care plan interventions were followed to reduce the risk of falls for 1 of 3 residents (R9) reviewed for accidents. Findings include: R97's quarterly Minimum Data Set (MDS) dated 2/26/15, identified R97 required extensive assistance of two staff to complete bed mobility and repositioning. R97's care plan, dated 3/25/14, identified R97 was at risk for skin breakdown and listed an intervention of, "Turn and reposition every 2 hours with assist of 1." During constant observation on 4/1/15, from 7:00 a.m. until 9:50 a.m. (2 hours and 50 minutes) R97 was observed to be laying on her back in bed. At 9:24 a.m., nursing assistant (NA)-A entered the room to see if R97 was wake, and finding she was not lowered the head of the bed (HOB) down and left the room. Registered nurse (RN)-C, stated on 04/01/2015 at 9:50 a.m., that R97 should of been	F 282	F282 SPECIFIC RESIDENTS AFFECTED: R97 expired 4/9/2015. An updated fall risk assessment was completed for R9. R9's care plan for safety was reviewed and remains current. Staff was reminded of R9's care plan interventions and the expectation that safety interventions are to be followed at all times. Nursing staff will receive additional, related training in this area as outlined below. A comprehensive skin risk assessment, including Braden scale and tissue tolerance testing was completed for R65. R65 s care plan was reviewed and remains current. R65 moved to another long term care unit within the facility and staff on R65 s new unit was updated on her specific skin interventions, including appropriate offloading techniques. Staff was reminded of specific interventions for these residents and the expectation that they be followed at all times. Nursing staff will receive additional, related training in this area as outlined below. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED:	5/12/15

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F 282 Continued From page 14

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 prior.

During an interview on 4/01/15, at 10:05 a.m., NA-A, stated she was unaware when R97 had last been turned, while nothing was reported to her from the night shift. NA-A then assisted R97 to turn to the side, and examined her coccyx with no redness noted.

During interview on 04/01/2015, at 1:31 p.m. registered nurse (RN)-B stated the facility had started a new shift reporting sheet, so that information on residents' need, such as last repositioning could be followed, but this had not been completed for R97. Further RN-B stated R97 should have been repositioned every two hours as care planned.

R65's quarterly MDS, dated 1/19/15, identified R65 had intact cognition, required extensive assistance with bed mobility and transfers, and was at risk for skin breakdown. R65's care plan, dated 1/19/15, identified she was at risk for skin breakdown, and listed an intervention of, "Turn and reposition every hour as res. [resident] allows."

During constant observation starting on 4/1/15, at 6:51 a.m. R65 was lying in bed positioned slightly (less than 15 degrees) on her left side. R65 remained in her bed, in the same position until 7:45 a.m. when NA-H entered the room lowered

F 282

NAR care sheets, which include specific care plan interventions for safety and skin, were reviewed for accuracy, especially as it relates to skin and safety interventions, and were revised as necessary. NAR turning and repositioning audits were initiated to identify immediate and specific staff training needs, and compliance issues. Concerns that may arise from these audits will be addressed as appropriate by the auditor and/or Clinical Managers. Nursing staff will receive additional, related training in this area as outlined below.

SYSTEMIC CHANGES:

Facility policies and procedures related to safety and skin/wound interventions were reviewed and remain current. Nursing staff will receive additional training on skin care, prevention of pressure ulcers, and appropriate techniques for assisting residents with pressure reduction by 5/12/2015. Nursing staff will also receive additional training on safety related to falls, proper use of equipment to assist residents with mobility, and following individualized safety interventions at all times. This training will be provided by 5/12/2015.

MONITOR CHANGES:

Clinical Managers and/or Director of Nursing will conduct 4 random monthly audits per unit/per shift for a minimum of 36 audits per month, to ensure compliance with repositioning and pressure reduction interventions. Also, 4 random monthly audits per unit/per shift for a minimum of 36 audits per month, to

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F 282	Continued From page 15	F 282		

the head of the bed and slightly (approximately 2 or 3 inches) pulled the draw sheet towards her. NA-H completed R65's range of motion exercises, however did not off load or reposition R65 in the bed, and left R65's room at 8:00 a.m.. R65 then remained in bed until 8:38 a.m. when she was assisted to roll onto her right side to have her incontinence product removed by NA-I. R65 was not off loaded or repositioned adequately to allow tissue perfusion to her coccyx for 1 hour and 37 minutes.

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 tries to follow a residents care plan, "I try to follow it as closely as I can." During interview on 4/1/15, at 12:12 p.m. NA-H stated she thought R65 was to be repositioned every 2 hours, and verified she did not off load R65's during her range of motion exercises earlier that morning.

During interview on 4/1/15, at 2:42 p.m. RN-B stated R65 was at risk for pressure ulcers, and should be repositioned every hour according to her plan of care, "Her care plan states every hour."

When interviewed on 4/2/15, at 2:51 p.m. the DON stated a care plan "drives resident care," and the expectation is they are followed by the staff.

R9's quarterly MDS, dated 1/20/2015, identified R9 had moderately impaired cognition, and required extensive, physical assistance for transferring, and toileting. R9's care plan, dated 3/30/2015, identified the goal of not having any fall-related injures and listed interventions to

ensure compliance with safety interventions. Audits will continue for a period of 90 days, or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing or designee at least weekly and reported to the QA task force monthly. Results of these audits will be reviewed by the QA task force monthly and further actions will be determined as necessary. Director of Nursing will be responsible for compliance.

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F 282	Continued From page 16	F 282		

prevent falls, among which included "A1-2 (assist of 1 to 2 persons) with all transfers and mobility," and "Do not leave resident in bathroom alone or unattended."

During observation on 4/1/2015, at 8:44 a.m. NA-G entered R9's room to assist him out of bed, and begin routine morning cares. NA-G assisted R9 into the bathroom, and provided assistance to transfer onto the toilet. NA-G stated she needed to help a co-worker "for a little bit and bring back some linens" to remake his bed, and left R9 in the bathroom alone at 8:55 a.m. At 9:04 a.m., (9 minutes later), NA-G returned to R9's room with bed linens and proceeded to make his bed. NA-G was out of R9's room from 8:55 a.m. to 9:04 a.m. (9 minutes); however, from 9:04 a.m. until 9:07 a.m. (3 minutes), NA-G was in R9's room, but not present with him in the bathroom. During the entire twelve minutes R9 was alone in the bathroom, he remained seated on the toilet, and made no attempts to stand up, self transfer, or otherwise move out from the room. Upon return to the bathroom, NA-G assisted R9 to get dressed for the day.

During an interview on 4/1/2015 at 9:13 a.m., NA-G verified she left "[R9] alone in the bathroom" when she briefly helped out a co-worker, and also left him alone while she made his bed. NA-G said she left R9 alone so "he could have some privacy." Further, NA-G stated she knew [R9] had a recent fall, and he was known to self transfer.

During an interview on 4/2/2015 at 1:36 p.m., registered nurse (RN)-B stated "[R9] was at risk for falls, and had a history of "self transferring." A new intervention for R9's fall prevention had

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F 282	Continued From page 17 recently been added to the care plan, "To not leave him unattended in the bathroom." RN-B said the new intervention should have been identified on the aide's care sheets, but that it had not been completed, "it should have added." When interviewed on 4/2/15, at 2:23 p.m. the director of nursing (DON) stated she would "expect" a resident's care plan be followed.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision and cues for eating to 1 of 4 residents (R15) who required staff assistance with eating. Findings include: R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assistance from staff to eat. R15's care plan, dated 1/27/15, identified a problem of being at nutritional risk and "leaving greater than 25% of food uneaten." Staff were directed to monitor and record intake of food, weekly weights and offer substitutes. The care plan also identified a problem of cognitive loss/dementia with impaired decision making	F 311	F311 SPECIFIC RESIDENTS AFFECTED: R15 s care plan was reviewed and revised to further promote dignity with meals by offering additional finger food menu items. Staff will offer finger foods when appropriate to promote highest level of ability to eat independently. R15's menu was updated to reflect offering additional finger foods. Staff has been assigned to R15 s table to provide closer supervision and assistance with meals as necessary, and as resident allows. Staff communication was provided regarding R15's updated interventions. Nursing staff will receive additional, related training in this area as outlined below. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED:	5/12/15

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F 311	Continued From page 18 related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client." During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a table in the 3rd floor dining room with two other residents, and had a clothing protector around her neck which covered her shirt. She was served a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cues to use the provided utensils to R15 who continued to eat the corn using her fingers, spilling on her lap and the floor. R15 opened the soft taco at 5:26 p.m. and began to eat the meat inside using her fingers, pulling the plate closer to the edge of the table as she ate it. At 5:27 p.m. she then picked up the small bowl of diced fruit and began to eat it using her fingers, resumed eating the taco meat from her plate, and then spilled the plate on her lap at 5:30 p.m.. R15 picked her plate back up, placed it on the table, and continued to eat using her fingers to eat her meal. Her clothing was now soiled with a tattered soft taco shell, taco meat, and corn. At 5:37 p.m. R15 began picking up pieces of food from her lap and eating them with her fingers. Registered Nurse (RN)-B approached the table where R15 was seated at 5:44 p.m., but did not offer eating assistance or cues to her as R15 continued to eat pieces of taco meat and corn from her lap with her fingers.	F 311	Clinical Managers and the interdisciplinary team reviewed residents, including routine weights and food intake logs, to identify those that may need additional mealtime interventions to promote adequate food and fluid intake. Care plans for identified residents were reviewed and revised as necessary. SYSTEMIC CHANGES: Nutritional Services has posted lists of foods available on the unit which may be appropriate as finger food substitutions and also ways to modify regular menu items to be served as finger foods. Nursing staff will continue to supervise residents at meal times, assisting as necessary and offering meal alternatives, including finger foods, as appropriate. Nursing staff and Client Dining Assistants (CDAs) have been made aware of this information. Nursing staff and CDA will receive additional training on resident supervision at meals, monitoring intake and offering assistance and/or substitutes if intake is less than 75%. Training will be completed by May 8, 2015. MONITOR CHANGES: Random dining room audits will be conducted at least three times weekly per meal by Clinical Managers and/or Director of Nursing to ensure that residents are receiving the appropriate level of supervision and/or assistance from staff. The Director of Nutrition Services will review menus weekly to ensure sufficient finger food items are available for each meal. Concerns that may arise from these audits will be addressed as appropriate by the auditor and/or Clinical Managers as	

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F 311	Continued From page 19 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 often find items like peas and corn left on the floor when she is finished eating adding, "Maybe they [nurses] could take a look at her that way." During interview on 4/2/15, at 10:06 a.m. NA-B stated staff should provide R15 with cues to eat, and offer assistance if she is seen to be struggling with her meals. When interviewed on 4/2/15, at 10:19 a.m. RN-B stated R15 should should have been offered assistance or cues with her meal. During interview on 4/2/15, at 2:51 p.m. the director of nursing (DON) stated staff should have offered R15 assistance, or at least provided cues to use the utensils to eat her meal. A facility policy on meal assistance was requested, but none was provided.	F 311	appropriate. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly for a period of 90 days, or until substantial compliance is achieved, whichever is greater. The QA task force will determine additional or alternative actions to be taken, if necessary.	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		5/12/15

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F 314	Continued From page 20 Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely repositioning to reduce the risk of pressure ulcer formation for 2 of 3 residents (R97, R65) reviewed for pressure ulcers. Findings include: R97's quarterly Minimum Data Set (MDS) dated 2/26/15, identified R97 had no current pressure ulcers, and required extensive assistance of two staff for bed mobility and repositioning. R97's Pressure Ulcers Care Area Assessment (CAA), dated 6/07/14, indicated " assist of 2 with mechanical lift to transfer; turns side to side with A2 [assist of 2] staff." During constant observation on 4/1/15, from 7:00 a.m until 9:50 a.m. (2 hours and 50 minutes), R97 was observed to be laying on her back in bed. At 9:24 a.m., nursing assistant (NA)A entered the room to see if R97 was wake, and finding that she was not, lowered the head of the bed (HOB) and left the room. Registered nurse (RN)-C, stated on 04/01/2015	F 314	F314 SPECIFIC RESIDENTS AFFECTED: R97 expired 4/9/2015. A comprehensive skin risk assessment, including Braden scale and tissue tolerance testing was completed for R65. R65 s care plan was reviewed and remains current. R65 moved to another long term care unit within the facility and staff on R65 s new unit was updated on her specific skin interventions, including appropriate offloading techniques. Staff was reminded of specific interventions for R65 and the expectation that they be followed at all times. Notices have been posted for nursing staff regarding complete offloading for at least 1 minute. Nursing staff will receive additional, related training in this area as outlined below. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: NAR care sheets, which include specific care plan interventions for safety and skin, were reviewed for accuracy, especially as it relates to skin and safety interventions,	

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F 314	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 this document identified to "Select the intervention plan", which was left blank. There was no indication of how frequent R97 needed to be repositioned. The (not dated) Braden Scale score form, (a form used to determine pressure ulcer risk) identified R97 had a score of 13 (13-14 moderate risk) for the development of pressure ulcers. In review of R97's care plan (problem start date of 3/25/14), the facility identified the resident was at risk for skin irritation/breakdown related to decreased mobility, incontinence of both bowel and bladder, and peripheral vascular disease (PVD). The interventions directed staff that R97 needed to be "turn and reposition every 2 hours with assist of 1."	F 314	and were revised as necessary. NAR turning and repositioning audits were initiated to identify immediate specific staff training needs and compliance issues. Concerns that may arise from these audits will be addressed as appropriate by the auditor and/or Clinical Managers. Nursing staff will receive additional, related training in this area as outlined below. SYSTEMIC CHANGES: Facility policies and procedures related to safety and skin/wound interventions were reviewed and remain current. Nursing staff will receive training on skin care, prevention of pressure ulcers, including proper offloading, and following care plan interventions by 5/12/2015. MONITOR CHANGES: Clinical Managers and/or Director of Nursing will conduct 4 random monthly audits per unit/per shift for a minimum of 36 audits per month, to ensure compliance with repositioning and pressure reduction interventions. Audits will continue for a period of 90 days, or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing or designee at least weekly and reported to the QA task force monthly. Results of these audits will be reviewed by the QA task force monthly and further actions will be determined as necessary. Director of Nursing will be responsible for compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 314	Continued From page 22	F 314		

During interview on 04/01/2015 at 1:31 p.m., a registered nurse (RN)B stated the facility had started a new shift reporting sheet, so that information on residents' need, such as last repositioning could be followed, and this was not done. RN-B stated that R97 should have been repositioned every two hours as assessed and care planned.

The facility's policy, entitled: Skin and Wound Care Protocol (dated 4/24/14) indicated that the facility would be utilizing tools such as: the Braden Scale, Skin Risk Assessment, Tissue Tolerance Observations and weekly Skin Breakdown Observations. This document further indicated: "The completed tools will be used to develop and implement and individualized plan of care" and further described interventions, treatments and monitoring systems.

R65's quarterly MDS, dated 1/19/15, identified R65 had intact cognition, required extensive assistance with bed mobility and transfers, and was at risk for skin breakdown. R65's Skin assessment, dated 1/29/15, identified R65 had an "open area on coccyx", and listed an intervention of, "Staff to continue to offer hourly repositioning." R65's care plan, dated 1/19/15, identified she was at risk for skin breakdown, and listed an intervention of, "Turn and reposition every hour as res. [resident] allows."

During constant observation starting on 4/1/15, at 6:51 a.m. R65 was lying in bed positioned slightly (less than 15 degrees) on her left side, without the use of a pillow or positioning device. R65

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F 314 — Continued From page 23 — F 314

remained in her bed, in the same position until 7:45 a.m. when NA-H entered the room lowered the head of the bed and slightly (approximately 2 or 3 inches) pulled R65's draw sheet towards her having her lay completely on her back. NA-H then completed R65's range of motion exercises, however did not off load or reposition her, and left 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 tries to follow a residents care plan, "I try to follow it as closely as I can." During interview on 4/1/15, at 12:12 p.m. NA-H stated she thought R65 was to be repositioned every 2 hours, and further stated she did not off load R65's from her coccyx area during her range of motion exercises earlier that morning.

During interview on 4/1/15, at 2:42 p.m. RN-B stated R65 admitted to the facility with a stage III (full thickness skin loss involving damage to, or necrosis of subcutaneous tissue) pressure ulcer on her coccyx, which has improved but continues to remain at risk for pressure ulcer development. Further, R65 should have been completely off-loaded from her coccyx every one hour as directed by her care plan.

When interviewed on 4/2/15, at 2:51 p.m. the DON stated a resident's care plan should be followed.

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F 314	Continued From page 24 A facility Skin and Wound Care Protocol policy, dated 4/24/14, identified, "Staff will provide appropriate care and services to reduce the risk skin [sp] breakdown or other wounds according to the individualized care plan." Further, the policy identified, "Nursing interventions may include...toileting and repositioning per care plan..."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to reduce urinary incontinence for 1 of 3 residents (R1) reviewed and who was incontinent of urine. Findings include: R1's admission Minimum Data Set (MDS), dated 12/18/14, identified R1 was moderately cognitively impaired, required extensive assist of one with transfers, was occasionally incontinent	F 315	F 315 SPECIFIC RESIDENTS AFFECTED: R1 s bowel and bladder care plan was updated to reflect current status. R1 s 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 toilet on each night rounds and upon request. IDENTIFICATION OF OTHERS WHO MAY BE AFFECTED: Clinical Managers, additional nursing staff,	5/12/15

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F 315	Continued From page 25 of urine, however did not have a toileting plan. R1's quarterly MDS, dated 3/19/15, identified she had a change and was now frequently incontinent of urine, but did not have a toileting plan in place. R1's care plan dated 1/2/15 identified a problem of urinary incontinent and staff were directed to "Assist to toilet Q [every] 2 hours, with NOC [night] rounds and PRN [as needed]." During observation of care on 4/01/15 at 7:55 a.m., nursing assistant (NA)-B removed R1's incontinent product which was soiled with urine. During an interview on 04/02/15 at 1:53 p.m., NA-B stated she typically works on the day shift and if R1 is sleeping when she gets here, she will frequently be incontinent in the morning. Review of R1's Bowel and Bladder 72-Hour Data Collection (a form used to monitor urinary incontinence over 72 hours), dated 12/12/14-12/14/14, identified R1 had two incontinent episodes for the period. An additional Bowel and Bladder collection sheet dated 1/28 thru 1/31/15, identified R1 was continent 13 out of 32 opportunities during the day shift with 14 shifts left blank. During the evening shift R1 was continent 27 out of 32 opportunities, and during the night was continent 20 out of 32 opportunities with 3 shifts being left blank. During this time R1 voided 12 times on the toilet/bedpan and was continent during these times. Although R1 had a voiding pattern of being more continent during the evening and day shifts, and voided on the toilet. The facility had not completed an analysis of the data to determine a specific toileting plan for R1 to help improve R1's bladder continence. Review of the Point of Care Bowel/Bladder Category Report from 2/28/15 through 3/21/15	F 315	and the interdisciplinary team reviewed residents to identify those with recent increased incontinence, as demonstrated by the last MDS assessment, staff reports, or other indications. Comprehensive bowel and bladder assessments were initiated for 11 residents that may benefit from further review. Care plans will be reviewed and revised as indicated, based on assessment results. SYSTEMIC CHANGES: The MDS Coordinators have assumed responsibility for following the MDS process through to completion, culminating in an accurate, individualized care plan. Clinical Managers will be responsible for ensuring care plans are updated between assessment periods. An interim MDS Coordinator has been contracted to supplement the existing MDS Coordinator until the vacant position is filled. MONITOR CHANGES: Random comprehensive care plan audits will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and remain current. These audits will be conducted monthly for at least 2 residents per unit, for a minimum of 6 per month. Audits will continue for a period of 90 days or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly. The QA task force will determine additional or alternative actions to be taken, if	

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F 315	Continued From page 26 identified R1, was continent 10 out of 22 opportunities during the day shift; 20 out of 22 opportunities for the evening shift, and was continent 0 of 9 opportunities for the night shift. Review of R1's quarterly Bladder Observation, dated 3/18/15, identified R1 had urge and stress incontinence, impaired mobility, and was not appropriate for toileting program or retraining due to her dementia. Even though the point click care data from 2/28/15 to 3/21/15 identifies a pattern of being more continent during the evening and day shift hours, which was a change from the December 2014 Bowel and Bladder 72-Hour Data Collection sheet, where she was only incontinent twice. When interviewed on 4/02/2015, at 10:03 registered nurse (RN)-B stated the facility protocol for resident bladder assessment is 3 day collection done annually, and "as a practice we would do a deeper investigation." Further, RN-B stated R1 was able to verbalize her need for toileting but this was inconsistent. During interview on 04/02/15, at 2:04 p.m., RN-B stated R1's Bladder Observation should have been completed upon admission, however it had not been. Further, RN-B stated the facility should have reviewed R1's incontinence more closely and put her on a more individualized toileing schedule to prevent some of her incontinent episodes. Although R1's incontinence went from occasionally to frequently incontinent, and R1 could verbalize her need for toileting. The facility failed to assess for patterns and the cause of R1's increased incontinence and implement a	F 315	necessary. The Director of Nursing will be responsible for compliance.	

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F 315	Continued From page 27 plan to help reduce her incontinence episodes. A facility Guidelines for Client's Bladder and Bowel Assessment policy, dated 3/13/15, identified it, "Directs staff to ensure clients are able to maintain their highest practicable level of toileting function and to develop and individualized toileting plan of care." Further, "A full assessment is to be completed upon admission, quarterly, annually and with a significant change of condition using a 72 hour Bladder and Bowel Data collection sheet, Bowel and Bladder analysis and summary of data."	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implemented interventions to reduce the risk of falls for 1 of 3 residents (R9, R1) reviewed for accidents hazards during the survey. In addition, the facility failed to ensure a seated four-wheeled walker was used as a transportation device, which the manufacturer had not recommended for use for 1 of 4 residents (R69) observed to use such a device during the survey.	F 323	F323 SPECIFIC RESIDENTS AFFECTED: A comprehensive fall risk assessment was completed for R1. R1's care plan was reviewed and additional minor interventions were implemented. NAR 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 current.	5/12/15

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F 323

Continued From page 28

Finding include:

FALLS RISK
R9's diagnoses, as identified on the physician's orders dated 2/22/2015, included arthritis, dementia, congestive heart failure, and obesity. The quarterly Minimum Data Set (MDS), dated 1/20/2015, identified R9 had moderately impaired cognition, and also that he needed extensive, physical assistance for transferring, and toileting. A care area assessment (CAA) for falls, dated 8/8/2014, indicated R9 was at high risk for falls, due to a high fall-risk score, and a history of falls, one resulting with a hip fracture. The CAA further identified additional factors, increasing R9's fall risk, including: use of anti-depressant and diuretic (water pill) medications, incontinence, hearing impairment, as well as cognition impairment.

R9's care plan (CP), updated 3/30/2015, identified the goal, that R9 would not have any fall-related injuries while at the nursing home, and R9 would use their call light for assistance, instead of self transferring. The CP listed numerous interventions to prevent falls, among which directed staff to "A1-2 (assist of 1 to 2 persons) with all transfers and mobility," and "Do not leave resident in bathroom alone or unattended."

During observation on 4/1/2015 at 8:44 a.m., nursing assistant (NA)-G entered R9's room to assist him out of bed, and begin routine morning cares. After putting shoes over R9's socks and feet, then assisting him to sit upright on the side of the bed, NA-G, with a transfer belt around his waist, assisted him to stand, pivot, then sit into the wheel chair. NA-A pushed R9 into the

F 323

Staff was reminded of R9's care plan interventions and the expectation that safety interventions are to be followed at all times. Nursing staff will receive additional, related training in this area as outlined below.
Regarding R69 being transported using a walker, staff received reminders that residents are never to be transported while seated on a walker seat, shower chair, or any other device not intended for that type of use. Nursing staff will receive additional, related training in this area as outlined below.

NOTIFICATION OF OTHERS WHO MAY BE AFFECTED:
The QA Committee Chair analyzed facility falls data from Jan 1-March 31, 2015 and reports were discussed at the QA Committee meeting on 4/21/15. The analysis compared overall falls data by day of the week, time of day, and unit. The fall/incident report log was entered into an electronic spreadsheet, allowing managers to sort information quickly. Information includes name, room, date, time, type of incident, and also tracks reports from initial IDT review through completion.
Entries were entered into the spreadsheet retrospectively from Jan 1, 2015 and continuing through present date and sorted to identify any patterns of specific residents. Incident reports and investigative reports were reviewed for identified residents to ensure interventions addressed all root causes. Care plans were reviewed and revisions were

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F 323	Continued From page 29 bathroom, and then provided him assistance to transfer onto the toilet. NA-G told R9 she needed to help a co-worker "for a little bit and bring back some linens" to remake his bed and left the room at 8:55 a.m., exited R9's room. At 9:04 a.m., (9 minutes later), NA-G returned to R9's room with clean bed linens and made R9's bed. At 9:07 a.m., NA-G removed two pairs of pants and a shirt out of the closet, then re-entered the bathroom, asking R9 which pair of pants he wanted to wear. NA-G was completely out of R9's room and site from 8:55 a.m. to 9:04 a.m. (9 minutes); however, from 9:04 a.m. until 9:07 a.m. (3 minutes) NA-G was in R9's room, but was not present with him in the bathroom. During the entire twelve minutes R9 was alone in the bathroom, he remained seated on the toilet, and made no attempts to stand up, self transfer, or otherwise move out from the room. Upon return to the bathroom, NA-G assisted R9 to complete getting dressed for the day. During an interview on 4/1/2015 at 9:13 a.m., NA-G acknowledged she left "[R9] alone in the bathroom" when she helped out a co-worker, and also left him alone while she made his bed. NA-G said she left R9 alone so "he could have some privacy." NA-G stated she was aware [R9] had a recent fall, and that he was known to self transfer. A review of nursing progress notes indicated R9 had two recent falls in the facility: on 3/16/15 and 3/21/2015. An interdisciplinary note (IDT) dated 3/18/2015, for the review of R9's fall on 3/16 identified "...res [resident] fell while attempting to straighten/rearrange items on bedside table. Nursing department assisted with reorganization of room/bedside table. Considered an isolated	F 323	completed as indicated. SYSTEMIC CHANGES: The facility policy and procedure for fall investigations, titled IDT Incident Review Process, was updated and revised to include the use of the electronic incident report log. Clinical Managers will sort the log by name, print data specific to the resident being investigated, and attach to the post-fall investigation form. This information will be used as part of the root cause investigation and analysis. Clinical Managers have been updated on the policy and procedure revisions and the process was implemented 4/24/2015. Nursing staff will receive additional training on safety related to falls, proper use of equipment to assist residents with mobility, and following individualized safety interventions at all times. Training will be provided by 5/12/2015. MONITOR CHANGES: Clinical Managers and/or the Director of Nursing will conduct 4 random monthly audits per unit/per shift, for a minimum of 36 audits per month, to ensure compliance with safety interventions. Random comprehensive care plan audits will be conducted by the Director of Nursing and/or Clinical Managers to ensure care plans are in place and remain current. These audits will include investigating whether appropriate safety interventions were identified and implemented after a fall or other incident. These audits will be conducted monthly for at least 6 residents, for a period of 90 days or until substantial compliance is	

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F 323	Continued From page 30 event as no other falls > [in the last] 60 days. Will continue to observe for changes in behavior/mobility." An IDT note dated 4/1/2015, which reviewed R9's fall on 3/21/15, indicated "...res. attempted to transfer self to toilet and subsequently fell back on floor....Res. was hospitalized with L [left] rib fractures, #9,10,11. Returned to facility on 3/23/2015. Staff to offer toileting assistance Q [every] 30 minutes during wake hours except when participating in TR [therapeutic recreation] programming or dining, w/NOC [with night] rounds and PRN [as needed] per request. Staff will continue to observe for changes in behavior and pain ongoing." During an interview on 4/2/2015 at 1:36 p.m., registered nurse (RN)-B stated "[R9] was at risk for falls, based on his "latest quarterly assessment from January, and that he 'triggered' due to his being unsteady." RN-B also stated that since R9's latest fall and return from the hospital, "[R9] did not walk and he was on a restorative program to maintain strength." RN-B also said they initiated having staff check on him every "every 30 minutes, and offer him toileting assistance," and that "we are trying to catch him before he goes." RN said she was very aware R9 had "a history of self transferring," which increased his fall risk. RN also said a new intervention for R9's fall prevention was just added to the care plan, and that was "not to leave him unattended in the bathroom." RN-B said she the new intervention was not part of the aide's care sheets, but "that it should have added." The nurse aide care sheets were not updated. RN-B said "I get to own that one." In an interview on 4/2/2015 at 2:23 p.m., the director of nursing (DON) said, in regard to	F 323	achieved, whichever is later. Audit results will be reviewed by the Director of Nursing weekly and reported to the Quality Assurance (QA) task force monthly. The QA task force will determine additional or alternative actions to be taken, if necessary. The Director of Nursing will be responsible for compliance.	

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F 323	Continued From page 31 leaving R9 unattended in the bathroom, but be present in a resident's room, "There had to be a balance between privacy and safety for this resident." The DON added, however, that she would "expect" a resident's care plan be followed. A facility policy regarding falls was requested, but none provided. R1's admission Minimum Data Set (MDS) dated 12/18/14, indicated she admitted on 12/14, and was moderately cognitively impaired needed extensive assist of one with transfers and was occasionally incontinent of urine and did not have a toileting plan. The MDS further indicated she had fallen in the last month prior to admission with a fracture and fallen once since admission without injury. R1's quarterly MDS dated 3/19/15, indicated she had two or more falls since admission with no injury, and was frequently incontinent of urine. R1's care plan dated 12/23/15, indicated she was at risk for falls and had dementia, hip fracture and a history of falls. The care plan directed staff to "Provide toileting assistance per individualized toileting plan." During observation and interview 4/1/15, at 7:55 a.m. nursing assistant (NA)-B was observed to assist R1 onto the toilet removed her soiled incontinence and left R1 alone on the toilet while she gathered clothing from the closet and returned to the bathroom to assist R1. NA-B stated she (R1) has had several falls from attempting to take herself to the bathroom. R1's falls care area assessment (CAA) dated 12/23/14, indicated she had memory impairment,	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING ______ B. WING ______	04/02/2015

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

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F 323	Continued From page 32 incontinence, history of falls at home and was hospitalized and sent to the facility. The CAA identified she had fallen at the facility attempting to self transfer to the toilet. A Fall Risk Observation dated 3/15/15, indicated she had fallen in the last 30 days, had loss of balance and that she was at high risk for falls and to continue with current plan of care. Although R1 had a history of falls before admission and falls since her admission a facility had not completed a fall risk assessment until 3/15/15, three months after admission to the facility. Review of R1's Post Incident Investigations indicated the following: R1 had a fall 12/12/14, at 9:00 p.m. resident was found on floor near the foot of her bed and a tab alarm was added. R1 had fall 12/22/14, at 8:02 p.m. was found on floor next to bed after apparent self transfer no tab alarm in room, tab alarm added. R1 had a fall 1/14/15, at 3:30 p.m. attempted to self transfer to toilet tab alarm did not work pressure alarm added to wheelchair and bed. R1 had fall 1/24/15, at 3:00 p.m. attempted to self transfer to toilet wheelchair brakes broke and staff to bring to nurses station during shift change. R1 fall 1/26/15 at 8:00 p.m. resident found on floor in bathroom and stated she was going to use the restroom. R1 had fall 3/11/15, at 8:20 p.m. resident found on floor in bathroom between sink and toilet. Review of the falls indicated four of the six falls occurred while R1 was in the bathroom attempting to self transfer. The review also indicated four of the falls occurred between 8:00 p.m. to 9:00 p.m. and the remainder two falls	F 323		

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F 323 Continued From page 33 F 323

occurred between 3:00 p.m. and 3:30 p.m. There was no indication the facility had analyzed R1's falls to determine if there was a pattern, even though six falls occurred while in the bathroom or attempting to self transfer.

During interview 4/2/15, at 2:04 p.m. RN-B stated she was aware that R1 had multiple falls and stated she did not complete a Fall Risk Observation upon admission and should have she stated "I missed it". RN-B then stated R1 had a 72 hour bladder study completed upon admission (a test to determine a pattern of incontinence) and according to the assessment it was decided due to her dementia no plan was indicated and that another . RN-B then went on to say they should have looked at her incontinence closer and maybe they could have established a individualized toileting plan to prevent some her incontinence and falls from self transfers.

The facilities Incident Review Process dated 11/12/14, indicated "Incident/Accident reports will be reviewed by the interdisciplinary Team (IDT), Team members will participate in the investigative process, root cause analysis, and determination of appropriate interventions.

Although R1 had fallen multiple times attempting to self transfer to the toilet the facility failed comprehensively assess these falls to determine if there was pattern related to her urinary incontinence and implement interventions to help reduce her falls.

FOUR WHEELED WALKER

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	245353	A. BUILDING ______ B. WING ______	04/02/2015

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F 323	Continued From page 34	F 323		

TRANSPORTATION:

R69's diagnoses, as identified on the physician's orders dated 3/26/2015, included Parkinson's disease, paralysis, generalized pain and macular degeneration. The admission Minimum Data Set (MDS) dated 1/16/2015, identified R69 had moderate cognitive impairment, and required extensive assistance of one person for locomotion, and utilized a wheel chair and walker.

The Care Area Assessment (CAA) for activities of daily living (ADLs), dated 1/16/2015, indicated R69 had a decline in ADLs related to pneumonia and hospital stay, which resulted in weakness and functional decline. The CAA also indicated R69 was participating in skilled rehab, and further she was at risk for falls. R69's care plan (CP) last updated 3/1/15 identified she was at risk for falls, and directed staff "Give resident verbal reminders not to ambulate/transfer without SBA 1 [stand-by assist of one person] and 4WW [four-wheeled walker].

During observation on 3/31/2015 at 10:07 a.m., R69 had a gait belt around her waist standing just outside her room door. Her hands on the handle bar grips of a Nova brand, four-wheeled walker (FWW), and nursing assistant (NA)-C was standing next to her. R69 sat on the seat of the FWW, and NA-C proceeded to pushed R69, who seated looking forward in the FWW from her room, past the nursing station, and into the Rose Cafe. Once in the cafe, NA-C assisted R69 to stand, transfer into a chair and removed the gait belt after R69 was seated in the chair. The FWW remained parked next to R69 as she ate breakfast.

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F 323	Continued From page 35	F 323		

In an interview on 3/31/2015 at 11:21 a.m., nursing assistant (NA)-C stated she pushed R69 from her room to breakfast in the Cafe. "[R69] will use the [four wheeled] walker to walk," and sometime request to use a wheel chair to push her, but has asked to sit in the walker and be pushed. NA-C stated "Today I pushed her in the four-wheeled walker," and "I don't do that all the time." NA-C said R69 usually "needed stand by assist" to walk.

Review of the Nova Medical Products brand information guide, "Nova Go! Mobility," dated 2014, indicated "Seat is for stationary sitting only. Do no ambulate or use as a transport chair while seated." Further the guide had a warning: "This is a walking aid only, and is not to be used as a transportation device."

During an interview on 4/1/2015 at 12:56 p.m., registered nurse (RN)-B stated it was not facility policy to transport residents using a four-wheeled walker, and that practice "was not condoned." RN-B also stated (R69's) care sheet could be updated, to include a reminder of appropriate transportation, and that some "education and re-education was needed for the staff. RN-B stated, "This is not our policy to transport residents that way."

In an interview on 4/2/2015 at 2:23 p.m., the director of nursing (DON) stated no residents should be transported using a four-wheeled walker. The DON said "This is not safe, and should not have been done."

A facility policy regarding safe resident transportation was requested, but none was provided.

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	245353	A. BUILDING ______ B. WING ______	04/02/2015

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F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		5/12/15

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F 441	Continued From page 37 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control program that included tracking, trending and analysis of infections to reduce the risk of transmission to 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: Review of the Monthly Infection Control Log for December 2014, January 2015 and February 2015 had categories on the sheet that identified residents name, unit, room number, infection, culture, antibiotic, classification, date resolved and isolated type. The following were noted in the Monthly Infection Control Logs form: The December 2014 Infection Control Data indicated they had five confirmed cases of influenza A and two of the suspected cases were on the second floor. There was no indication if the rooms were in the same proximity, or if and when the symptoms resolved. There was no analysis or summary regarding the infection control practices. The January 2015 Monthly Infection Control Log indicated under type they had five residents with	F 441	F441 SPECIFIC RESIDENTS AFFECTED: N/A IDENTIFICATION OF OTHERS WHO 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 training on the facility policy and procedure on glucose meter disinfection. SYSTEMIC CHANGES: The facility policy and procedure, Infection Control Surveillance, which includes trending and analysis of infection control data has been reviewed and remains current. Data for 1st quarter was reviewed and analyzed by the Director of Nursing. The analysis report, including incidence and prevalence of infections within the time period, was submitted to the QA Committee and discussed on 4/21/2015. Infection control data analysis and will be conducted monthly by the Director of Nursing or designee. Infection control analysis with summary will be submitted to the QA Committee quarterly. The facility policy and procedure, Cleaning and Disinfecting Blood Glucose Meters was reviewed and remains current. This policy and procedure was immediately included in the agency staff orientation materials for all appropriate	

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F 441	Continued From page 38 elevated temperatures from 99-100 degrees with the date of onset 1/29/15, the log did not indicate the body site, organism, antibiotic or the date resolved. The February 2015 Monthly Infection Control Log indicated they had two resident with c-diff (clostridium difficile colitis which is a bacteria that causes swelling and irritation of the large intestine or colon that can be passed from person to person) the first resident listing did not identify the date of onset, if when it resolved. The second listing did not identify a onset day, the start date of the antibiotic and if the symptoms had resolved and when. Another resident listing indicated he was on ceftin (antibiotic) for four days the listing did not indicate the type of infection, date of onset, organism/culture and if it had resolved. During interview on 4/1/15, at 1:16 p.m., the Director of Nursing (DON) stated the infection control logs were done by the floor staff beginning in January of 2015. She would then take the information, try to get it together with spread sheet reports from lab and pharmacy and cross check them. She stated, "We didn't want to do anything too complicated", at this time because they were trying to get information into Matrix (Matrix is the electronic medical record system used by the facility). In regard to tracking, trending and analysis of infections, the DON stated that they look at the information at QA (Quality Assurance) but they do more with the information right away. A summary of the analysis was requested and not received. During an interview of 4/2/15, at 10:20 a.m., the DON stated that the Clinical Managers are tracking the infections on their units	F 441	supplemental staff. This policy and procedure MONITOR CHANGES: The QA Committee Chair will ensure infection control data and analysis is submitted quarterly. Data will be reviewed and discussed to determine if appropriate and timely actions are being taken to prevent the spread of infection in the facility. Clinical Managers and/or Director of Nursing will conduct 2 random monthly audits per unit/per shift, other than night shift, for a minimum of 12 audits per month, to ensure compliance with proper disinfection of glucose meters. Audits will continue for a period of 90 days, or until substantial compliance is achieved, whichever is later. Audit results will be reviewed by the Director of Nursing or designee at least weekly and reported to the QA task force monthly. Results of these audits will be reviewed by the QA task force monthly and further actions will be determined as necessary. Director of Nursing will be responsible for compliance.	

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	245353	A. BUILDING ______ B. WING ______	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 39	F 441		

independently. She stated that they look at the admit diagnosis, attempt to look at the "bug" if hospital acquired and that the symptoms should be listed on a concern form.

During an interview on 4/2/15 at 2:14 p.m., registered nurse (RN)-B stated that if there is a change in resident condition she alerts floor staff, they make sure they have supplies that they need 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:

R75 was observed on 4/1/15, at 12:56 p.m. with trained medical assistant (TMA)-A doing a blood glucose check. The TMA-A had a pair of gloves on and wiped R75's finger with an alcohol prep pad. TMA-A pierced R75's finger with a lancet exposing blood, and applied it to the test strip that was inserted into the McKesson Glucometer

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	245353	A. BUILDING ______ B. WING ______	04/02/2015

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F 441	Continued From page 40	F 441		

(machine to check blood sugar). TMA-A then removed the test strip out of the Glucometer, put the strip in a sharps container, removed a new strip from a bottle, and inserted it into the Glucometer. TMA-A proceeded to pierce a finger on R75's right hand exposing more blood, and then applied it to the test strip. TMA-A then disposed of lancet and test strip in a sharps container, removed the gloves and placed the Glucometer in a drawer of the medication cart to 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 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 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

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F 441	Continued From page 41 pathogens."	F 441		

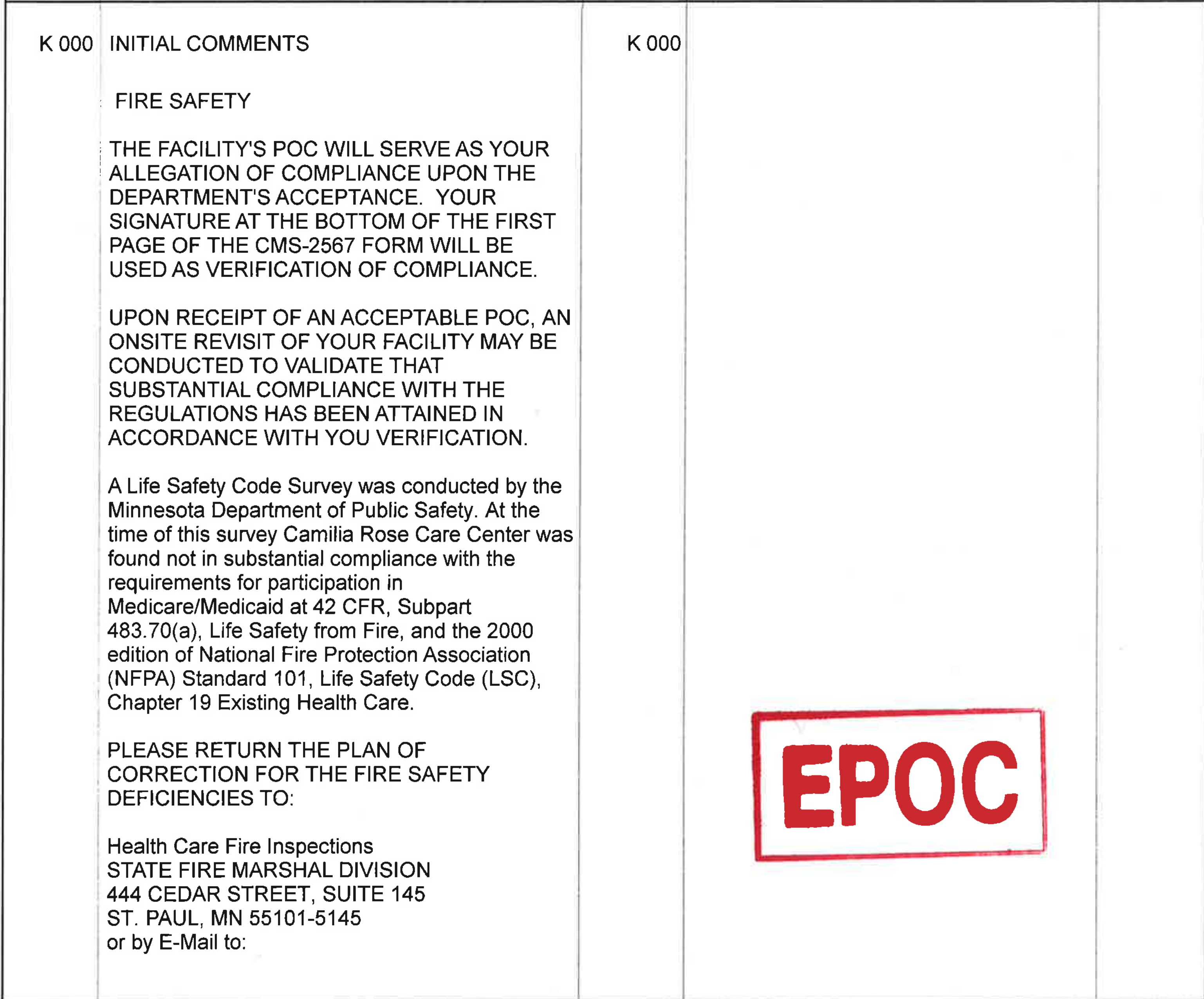
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5353023

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING **01 - MAIN BUILDING 01** B. WING	**04/06/2015**

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



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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOU VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Camilia Rose Care Center was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO:

Health Care Fire Inspections
STATE FIRE MARSHAL DIVISION
444 CEDAR STREET, SUITE 145
ST. PAUL, MN 55101-5145
or by E-Mail to:

EPOC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/06/2015**

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K 000	Continued From page 1 Marian Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Camilia Rose Care Center is a 3-story building with no basement. The original building was constructed in 1976 and an addition was constructed to the facility in 1993 both the original building and the addition are Type I (332) construction. Therefore, the nursing home was inspected as one building. The building is fully sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 80 beds and had a census of 74 at the time of the survey. At this time, the conditions of 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1	K 029		5/12/15

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING **01 - MAIN BUILDING 01** B. WING ______	**04/06/2015**

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

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K 029	Continued From page 2 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the hazardous areas are not maintained in accordance with NFPA 101-2000, Section 19.3.2.1. This deficient practice could affect the residents. Findings include: During facility tour between 9:45 AM and 12:15 PM on 04/06/2015, observation revealed that the kitchen is not properly separated from either the dining room or corridor system. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 029	K29 A. The double doors separating the dining room from the corridor have been equipped with: 1. Door closers for both leafs 2. A crash bar on the inactive leaf that latches into the top of the door frame. 3. A crash bar and door handle on the active leaf that latches into the top of the door frame. B. 1. The latching system was installed by Blaine Lock and Safe 4-23-2015. 2. The closers were installed by maintenance 4-17-2015. 3. Magnetic door holders with emergency alarm release will be installed for both leafs 4-27-2015 by Blaine Lock and Safe. C. 1. All doors, and hardware will be inspected monthly on an interior checklist to be completed by the maintenance department.	5/12/15
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily	K 038		

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K 038	Continued From page 3 accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide means of egress in accordance with the following requirements of 2000 NFPA 101, Section 7.2.1.5.4. The deficient practice could affect the residents. Findings include: On facility tour between 9:45 AM and 12:15 PM on 04/06/2015, observation revealed that several of the exterior walkways have heaved or subsided creating an uneven walking path to the public way. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 038	K38 A. 1. An exterior inspection of the exterior walkway system was completed 4-17-2015. And a determination of 10 slab sections needed corrective action. 2. Camilia Rose Care center 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 Lifting has scheduled to complete work for this project on 5-6-2015. C. 1. Louis Burns, Director of Maintenance will do monthly exterior facility inspections to ensure the integrity of the exterior walkways.	
K 069 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility's kitchen cooking equipment has not been maintained in accordance with Sec. 9.2.3 and NFPA 10. This deficient practice could affect the residents if near the kitchen.	K 069	K69 A. Camilia Rose Care Center LLC. Has contracted with HOODZ International (763 -753-3903) to complete UL-300A inspection and testing for the 2nd floor	5/12/15

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

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K 069	Continued From page 4 Findings include: On facility tour between 9:45 AM and 12:15 PM on 04/06/2015, record review revealed that there is not any documentation of the semi-annual testing of the second floor UL-300A hood system. This deficient practice was verified by the Maintenance Director at the time of the inspection.	K 069	kitchen Denlar hood. B. Inspection and testing will be completed 4-27-2015. C. Louis Burns, Maintenance Director will set a bi-annual inspection / testing schedule with HOODZ International on 4-27-2015 to ensure proper compliance.	
K 076 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD 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 failed to maintain the medical gas storage in accordance with NFPA 99. This deficient practice could affect the residents. Findings include: During facility tour on between 9:45 AM and	K 076	K76 A. 1. A Policy and Procedure has been created for the Storage and use of oxygen tanks while inside Camilia Rose Care Center LLC.. 2. E cylinder racks have placed in the oxygen storage room and empty tank room.	5/12/15

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K 076	Continued From page 5 12:15 PM on 04/06/2015, observation revealed that: 1. There are (2) E-Cylinders being stored in resident room 213 next to the resident's 41L liquid oxygen tank, 2. There is a 41L liquid oxygen tank being stored in the linen room adjacent to the oxygen storage room on the first floor, 3. There are several compressed gas cylinders in the oxygen storage room that are not properly secured. These deficient practices were verified by the Maintenance Director at the time of the inspection.	K 076	3. Chains have been securely installed in the wall of the oxygen storage room.	

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 only a suggestion 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

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.

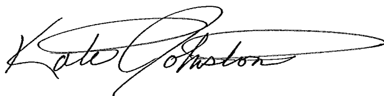
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting 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,



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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. 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. INITIAL COMMENTS: 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	2 000		

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Electronically Signed — 04/24/15

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. 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. On 3/30/15 to 4/2/15, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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 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 which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and 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.	2 000		

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2 560	Continued From page 2	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop comprehensive care plans, based on the resident's assessed needs, for 2 of 3 residents (R99, R15) reviewed for care planning. Findings include: R99's Admission Minimum Data Set (MDS) dated 12/16/14, included he had difficulty with hearing, impaired vision, severe cognitive impairment, mild mood indicators, rejection of cares, he had preferences for daily care and activities that were very important to him, limited assistance with most activities of daily living (ADL's), unsteady balance, use of an indwelling catheter, diagnoses including cancer and pneumonia, shortness of breath, oral/dental status had not been assessed, and he had skin tears. The MDS triggered out the following Care Care Assessments (CAA) which were completed by the facility on 12/22/14: cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling	2 560	Corrected.	5/12/15

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2 560	Continued From page 3 Foley catheter, psychosocial well-being, behavioral symptoms, falls, activities, and dehydration/fluid maintenance. The MDS indicated that all of these areas had been addressed in R99's care plan. R99's Temporary Care Plan dated 12/9/14, included check boxes indicating that R99 needed assistance for dressing, grooming, transferring, walking and wheeling. However, it failed to direct staff on how much assistance, or any special needs R99 had in these areas. The Temporary Care Plan also indicated R99 had his own teeth and a lower partial was missing, his hearing, vision and communication were normal, which was different than the MDS information. R99's electronic Care Plan dated 12/19/14, included, a generic activities care plan that was not specific to R99's interests and preference which were indicated on the MDS. The electronic Care Plan also addressed nutrition, but not a dehydration risk. These were the only two components completed on the electronic care pan for R99. Even though R99's MDS dated 12/16/14, identified care planning was completed for each CAA, neither R99's Temporary Care Plan or electronic Care Plans addressed, or directed staff on how to care for R99, in regards to cognitive loss/dementia, visual function, communication, urinary incontinence/indwelling Foley catheter, psychosocial well-being, behavioral symptoms, falls, activities, and dehydration/fluid maintenance. When interviewed on 4/2/15, at 1:30 p.m. the director of nursing (DON) stated each resident should have a comprehensive care plan	2 560		

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2 560	Continued From page 4	2 560		

completed within 21 days of admission, but this had not been done for R99. The nurses had not been routinely completing care plans for residents. She was aware of this and had recently been approved to add additional nursing hours so that care plans could be completed.

A facility Care Plans policy, dated 8/2010, identified a resident care plan should be developed, "...21 days after admission in the RAI [Resident Assessment Instrument] is completed on the 14th day, B. 7 days after completion of RAI if done earlier than 14th day." Further, the care plan "needs to be up to date and reflect the clients care/condition at all times."

R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assist of one to eat.

R15's care plan, dated 1/27/15, identified a problem of being at nutritional risk and "leaving greater than 25% of food uneaten." Staff were directed to provide 6 ounces chocolate milk, regular diet, monitor and record intake of food, weekly weights and offer substitutes. The care plan also identified a problem of cognitive loss/dementia with impaired decision making related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client." There was no indication in the care plan that identified how much staff assistance was required for R15 to eat her meals.

During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a

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2 560	Continued From page 5	2 560		

table and received a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of kernel corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cued R15 to use the provided utensils. R15 continued to eat the corn, and diced fruit with her fingers. She spilled the taco, and began eating the contents of the taco with her fingers until she was finished with her meal at 5:47 p.m.

When interviewed on 4/2/15, at 10:19 a.m. registered nurse (RN)-B stated R15's ability to feed herself often varies from day to day adding, "she is a complex person." Further, RN-B stated R15's care plan should have identified the level of assistance that she required for eating.

During interview on 4/2/15, at 2:51 p.m. the DON stated a care plan "drives resident care," and since late 2014 the facility's MDS nurse had "zero" involvement with the care planning process. Further, R15's care plan should have identified how much assistance she required to eat her meals, "We've had a real problem with the flow [of the care plans]."

A facility Care Plan policy, dated 8/2010, identified a purpose of, "...assist the client towards a goal of optimal wellness based on the Comprehensive Assessment." A procedure was listed for staff to follow, and identified "Nutritional needs" should be identified on a resident care plan. Further, the policy added, "...Care plan needs to be up to date and reflect the clients care/condition at all times."

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2 560	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding development of the resident care plan, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely repositioning as care planned for 2 of 3 residents (R97, R65) reviewed for activities of daily living. In addition, the facility failed to ensure care plan interventions were followed to reduce the risk of falls for 1 of 3 residents (R9) reviewed for accidents. Findings include: R97's quarterly Minimum Data Set (MDS) dated 2/26/15, identified R97 required extensive assistance of two staff to complete bed mobility and repositioning. R97's care plan, dated 3/25/14, identified R97 was at risk for skin breakdown and listed an intervention of, "Turn	2 565	Corrected.	5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 565	Continued From page 7	2 565		

and reposition every 2 hours with assist of 1."

During constant observation on 4/1/15, from 7:00 a.m. until 9:50 a.m. (2 hours and 50 minutes) R97 was observed to be laying on her back in bed. At 9:24 a.m., nursing assistant (NA)-A entered the room to see if R97 was wake, and finding she was not lowered the head of the bed (HOB) down and left the room.

Registered nurse (RN)-C, stated on 04/01/2015 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 prior.

During an interview on 4/01/15, at 10:05 a.m., NA-A, stated she was unaware when R97 had last been turned, while nothing was reported to her from the night shift. NA-A then assisted R97 to turn to the side, and examined her coccyx with no redness noted.

During interview on 04/01/2015, at 1:31 p.m. registered nurse (RN)-B stated the facility had started a new shift reporting sheet, so that information on residents' need, such as last repositioning could be followed, but this had not been completed for R97. Further RN-B stated R97 should have been repositioned every two hours as care planned.

R65's quarterly MDS, dated 1/19/15, identified R65 had intact cognition, required extensive assistance with bed mobility and transfers, and was at risk for skin breakdown. R65's care plan,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 565	Continued From page 8 dated 1/19/15, identified she was at risk for skin breakdown, and listed an intervention of, "Turn and reposition every hour as res. [resident] allows." During constant observation starting on 4/1/15, at 6:51 a.m. R65 was lying in bed positioned slightly (less than 15 degrees) on her left side. R65 remained in her bed, in the same position until 7:45 a.m. when NA-H entered the room lowered the head of the bed and slightly (approximately 2 or 3 inches) pulled the draw sheet towards her. NA-H completed R65's range of motion exercises, however did not off load or reposition R65 in the bed, and left R65's room at 8:00 a.m.. R65 then remained in bed until 8:38 a.m. when she was assisted to roll onto her right side to have her incontinence product removed by NA-I. R65 was not off loaded or repositioned adequately to allow tissue perfusion to her coccyx for 1 hour and 37 minutes. 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 tries to follow a residents care plan, "I try to follow it as closely as I can." During interview on 4/1/15, at 12:12 p.m. NA-H stated she thought R65 was to be repositioned every 2 hours, and verified she did not off load R65's during her range of motion exercises earlier that morning. During interview on 4/1/15, at 2:42 p.m. RN-B stated R65 was at risk for pressure ulcers, and should be repositioned every hour according to her plan of care, "Her care plan states every hour." When interviewed on 4/2/15, at 2:51 p.m. the DON stated a care plan "drives resident care,"	2 565		

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	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 565	Continued From page 9 and the expectation is they are followed by the staff. R9's quarterly MDS, dated 1/20/2015, identified R9 had moderately impaired cognition, and required extensive, physical assistance for transferring, and toileting. R9's care plan, dated 3/30/2015, identified the goal of not having any fall-related injures and listed interventions to prevent falls, among which included "A1-2 (assist of 1 to 2 persons) with all transfers and mobility," and "Do not leave resident in bathroom alone or unattended." During observation on 4/1/2015, at 8:44 a.m. NA-G entered R9's room to assist him out of bed, and begin routine morning cares. NA-G assisted R9 into the bathroom, and provided assistance to transfer onto the toilet. NA-G stated she needed to help a co-worker "for a little bit and bring back some linens" to remake his bed, and left R9 in the bathroom alone at 8:55 a.m. At 9:04 a.m., (9 minutes later), NA-G returned to R9's room with bed linens and proceeded to make his bed. NA-G was out of R9's room from 8:55 a.m. to 9:04 a.m. (9 minutes); however, from 9:04 a.m. until 9:07 a.m. (3 minutes), NA-G was in R9's room, but not present with him in the bathroom. During the entire twelve minutes R9 was alone in the bathroom, he remained seated on the toilet, and made no attempts to stand up, self transfer, or otherwise move out from the room. Upon return to the bathroom, NA-G assisted R9 to get dressed for the day. During an interview on 4/1/2015 at 9:13 a.m., NA-G verified she left "[R9] alone in the bathroom" when she briefly helped out a co-worker, and also left him alone while she made his bed. NA-G said she left R9 alone so	2 565		

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CAMILIA ROSE CARE CENTER LLC	**11800 XEON BOULEVARD COON RAPIDS, MN 55448**

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2 565	Continued From page 10 "he could have some privacy." Further, NA-G stated she knew [R9] had a recent fall, and he was known to self transfer. During an interview on 4/2/2015 at 1:36 p.m., registered nurse (RN)-B stated "[R9] was at risk for falls, and had a history of "self transferring." A new intervention for R9's fall prevention had recently been added to the care plan, "To not leave him unattended in the bathroom." RN-B said the new intervention should have been identified on the aide's care sheets, but that it had not been completed, "it should have added." When interviewed on 4/2/15, at 2:23 p.m. the director of nursing (DON) stated she would "expect" a resident's care plan be followed. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding the purpose of a resident care plan, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the	2 830		5/12/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 00757	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ______ B. WING ______	(X3) DATE SURVEY COMPLETED 04/02/2015

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2 830	Continued From page 11 resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and implemented interventions to reduce the risk of falls for 1 of 3 residents (R9, R1) reviewed for accidents hazards during the survey. In addition, the facility failed to ensure a seated four-wheeled walker was used as a transportation device, which the manufacturer had not recommended for use for 1 of 4 residents (R69) observed to use such a device during the survey. Finding include: FALLS RISK R9's diagnoses, as identified on the physician's orders dated 2/22/2015, included arthritis, dementia, congestive heart failure, and obesity. The quarterly Minimum Data Set (MDS), dated 1/20/2015, identified R9 had moderately impaired cognition, and also that he needed extensive, physical assistance for transferring, and toileting. A care area assessment (CAA) for falls, dated 8/8/2014, indicated R9 was at high risk for falls, due to a high fall-risk score, and a history of falls, one resulting with a hip fracture. The CAA further identified additional factors, increasing R9's fall risk, including: use of anti-depressant and diuretic (water pill) medications, incontinence, hearing impairment, as well as cognition impairment. R9's care plan (CP), updated 3/30/2015,	2 830	Corrected.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 830	Continued From page 12	2 830		

identified the goal, that R9 would not have any fall-related injuries while at the nursing home, and R9 would use their call light for assistance, instead of self transferring. The CP listed numerous interventions to prevent falls, among which directed staff to "A1-2 (assist of 1 to 2 persons) with all transfers and mobility," and "Do not leave resident in bathroom alone or unattended."

During observation on 4/1/2015 at 8:44 a.m., nursing assistant (NA)-G entered R9's room to assist him out of bed, and begin routine morning cares. After putting shoes over R9's socks and feet, then assisting him to sit upright on the side of the bed, NA-G, with a transfer belt around his waist, assisted him to stand, pivot, then sit into the wheel chair. NA-A pushed R9 into the bathroom, and then provided him assistance to transfer onto the toilet. NA-G told R9 she needed to help a co-worker "for a little bit and bring back some linens" to remake his bed and left the room at 8:55 a.m., exited R9's room. At 9:04 a.m., (9 minutes later), NA-G returned to R9's room with clean bed linens and made R9's bed. At 9:07 a.m., NA-G removed two pairs of pants and a shirt out of the closet, then re-entered the bathroom, asking R9 which pair of pants he wanted to wear. NA-G was completely out of R9's room and site from 8:55 a.m. to 9:04 a.m. (9 minutes); however, from 9:04 a.m. until 9:07 a.m. (3 minutes) NA-G was in R9's room, but was not present with him in the bathroom. During the entire twelve minutes R9 was alone in the bathroom, he remained seated on the toilet, and made no attempts to stand up, self transfer, or otherwise move out from the room. Upon return to the bathroom, NA-G assisted R9 to complete getting dressed for the day.

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2 830	Continued From page 13 During an interview on 4/1/2015 at 9:13 a.m., NA-G acknowledged she left "[R9] alone in the bathroom" when she helped out a co-worker, and also left him alone while she made his bed. NA-G said she left R9 alone so "he could have some privacy." NA-G stated she was aware [R9] had a recent fall, and that he was known to self transfer. A review of nursing progress notes indicated R9 had two recent falls in the facility: on 3/16/15 and 3/21/2015. An interdisciplinary note (IDT) dated 3/18/2015, for the review of R9's fall on 3/16 identified "...res [resident] fell while attempting to straighten/rearrange items on bedside table. Nursing department assisted with reorganization of room/bedside table. Considered an isolated event as no other falls > [in the last] 60 days. Will continue to observe for changes in behavior/mobility." An IDT note dated 4/1/2015, which reviewed R9's fall on 3/21/15, indicated "...res. attempted to transfer self to toilet and subsequently fell back on floor....Res. was hospitalized with L [left] rib fractures, #9,10,11. Returned to facility on 3/23/2015. Staff to offer toileting assistance Q [every] 30 minutes during wake hours except when participating in TR [therapeutic recreation] programming or dining, w/NOC [with night] rounds and PRN [as needed] per request. Staff will continue to observe for changes in behavior and pain ongoing." During an interview on 4/2/2015 at 1:36 p.m., registered nurse (RN)-B stated "[R9] was at risk for falls, based on his "latest quarterly assessment from January, and that he 'triggered' due to his being unsteady." RN-B also stated that since R9's latest fall and return from the hospital, "[R9] did not walk and he was on a restorative program to maintain strength." RN-B also said	2 830		

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2 830	Continued From page 14 they initiated having staff check on him every "every 30 minutes, and offer him toileting assistance," and that "we are trying to catch him before he goes." RN said she was very aware R9 had "a history of self transferring," which increased his fall risk. RN also said a new intervention for R9's fall prevention was just added to the care plan, and that was "not to leave him unattended in the bathroom." RN-B said she the new intervention was not part of the aide's care sheets, but "that it should have added." The nurse aide care sheets were not updated. RN-B said "I get to own that one." In an interview on 4/2/2015 at 2:23 p.m., the director of nursing (DON) said, in regard to leaving R9 unattended in the bathroom, but be present in a resident's room, "There had to be a balance between privacy and safety for this resident." The DON added, however, that she would "expect" a resident's care plan be followed. A facility policy regarding falls was requested, but none provided. R1's admission Minimum Data Set (MDS) dated 12/18/14, indicated she admitted on 12/14, and was moderately cognitively impaired needed extensive assist of one with transfers and was occasionally incontinent of urine and did not have a toileting plan. The MDS further indicated she had fallen in the last month prior to admission with a fracture and fallen once since admission without injury. R1's quarterly MDS dated 3/19/15, indicated she had two or more falls since admission with no injury, and was frequently incontinent of urine. R1's care plan dated 12/23/15, indicated she was at risk for falls and had dementia, hip fracture and	2 830		

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	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 830	Continued From page 15	2 830		

a history of falls. The care plan directed staff to "Provide toileting assistance per individualized toileting plan."

During observation and interview 4/1/15, at 7:55 a.m. nursing assistant (NA)-B was observed to assist R1 onto the toilet removed her soiled incontinence and left R1 alone on the toilet while she gathered clothing from the closet and returned to the bathroom to assist R1. NA-B stated she (R1) has had several falls from attempting to take herself to the bathroom.

R1's falls care area assessment (CAA) dated 12/23/14, indicated she had memory impairment, incontinence, history of falls at home and was hospitalized and sent to the facility. The CAA identified she had fallen at the facility attempting to self transfer to the toilet. A Fall Risk Observation dated 3/15/15, indicated she had fallen in the last 30 days, had loss of balance and that she was at high risk for falls and to continue with current plan of care. Although R1 had a history of falls before admission and falls since her admission a facility had not completed a fall risk assessment until 3/15/15, three months after admission to the facility.

Review of R1's Post Incident Investigations indicated the following:
R1 had a fall 12/12/14, at 9:00 p.m. resident was found on floor near the foot of her bed and a tab alarm was added.
R1 had fall 12/22/14, at 8:02 p.m. was found on floor next to bed after apparent self transfer no tab alarm in room, tab alarm added.
R1 had a fall 1/14/15, at 3:30 p.m. attempted to self transfer to toilet tab alarm did not work pressure alarm added to wheelchair and bed.
R1 had fall 1/24/15, at 3:00 p.m. attempted to self

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 16 transfer to toilet wheelchair brakes broke and staff to bring to nurses station during shift change. R1 fall 1/26/15 at 8:00 p.m. resident found on floor in bathroom and stated she was going to use the restroom. R1 had fall 3/11/15, at 8:20 p.m. resident found on floor in bathroom between sink and toilet. Review of the falls indicated four of the six falls occurred while R1 was in the bathroom attempting to self transfer. The review also indicated four of the falls occurred between 8:00 p.m. to 9:00 p.m. and the remainder two falls occurred between 3:00 p.m. and 3:30 p.m. There was no indication the facility had analyzed R1's falls to determine if there was a pattern, even though six falls occurred while in the bathroom or attempting to self transfer. During interview 4/2/15, at 2:04 p.m. RN-B stated she was aware that R1 had multiple falls and stated she did not complete a Fall Risk Observation upon admission and should have she stated "I missed it". RN-B then stated R1 had a 72 hour bladder study completed upon admission (a test to determine a pattern of incontinence) and according to the assessment it was decided due to her dementia no plan was indicated and that another . RN-B then went on to say they should have looked at her incontinence closer and maybe they could have established a individualized toileting plan to prevent some her incontinence and falls from self transfers. The facilities Incident Review Process dated 11/12/14, indicated "Incident/Accident reports will be reviewed by the interdisciplinary Team (IDT), Team members will participate in the investigative	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE CARE CENTER LLC	**11800 XEON BOULEVARD COON RAPIDS, MN 55448**

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2 830	Continued From page 17	2 830		

process, root cause analysis, and determination of appropriate interventions.

Although R1 had fallen multiple times attempting to self transfer to the toilet the facility failed comprehensively assess these falls to determine if there was pattern related to her urinary incontinence and implement interventions to help reduce her falls.

FOUR WHEELED WALKER TRANSPORTATION:

R69's diagnoses, as identified on the physician's orders dated 3/26/2015, included Parkinson's disease, paralysis, generalized pain and macular degeneration. The admission Minimum Data Set (MDS) dated 1/16/2015, identified R69 had moderate cognitive impairment, and required extensive assistance of one person for locomotion, and utilized a wheel chair and walker.

The Care Area Assessment (CAA) for activities of daily living (ADLs), dated 1/16/2015, indicated R69 had a decline in ADLs related to pneumonia and hospital stay, which resulted in weakness and functional decline. The CAA also indicated R69 was participating in skilled rehab, and further she was at risk for falls. R69's care plan (CP) last updated 3/1/15 identified she was at risk for falls, and directed staff "Give resident verbal reminders not to ambulate/transfer without SBA 1 [stand-by assist of one person] and 4WW [four-wheeled walker].

During observation on 3/31/2015 at 10:07 a.m., R69 had a gait belt around her waist standing just outside her room door. Her hands on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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CAMILIA ROSE CARE CENTER LLC	**11800 XEON BOULEVARD COON RAPIDS, MN 55448**

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2 830	Continued From page 18	2 830		

handle bar grips of a Nova brand, four-wheeled walker (FWW), and nursing assistant (NA)-C was standing next to her. R69 sat on the seat of the FWW, and NA-C proceeded to pushed R69, who seated looking forward in the FWW from her room, past the nursing station, and into the Rose Cafe. Once in the cafe, NA-C assisted R69 to stand, transfer into a chair and removed the gait belt after R69 was seated in the chair. The FWW remained parked next to R69 as she ate breakfast.

In an interview on 3/31/2015 at 11:21 a.m., nursing assistant (NA)-C stated she pushed R69 from her room to breakfast in the Cafe. "[R69] will use the [four wheeled] walker to walk," and sometime request to use a wheel chair to push her, but has asked to sit in the walker and be pushed. NA-C stated "Today I pushed her in the four-wheeled walker," and "I don't do that all the time." NA-C said R69 usually "needed stand by assist" to walk.

Review of the Nova Medical Products brand information guide, "Nova Go! Mobility," dated 2014, indicated "Seat is for stationary sitting only. Do no ambulate or use as a transport chair while seated." Further the guide had a warning: "This is a walking aid only, and is not to be used as a transportation device."

During an interview on 4/1/2015 at 12:56 p.m., registered nurse (RN)-B stated it was not facility policy to transport residents using a four-wheeled walker, and that practice "was not condoned." RN-B also stated (R69's) care sheet could be updated, to include a reminder of appropriate transportation, and that some "education and re-education was needed for the staff. RN-B stated, "This is not our policy to transport

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 19 residents that way." In an interview on 4/2/2015 at 2:23 p.m., the director of nursing (DON) stated no residents should be transported using a four-wheeled walker. The DON said "This is not safe, and should not have been done." A facility policy regarding safe resident transportation was requested, but none was provided. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review and revice policies and procedures related to falls, and accident hazzard assessments. They could provide staff education related to the care of resident related to falls and accident hazzards. The director of nursing or designee could develop an audit tool to ensure appropriate care is provided.	2 830		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician	2 900		5/12/15

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2 900	Continued From page 20 authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to complete timely repositioning to reduce the risk of pressure ulcer formation for 2 of 3 residents (R97, R65) reviewed for pressure ulcers. Findings include: R97's quarterly Minimum Data Set (MDS) dated 2/26/15, identified R97 had no current pressure ulcers, and required extensive assistance of two staff for bed mobility and repositioning. R97's Pressure Ulcers Care Area Assessment (CAA), dated 6/07/14, indicated " assist of 2 with mechanical lift to transfer; turns side to side with A2 [assist of 2] staff." During constant observation on 4/1/15, from 7:00 a.m until 9:50 a.m. (2 hours and 50 minutes), R97 was observed to be laying on her back in bed. At 9:24 a.m., nursing assistant (NA)A entered the room to see if R97 was wake, and finding that she was not, lowered the head of the bed (HOB) and left the room. Registered nurse (RN)-C, stated on 04/01/2015 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	2 900	Corrected.	

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	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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2 900	Continued From page 21	2 900		

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 this document identified to "Select the intervention plan", which was left blank. There was no indication of how frequent R97 needed to be repositioned.

The (not dated) Braden Scale score form, (a form used to determine pressure ulcer risk) identified R97 had a score of 13 (13-14 moderate risk) for the development of pressure ulcers.

In review of R97's care plan (problem start date of 3/25/14), the facility identified the resident was at risk for skin irritation/breakdown related to decreased mobility, incontinence of both bowel and bladder, and peripheral vascular disease (PVD). The interventions directed staff that R97 needed to be "turn and reposition every 2 hours with assist of 1."

During interview on 04/01/2015 at 1:31 p.m., a registered nurse (RN)B stated the facility had started a new shift reporting sheet, so that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 22	2 900		

information on residents' need, such as last repositioning could be followed, and this was not done. RN-B stated that R97 should have been repositioned every two hours as assessed and care planned.

The facility's policy, entitled: Skin and Wound Care Protocol (dated 4/24/14) indicated that the facility would be utilizing tools such as: the Braden Scale, Skin Risk Assessment, Tissue Tolerance Observations and weekly Skin Breakdown Observations. This document further indicated: "The completed tools will be used to develop and implement and individualized plan of care" and further described interventions, treatments and monitoring systems.

R65's quarterly MDS, dated 1/19/15, identified R65 had intact cognition, required extensive assistance with bed mobility and transfers, and was at risk for skin breakdown. R65's Skin assessment, dated 1/29/15, identified R65 had an "open area on coccyx", and listed an intervention of, "Staff to continue to offer hourly repositioning." R65's care plan, dated 1/19/15, identified she was at risk for skin breakdown, and listed an intervention of, "Turn and reposition every hour as res. [resident] allows."

During constant observation starting on 4/1/15, at 6:51 a.m. R65 was lying in bed positioned slightly (less than 15 degrees) on her left side, without the use of a pillow or positioning device. R65 remained in her bed, in the same position until 7:45 a.m. when NA-H entered the room lowered the head of the bed and slightly (approximately 2 or 3 inches) pulled R65's draw sheet towards her having her lay completely on her back. NA-H then completed R65's range of motion exercises, however did not off load or reposition her, and left

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2 900	Continued From page 23	2 900		

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 tries to follow a residents care plan, "I try to follow it as closely as I can." During interview on 4/1/15, at 12:12 p.m. NA-H stated she thought R65 was to be repositioned every 2 hours, and further stated she did not off load R65's from her coccyx area during her range of motion exercises earlier that morning.

During interview on 4/1/15, at 2:42 p.m. RN-B stated R65 admitted to the facility with a stage III (full thickness skin loss involving damage to, or necrosis of subcutaneous tissue) pressure ulcer on her coccyx, which has improved but continues to remain at risk for pressure ulcer development. Further, R65 should have been completely off-loaded from her coccyx every one hour as directed by her care plan.

When interviewed on 4/2/15, at 2:51 p.m. the DON stated a resident's care plan should be followed.

A facility Skin and Wound Care Protocol policy, dated 4/24/14, identified, "Staff will provide appropriate care and services to reduce the risk skin [sp] breakdown or other wounds according to the individualized care plan." Further, the policy identified, "Nursing interventions may include...toileting and repositioning per care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 900	Continued From page 24 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 (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess and implement interventions to reduce urinary incontinence for 1 of 3 residents (R1)	2 910	Corrected.	5/12/15

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2 910	Continued From page 25	2 910		

reviewed and who was incontinent of urine.

Findings include:

R1's admission Minimum Data Set (MDS), dated 12/18/14, identified R1 was moderately cognitively impaired, required extensive assist of one with transfers, was occasionally incontinent of urine, however did not have a toileting plan. R1's quarterly MDS, dated 3/19/15, identified she had a change and was now frequently incontinent of urine, but did not have a toileting plan in place. R1's care plan dated 1/2/15 identified a problem of urinary incontinent and staff were directed to "Assist to toilet Q [every] 2 hours, with NOC [night] rounds and PRN [as needed]."

During observation of care on 4/01/15 at 7:55 a.m., nursing assistant (NA)-B removed R1's incontinent product which was soiled with urine. During an interview on 04/02/15 at 1:53 p.m., NA-B stated she typically works on the day shift and if R1 is sleeping when she gets here, she will frequently be incontinent in the morning.

Review of R1's Bowel and Bladder 72-Hour Data Collection (a form used to monitor urinary incontinence over 72 hours), dated 12/12/14-12/14/14, identified R1 had two incontinent episodes for the period. An additional Bowel and Bladder collection sheet dated 1/28 thru 1/31/15, identified R1 was continent 13 out of 32 opportunities during the day shift with 14 shifts left blank. During the evening shift R1 was continent 27 out of 32 opportunities, and during the night was continent 20 out of 32 opportunities with 3 shifts being left blank. During this time R1 voided 12 times on the toilet/bedpan and was continent during these times. Although R1 had a voiding pattern of being more continent during the

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2 910	Continued From page 26	2 910		

evening and day shifts, and voided on the toilet. The facility had not completed an analysis of the data to determine a specific toileting plan for R1 to help improve R1's bladder continence.

Review of the Point of Care Bowel/Bladder Category Report from 2/28/15 through 3/21/15 identified R1, was continent 10 out of 22 opportunities during the day shift; 20 out of 22 opportunities for the evening shift, and was continent 0 of 9 opportunities for the night shift.

Review of R1's quarterly Bladder Observation, dated 3/18/15, identified R1 had urge and stress incontinence, impaired mobility, and was not appropriate for toileting program or retraining due to her dementia. Even though the point click care data from 2/28/15 to 3/21/15 identifies a pattern of being more continent during the evening and day shift hours, which was a change from the December 2014 Bowel and Bladder 72-Hour Data Collection sheet, where she was only incontinent twice.

When interviewed on 4/02/2015, at 10:03 registered nurse (RN)-B stated the facility protocol for resident bladder assessment is 3 day collection done annually, and "as a practice we would do a deeper investigation." Further, RN-B stated R1 was able to verbalize her need for toileting but this was inconsistent.

During interview on 04/02/15, at 2:04 p.m., RN-B stated R1's Bladder Observation should have been completed upon admission, however it had not been. Further, RN-B stated the facility should have reviewed R1's incontinence more closely and put her on a more individualized toileing schedule to prevent some of her incontinent episodes.

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2 910	Continued From page 27 Although R1's incontinence went from occasionally to frequently incontinent, and R1 could verbalize her need for toileting. The facility failed to assess for patterns and the cause of R1's increased incontinence and implement a plan to help reduce her incontinence episodes. A facility Guidelines for Client's Bladder and Bowel Assessment policy, dated 3/13/15, identified it, "Directs staff to ensure clients are able to maintain their highest practicable level of toileting function and to develop and individualized toileting plan of care." Further, "A full assessment is to be completed upon admission, quarterly, annually and with a significant change of condition using a 72 hour Bladder and Bowel Data collection sheet, Bowel and Bladder analysis and summary of data." SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding the assessment of residents with incontinence, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of	2 915		5/12/15

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2 915	Continued From page 28 the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision and cues for eating to 1 of 4 residents (R15) who required staff assistance with eating. Findings include: R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assistance from staff to eat. R15's care plan, dated 1/27/15, identified a problem of being at nutritional risk and "leaving greater than 25% of food uneaten." Staff were directed to monitor and record intake of food, weekly weights and offer substitutes. The care plan also identified a problem of cognitive loss/dementia with impaired decision making related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client."	2 915	Corrected.	

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CAMILIA ROSE CARE CENTER LLC	11800 XEON BOULEVARD COON RAPIDS, MN 55448

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2 915	Continued From page 29 During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a table in the 3rd floor dining room with two other residents, and had a clothing protector around her neck which covered her shirt. She was served a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cues to use the provided utensils to R15 who continued to eat the corn using her fingers, spilling on her lap and the floor. R15 opened the soft taco at 5:26 p.m. and began to eat the meat inside using her fingers, pulling the plate closer to the edge of the table as she ate it. At 5:27 p.m. she then picked up the small bowl of diced fruit and began to eat it using her fingers, resumed eating the taco meat from her plate, and then spilled the plate on her lap at 5:30 p.m.. R15 picked her plate back up, placed it on the table, and continued to eat using her fingers to eat her meal. Her clothing was now soiled with a tattered soft taco shell, taco meat, and corn. At 5:37 p.m. R15 began picking up pieces of food from her lap and eating them with her fingers. Registered Nurse (RN)-B approached the table where R15 was seated at 5:44 p.m., but did not offer eating assistance or cues to her as R15 continued to eat pieces of taco meat and corn from her lap with her fingers. 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	2 915		

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2 915	Continued From page 30 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 often find items like peas and corn left on the floor when she is finished eating adding, "Maybe they [nurses] could take a look at her that way." During interview on 4/2/15, at 10:06 a.m. NA-B stated staff should provide R15 with cues to eat, and offer assistance if she is seen to be struggling with her meals. When interviewed on 4/2/15, at 10:19 a.m. RN-B stated R15 should should have been offered assistance or cues with her meal. During interview on 4/2/15, at 2:51 p.m. the director of nursing (DON) stated staff should have offered R15 assistance, or at least provided cues to use the utensils to eat her meal. A facility policy on meal assistance was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding how to assist residents to eat by providing supervision, and then audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00757	A. BUILDING: ______ B. WING ______	04/02/2015

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21390	Continued From page 31	21390		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and implement an infection control program that included tracking, trending and analysis of infections to reduce the risk of transmission to	21390	Corrected.	5/12/15

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	00757	A. BUILDING: ______ B. WING ______	04/02/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21390	Continued From page 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:

Review of the Monthly Infection Control Log for December 2014, January 2015 and February 2015 had categories on the sheet that identified residents name, unit, room number, infection, culture, antibiotic, classification, date resolved and isolated type. The following were noted in the Monthly Infection Control Logs form:

The December 2014 Infection Control Data indicated they had five confirmed cases of influenza A and two of the suspected cases were on the second floor. There was no indication if the rooms were in the same proximity, or if and when the symptoms resolved. There was no analysis or summary regarding the infection control practices.

The January 2015 Monthly Infection Control Log indicated under type they had five residents with elevated temperatures from 99-100 degrees with the date of onset 1/29/15, the log did not indicate the body site, organism, antibiotic or the date resolved.

The February 2015 Monthly Infection Control Log indicated they had two resident with c-diff (clostridium difficile colitis which is a bacteria that

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21390	Continued From page 33 causes swelling and irritation of the large intestine or colon that can be passed from person to person) the first resident listing did not identify the date of onset, if when it resolved. The second listing did not identify a onset day, the start date of the antibiotic and if the symptoms had resolved and when. Another resident listing indicated he was on ceftin (antibiotic) for four days the listing did not indicate the type of infection, date of onset, organism/culture and if it had resolved. During interview on 4/1/15, at 1:16 p.m., the Director of Nursing (DON) stated the infection control logs were done by the floor staff beginning in January of 2015. She would then take the information, try to get it together with spread sheet reports from lab and pharmacy and cross check them. She stated, "We didn't want to do anything too complicated", at this time because they were trying to get information into Matrix (Matrix is the electronic medical record system used by the facility). In regard to tracking, trending and analysis of infections, the DON stated that they look at the information at QA (Quality Assurance) but they do more with the information right away. A summary of the analysis was requested and not received. During an interview of 4/2/15, at 10:20 a.m., the DON stated that the Clinical Managers are tracking the infections on their units independently. She stated that they look at the admit diagnosis, attempt to look at the "bug" if hospital acquired and that the symptoms should be listed on a concern form. During an interview on 4/2/15 at 2:14 p.m., registered nurse (RN)-B stated that if there is a change in resident condition she alerts floor staff, they make sure they have supplies that they need	21390		

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21390	Continued From page 34 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: R75 was observed on 4/1/15, at 12:56 p.m. with trained medical assistant (TMA)-A doing a blood glucose check. The TMA-A had a pair of gloves on and wiped R75's finger with an alcohol prep pad. TMA-A pierced R75's finger with a lancet exposing blood, and applied it to the test strip that was inserted into the McKesson Glucometer (machine to check blood sugar). TMA-A then removed the test strip out of the Glucometer, put the strip in a sharps container, removed a new strip from a bottle, and inserted it into the Glucometer. TMA-A proceeded to pierce a finger on R75's right hand exposing more blood, and then applied it to the test strip. TMA-A then disposed of lancet and test strip in a sharps container, removed the gloves and placed the Glucometer in a drawer of the medication cart to	21390		

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21390	Continued From page 35	21390		

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 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 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 pathogens."

SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review/revise policies and procedures for infection control surveillance and data collection/analysis, then inservice staff and audit to ensure compliance.

TIME PERIOD FOR CORRECTION: Twenty-one

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21390	Continued From page 36 (21) days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to ensure tuberculosis (TB) symptom screenings were completed for 5 of 5 residents (R69, R67, R209, R198, and R95) reviewed during the Quality Indicator Survey (QIS). Findings include: During review of R69, R67, R209, R198, and	21426	Corrected.	5/12/15

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21426	Continued From page 37 R95's medical record, no TB symptom screenings (a tool used to determine if active TB infection could be present) were identified. During interview on 3/31/15, at 1:08 p.m. registered nurse (RN)-A stated the facility stopped completing a symptom screening on new residents approximately 8 months prior when the facility no longer had a shortage of tuberculin derivative (solution injected under the skin to test for exposure to TB). When interviewed on 3/31/14, at 2:04 p.m. the director of nursing (DON) stated staff had been educated regarding TB, and R69, R67, R209, R198, and R95 should have had a TB symptom screening completed upon their admission to the facility. A facility Tuberculosis Exposure Control Plan, dated 10/10/11, identified a policy of, "To institute an effective Tuberculosis (TB) Control Plan that includes early detection of latent TB infection, screening for infectious TB disease...and treatment of persons with non-infectious TB." However, the policy did not identify if a symptom screening should be completed for residents upon admission to the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could review TB policy and procedure to ensure symptom screenings are completed, then inservice staff and audit for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		

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21800	Continued From page 38	21800		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.	21800		5/12/15
	This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required notices to inform residents who discharged from Medicare,		Corrected.	

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21800	Continued From page 39 of their right to an expedited review and/or the estimated costs for non-covered services, for 2 of 3 residents (R63, and R49) reviewed for compliance with liability and appeal rights. Findings include: R63's current Resident Admission Record identified he was admitted to the facility on 4/24/14, where he remained a resident to date. Review of a Notice of Provider Non-coverage (Centers for Medicare & Medicaid Services [CMS]-10123) signed 7/8/14, identified R63 had received Medicare covered services that were to end on 7/10/14, due to his discharge from skilled therapies. Though R63 remained in the facility after services ended, the facility was unable to provide evidence R63 and/or his legal representative received the Skilled Nursing Facility Advance Beneficiary Notice (CMS-10055) to notify him of estimated costs for non-covered services. R63 also received skilled services from therapy. The OT (occupational therapy) Therapist Progress & Discharge Summary signed 1/29/15, and PT (physical therapy) Therapist Progress & Discharge Summary signed 1/30/15, identified R63 received Medicare covered services for treatment of muscle weakness from 1/13/15, through 1/30/15, after a qualifying hospital stay. The facility was unable to provide evidence R63 and/or his legal representative received the form CMS-10123 to notify him of Medicare services ending and a right to an appeal process. Also there was no indication the facility gave him the CMS-10055 form that notified him of estimated costs for non-covered services after Medicare ended. R49's current Resident Admission Record identified she was admitted to the facility on 12/14, and was discharged on 1/8/15. Review of	21800		

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21800	Continued From page 40 OT Therapist Progress & Discharge Summary signed 1/5/15, and PT Therapist Progress & Discharge Summary signed 1/7/15, identified R49 had received Medicare covered services for difficulty in walking from 12/19/14, through 1/7/15, after a qualifying hospital stay. A CMS-10095 (an incorrect Medicare form) was provided to R49 and signed on 1/5/15. There was no indication that R49 and/or her legal representative received the required CMS-10123 form to notify her of her right to an expedited review, nor was a CMS-10055 form completed that notified the resident and/or legal representative of estimated costs for non-covered services after Medicare ended. The CMS-10095, was not the correct Medicare part A form that was used by the facility. On 4/2/15, at 3:07 p.m. the director of nursing (DON) was interviewed regarding the facility's liability and appeal rights processes and the CMS-10095 form the facility used for providing residents with notices of services ending and costs for services. The DON knowledge the facility had not been using the correct forms as required for notification of liability and appeal rights. She stated the facility had identified their process was not compliant with the requirements, but had not yet developed or implemented systems to remedy the errors of the incorrect forms. Registered nurse (RN)-Z, who was responsible for providing liability and appeal right notices within the facility, was unavailable for interview. A policy was requested, but none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing, or designee, could inservice staff regarding providing correct Medicare liability notice(s), and audit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one	21800		

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21800	Continued From page 41 (21) days.	21800		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide supervision and cues to enhance dignity during a dining observation for 1 of 1 residents (R15) who was observed eating kernel corn, and diced fruit with her fingers. Findings include: R15's significant change Minimum Data Set (MDS), dated 1/28/15, identified R15 had short and long term memory problems, and required supervision with assistance from staff to eat. R15's care plan, dated 1/27/15, identified a problem of cognitive loss/dementia with impaired decision making related to memory and judgment deficits. Staff were directed to "provide cues and reminders PRN [as needed]" and to "anticipate needs-inquire with client." During observation of the evening meal service, on 3/30/15 at 5:20 p.m., R15 was seated at a table in the 3rd floor dining room with two other residents, and had a clothing protector around	21805	Corrected.	5/12/15

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21805	Continued From page 42 her neck which covered her shirt. She was served a plate of food consisting of kernel corn, small diced fruit bowl, and a soft taco with shredded lettuce and cheese on top. A fork and spoon were sitting on the table next to her plate. R15 began to pick up pieces of corn using her fingers, spilling a large amount of the corn on the floor as she attempted to eat it. Nursing assistant (NA)-D, NA-E, and NA-F walked by the table and did not offer assistance, or cues to use the provided utensils to R15 who continued to eat the corn using her fingers, spilling on her lap and the floor. R15 opened the soft taco at 5:26 p.m. and began to eat the meat inside using her fingers, pulling the plate closer to the edge of the table as she ate it. At 5:27 p.m. she then picked up the small bowl of diced fruit and began to eat it using her fingers, resumed eating the taco meat from her plate, and then spilled the plate on her lap at 5:30 p.m.. R15 picked her plate back up, placed it on the table, and continued to eat using her fingers to eat her meal. Her clothing was now soiled with a tattered soft taco shell, taco meat, and corn. At 5:37 p.m. R15 began picking up pieces of food from her lap and eating them with her fingers. Registered Nurse (RN)-B approached the table where R15 was seated at 5:44 p.m., but did not offer eating assistance or cues to her as R15 continued to eat pieces of taco meat and corn from her lap with her fingers. 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 even though R15 was eating, kernel corn and diced fruit with her fingers.	21805		

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21805	Continued From page 43 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." When interviewed on 4/2/15, at 10:19 a.m. RN-B stated R15 should should have been offered assistance or cues with her meal. During interview on 4/2/15, at 2:51 p.m. the director of nursing (DON) who had observed R15 during the 3/30/15 evening meal with food on her lap, and eating kernel corn and diced fruit with her fingers stated staff should have offered R15 assistance during her meal. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to the provision of dignified care and services. Employees could be re-educated on these policies. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		