Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
August 21, 2020

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

RE: CCN: 245353
Cycle Start Date: June 29, 2020

Dear Administrator:

On July 21, 2020, we informed you of imposed enforcement remedies.

On July 31, 2020, the Minnesota Department of Health completed a survey and it has been determined that your facility continues to not to be in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

As a result of the survey findings:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective August 5, 2020, will remain in effect.

This Department continues to recommend that CMS impose a civil money penalty. (42 CFR 488.430 through 488.444).

You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 29, 2020. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 29, 2020.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

As we notified you in our letter of July 21, 2020, in accordance with Federal law, as specified in the Act

at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from June 29, 2020

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (ePOC) for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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:

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

- Civil money penalty (42 CFR 488.430 through 488.444).

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:

Susie Haben, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
3333 West Division Street, Suite 212
St. Cloud, Minnesota 56301

Email: susie.haben@state.mn.us
Phone: 320-223-7356

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 29, 2020 (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.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A

copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION/ INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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:

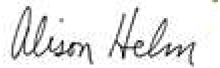
Nursing Home Informal Dispute Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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.

Feel free to contact me if you have questions.



Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 ______	C 07/31/2020

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 On 7/30/20, through 7/31/20, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint(s) were found to be substantiated with no deficiencies cited due to actions implemented by the facility prior to survey. H5353075C H5353076C H5353077C H5353078C H5353079C However, as a result of the investigation deficiencies were identified at F607, F608 and F610. 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 607 SS=C	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607		9/2/20

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed — TITLE — (X6) DATE: 08/31/2020

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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F 607	Continued From page 1 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive abuse prevention policy to include how the facility was meeting the required screening, training, prevention, identification, protection and response requirements. This had the potential to affect all 56 residents residing in the facility. Findings include: The facility policy Abuse Prevention Program dated 3/26/20, identified residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy identified the facility would conduct employee background checks and would not knowingly employ or otherwise engage any individual who had: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or had a disciplinary action in effect against his or her professional license by a state	F 607	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Camilia Rose recognizes that the abuse prevention program of the facility was lacking a few elements to it. To rectify this the facility has addended to policy and added: 8A. Immediately separate the potential abuser from the victim of any other potential victims via changes to work location or removal from facility of potential abuser until investigation is complete. The facility also added 8B. Immediately contact the Administrator, Director of Nursing or Social Services Director for guidance as to how to proceed and maintain the	

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F 607	Continued From page 2 licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment of residents or misappropriation of resident property. The screening section lacked how the facility was going to screen volunteers and non-employed staff (i.e. agency staff and contracted), students, consultants etc... Further, the policy did not include attempts at obtaining information from current/ previous employers. The policy identified the facility would require staff training/orientation programs that included such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The policy did not identify how often the staff would be trained. In addition, the policy did not include training of volunteers and/or non- employed staff. The policy identified the facility would develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of residents. Further the policy identified factors that may lead to abusive situations, for example: provide staff with opportunities to express challenges related to their job and work environment without reprimand or retaliation; Instruct staff regarding appropriate ways to address interpersonal conflicts; and help staff understand how cultural , religious and ethnic differences could lead to misunderstandings and conflict. The policy did not provide detail or referrals to additional policies on how the facility was meeting the prevention of abuse component. The policy identified they would identify and assess all possible incidents of abuse. The policy	F 607	integrity of the investigation. 8C. A nursing assessment and psychosocial assessment will be completed for all potential abuse. 8D. If appropriate potential victim room change. The facility will audit investigations once a month for the next three months to ensure all proper steps are being completed. The monthly audits will also be followed by a monthly root cause analysis to be discussed during QAPI to ensure that the facility is not only addressing the appropriate root causes for the investigations but to also see if there are trends that need to be addressed. Administrator, Social Services Director, and Director of Nursing will be responsible for the training, reeducation and follow through for this plan of correction. Social Services Director will be responsible for the monthly audits and root cause analysis.	

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F 607	Continued From page 3 did not identify the different types of abuse such as mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. Further, the policy did not identify how the facility could identify potential abuse in their residents. The policy identified the facility would protect residents from during abuse investigations; however, the policy lacked how the facility would provide protection to the residents. The facility policy Abuse Investigation and Reporting dated 3/26/20, identified all reports of resident abuse, neglect , exploitation, misappropriation of resident property, mistreatment and/or injuries of unknowns source would be reported to local, state and federal agencies and thoroughly investigations by facility management. Findings of abuse investigations would also be reported. The policy identified the administrator would immediately suspend any employee who had been accused of resident abuse, pending the outcome of the abuse. The policy did not identify ways to protect physical and psychosocial harm to include the following: respond immediately to protect the alleged victim and integrity of the investigation; Examine the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; Increased supervision of the alleged victim and residents; Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; Protection from retaliation; and Providing emotional support and counseling to the resident during and after the investigation, as needed.	F 607		

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F 607	Continued From page 4 The policy identified if the abuse allegations were founded, the employee(s) would be terminated. However the policy did not identify the response to include: taking all necessary actions as a result of the investigation, which could include, but are not limited to, the following; Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining how care provision would be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training was implemented ; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan. During interview on 7/31/20, at 11:27 a.m. the administrator stated the facility abuse prevention policies were vague and did not contain the detail needed to meet the abuse policy requirement. It was important the policy contained all the requirements on how the facility was implementing the requirements in case the administrator was not available to give direction.	F 607		
F 608 SS=C	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the	F 608		9/2/20

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F 608	Continued From page 5 Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure their Reporting Suspicion of a Crime policy included direction on how to preserve a crime scene and how to obtain a rape kit if required. This had the potential to affect all 56 residents currently residing in the facility. Findings include: The facility policy Reporting Suspicion of a Crime dated 8/21/19, identified the following crimes reported to law enforcement included but were not limited to: murder, manslaughter, rape, assault/battery, sexual abuse, theft/robbery, drug	F 608	Camilia Rose recognizes that the Reporting of Reasonable Suspicion of a Crime policy for the facility was lacking a few elements namely securing a crime scene. To rectify this the facility has addended the policy and added the following section: d. Staff must ensure that the crime scene is secured until given notice or direction from the Administrator or local law enforcement. It is preferred that staff take their direction for securing a crime scene from law enforcement if at all possible.	

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F 608	Continued From page 6 diversion, identity theft and fraud/forgery. The policy identified when and who to report the potential crime to, but did not identify how the staff would maintain a potential crime scene including but not limited to handling materials, laundering of linens/clothing, bathing/cleaning of a resident and obtaining a rape kit as appropriate. During interview on 7/31/20, at p.m. the administrator stated the facility policy on reporting a suspicion of a crime was vague and lacked details on preserving a potential crime scene and obtaining a rape kit. The administrator stated he contacted law enforcement with any concern about a potential crime immediately. The administrator relayed the information directed by law enforcement to staff to ensure the potential crime scene would be maintained and send the resident to the emergency room for a rape kit if directed by law enforcement.	F 608	When not possible staff should follow the steps below: 1. To secure the scene the staff are to not allow anyone in or out of the area (exception being to remove a potential perpetrator from the area for the safety of the victim). 2. Staff (preferably two) should be available one to document the state of the resident and the other to provide medical attention if necessary. 3. Take a detailed account of the area with as much detail as possible and have this account ready for law enforcement when they arrive. 4. In the case of potential rape or sexual abuse refrain from washing the potential victim in order to preserve the integrity of specimens collected by a rape kit. (Residents will be sent out for rape kit assessments). Director of Nursing, Social Service Director and Administrator will be responsible for the training of the policy update and the follow through for the plan of correction.	
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse,	F 610		9/2/20

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F 610	Continued From page 7 neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of potential abuse were thoroughly investigated to ensure resident protection and well-being for 1 of 2 residents (R2) whose allegations of staff to resident abuse were reviewed. Findings include: R2's admission Minimum Data Set (MDS) dated 5/9/20, identified R2 had moderate cognitive impairments. The MDS identified R2 was occasionally incontinent and required extensive assistance of two for bed mobility, transfers and toileting. Diagnoses included were schizophrenia and diabetes. R2's Incident Report Summary dated 7/20/20, identified R2 had an allegation of physical abuse by a staff member. R2 stated while attempting to use their side rail in the early morning a nursing assistant slapped their hand and was told not to do that. In addition R2 had requested their "diaper" be changed and the nursing assistant stated "no." The alleged perpetrator was identified as nursing assistant (NA)-A. The report identified NA-A was suspended pending investigation. A	F 610	Camilia Rose recognizes the importance of investigating properly all suspected and potential abuse allegations. Camilia Rose has an Abuse Investigation and Reporting. The policy has been amended under the Role of the investigator section h to include: h. Interview the resident's roommate, family members, and visitors; and other residents on the unit. The social service director will audit all investigations for the next month to ensure witness statements and interviews are being collected from multiple staff and residents during the interview.	

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F 610	Continued From page 8	F 610		

body audit and pain assessment would be completed and R2 continued to remain safe with their needs met.

R2's Investigation Report Summary dated 7/27/20, identified abuse and neglect of care did not occur. NA-A stated they were providing care to R2 without assistance of a second staff because R2 required immediate assistance; however, R2 became fearful of falling off the edge of the bed and was pushing and pulling at the side rail. NA-A stated she asked R2 not to grab or push the bed rail, because she was afraid R2 may cause and injury to her wrist. NA-A patted R2 on the shoulder in an attempt to reassure her she would not fall from the bed. NA-A received re-education on following the resident care plan and providing care with dignity and respect.

The report identifed the care plan, skin assessment , pain assessment, physical therapy and team sheet were reviewed as part of the investigation. The report identifed R2 and NA-A were the only ones interviewed regarding the incident. The investigation lacked observations of NA-A providing cares to residents; Interviews with other residents and/or skin audits of residents that could not speak for themselves that NA-A provided care to; Along with interviews with staff that worked with NA-A.

During interview on 7/30/20, at R2 stated NA-A slapped her on the hand and told her she would not change her "diaper." she was not happy with the way NA-A treated her, but denied NA-A abused her. R2 demonstrated how NA-A slapped her hand. R2 tapped lighly on the surveyors hand.

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 ______	C 07/31/2020

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 610	Continued From page 9	F 610		

During interview on 7/31/20, at 10:41 a.m. licensed social worker (LSW) stated when completing an investigation into an abuse allegation, she interviewed the resident and the alleged perpretrator if one was identified. Completed skin and pain assessments and reviewed the care plan and progress notes. LSW was not aware if NA-A was observed providing care to residents. Further, LWS was not aware if any residents or staff that interacted with NA-A were interviewed to determine if there were any concerns regarding care and treatment. In addition, non-interviewable residents were not assessed for potential signs of abuse. LSW identifed the assistant director of nursing (ADON) assissed with the abuse allegation investigation.

During interview on 7/31/20, at 11:13 a.m. ADON stated he did not complete any observations of NA-A providing resident cares. Nor did he interview any additional residents and staff as part of the abuse investigation. Further, ADON stated abuse did not occur, but neglect of care did when NA-A completed cares by not following the care plan. In hindsight the investigation should include other resident interviews, other staff interviews and skin audits for non-interviwable staff to ensure a complete investigation was done.

The facility policy Abuse Investigation and Reporting dated 3/26/20, identified the individual conducting the investigation would include at a minimum: the completed documentation forms; The resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Interview the

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F 610	Continued From page 10 resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care or services: and Review all events leading up to the alleged incident.	F 610		

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
August 21, 2020

Administrator
Camilia Rose Care Center LLC
11800 Xeon Boulevard
Coon Rapids, MN 55448

Re: Event ID: VJW111

Dear Administrator:

The above facility survey was completed on July 31, 2020 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 no violations of these rules promulgated under Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10.

Electronically posted is the Minnesota Department of Health order form stating that no violations were noted at the time of this survey. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Please disregard the heading of the fourth column which states, "Provider's Plan of Correction." This applies to Federal deficiencies only. There is no requirement to submit a Plan of Correction.

Please feel free to call me with any questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

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 ______	C 07/31/2020

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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2 000	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: On 7/30/20, through 7/31/20, an abbreviated survey was conducted to determine compliance with State Licensure. Your facility was found to be IN compliance with the MN State Licensure. The following complaint(s) were found to be substantiated with no deficiencies cited due to	2 000		

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/31/20

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 actions implemented by the facility prior to survey. H5353075C H5353076C H5353077C H5353078C H5353079C The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	2 000		