MDH Minnesota Department of Health

Office of Health Facility Complaints Investigative Report
PUBLIC

Facility Name: Camilia Rose Group Home	**Report Number:** HG186007	**Date of Visit:** May 10, 2016
Facility Address: 11820 Xeon Boulevard	**Time of Visit:** 7:00 AM- 2:30 PM	**Date Concluded:** August 5, 2016
Facility City: Coon Rapids	**Investigator's Name and Title:** Elizabeth Swan, RN	
State: Minnesota	**ZIP:** 55448	**County:** Anoka

☒ **ICF/IID**

Allegation(s):

It is alleged that a client was neglected when s/he had two falls with injuries requiring stitches.

- ☒ Federal Regulations for ICF/IID (42 CFR Part 483, subpart I)
- ☒ State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665)
- ☒ State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557)
- ☒ State Statutes Chapters 144 and 144A

Conclusion:

Based on preponderance of evidence neglect occurred when the facility failed maintain equipment in working order and a shower chair malfunctioned while being used during client care. The shower chair handle detached from the frame of the chair. The client fell and sustained a head laceration. The facility did not have a system in place for monitoring equipment to ensure safe functioning during use .

The client had diagnoses that included cerebral palsy with quadriplegia. The client had physical limitations and required a safety straps for posture control while seated in the wheelchair and shower chair.

The facility staff stated on interview that on the day of the client's weekly shower, the staff secured the client in the shower chair and transported the client to the shower room. Upon completion of the shower, the staff wheeled the client backwards by holding unto the back handle of the chair and pulling the client backwards out of the shower room over the door threshold. The staff stated this was usual procedure due to the raised lip on the threshold. When pulling the chair, the shower chair handle came off from the frame of the chair, and the chair and client fell backwards. The client hit his/her head on the floor. The client was sent to the hospital and required sutures to the back of the head.

The shower chair handle was missing two screws used to secure the handle to the frame of the shower chair. The facility staff stated there were no screws found on the floor after the incident.

Interviews with facility staff revealed no one was aware of when or who received the shower chair on

delivery as the chair was fairly new. However, no one knew when the chair arrived or of any specifics on assembly of the chair. Staff had used the chair daily, morning and/or evening for at least one of the ten clients who resided in the home, no one was aware of maintenance checks to ensure chair function for safe client use.

The Manufactures Operating Instructions included the following Safety/Maintenance information:
1. Make certain chair is assembled according to enclosed instructions
2. Check pipe and fittings for hairline fractures monthly
3. Check all junctures to make certain the pipe and fittings do not pull apart

The client fell a second time but was an accident. Staff were in attendance as the client was wheeled to the bedside while seated in the shower chair with the safety belt secured for client posture control. The client leaned forward and hit his/her forehead on the floor. Staff were behind the client and could not reach to intervene. All safety interventions were being followed at the time of this fall.

Minnesota Vulnerable Adults Act (MN 626.557)

Under the Minnesota Vulnerable Adults Act (MN. 626.557):

☐ Abuse ☒ Neglect ☐ Financial Exploitation

☒ Substantiated ☐ Not Substantiated ☐ Inconclusive based on the following information:

Click Here and Type

Mitigating Factors:

The "mitigating factors" in Minnesota Statutes, section 626.557, subdivision 9c (c) were considered and it was determined that the ☐ Individual(s) and/or ☒ Facility is responsible for the

☐ Abuse ☒ Neglect ☐ Financial Exploitation. This determination was based on the following:

The facility did not have policies and procedures in place that identified how client equipment is monitored and maintained to ensure it is kept in a safe working condition.

The responsible party will be notified of their right to appeal the maltreatment finding. If the maltreatment is substantiated against an identified employee, this report will be submitted to the nurse aide registry for possible inclusion of the finding on the abuse registry and/or to the Minnesota Department of Human Services for possible disqualification in accordance with the provisions of the background study requirements under Minnesota 245C.

Compliance:

State Licensing Rules for Supervised Living Facility (MN Rules Chapter 4665) – Compliance Met
The facility was found to be in compliance with State Licensing Rules for Supervised Living Facilities (MN Rules Chapter 4665). No state licensing orders were issued.

State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557) – Compliance Met
The facility was found to be in compliance with State Statutes for Vulnerable Adults Act (MN Statutes, section 626.557. No state licensing orders were issued.

Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B) - Compliance Not Met
The requirements under the Federal Regulations for Long Term Care Facilities (42 CFR, Part 483, subpart B),

were not met.

Deficiencies are issued on form 2567: ☐ Yes ☐ No

(The 2567 will be available on the MDH website.)

State Statutes Chapters 144 & 144A – Compliance Not Met - Compliance Not Met
The requirements under State Statues for Chapters 144 &144A were not met.

State licensing orders were issued: ☐ Yes ☐ No

(State licensing orders will be available on the MDH website.)

Compliance Notes:
A Federal deficiency and State licensing order were issued.

Facility Corrective Action:
The facility took the following corrective action(s):

Definitions:

Minnesota Statutes, section 626.5572, subdivision 17 - Neglect
"Neglect" means:

(b) The absence or likelihood of absence of care or services, including but not limited to, food, clothing, shelter, health care, or supervision necessary to maintain the physical and mental health of the vulnerable adult which a reasonable person would deem essential to obtain or maintain the vulnerable adult's health, safety, or comfort considering the physical or mental capacity or dysfunction of the vulnerable adult.

Minnesota Statutes, section 626.5572, subdivision 19 - Substantiated
"Substantiated" means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.

The Investigation included the following:
Document Review: The following records were reviewed during the investigation:

☒ Medical Records

Facility Name: Camilia Rose Group Home Report Number: HG186007

- ☐ Nurses Notes
- ☒ Assessments
- ☒ Physician Orders
- ☒ Facility Incident Reports
- ☒ Laboratory and X-ray Reports

Other pertinent medical records:

- ☒ Hospital Records

Additional facility records:

- ☒ Staff Time Sheets, Schedules, etc.
- ☒ Facility Internal Investigation Reports
- ☒ Personnel Records/Background Check, etc.
- ☒ Facility Policies and Procedures

Number of additional resident(s) reviewed: 2

Were residents selected based on the allegation(s)? ◉ Yes ○ No ○ N/A

Specify:

Were resident(s) identified in the allegation(s) present in the facility at the time of the investigation?

◉ Yes ○ No ○ N/A

Specify:

Interviews: The following interviews were conducted during the investigation:

Interview with complainant(s) ◉ Yes ○ No ○ N/A

Specify:

If unable to contact complainant, attempts were made on:

Date: Time: Date: Time: Date: Time:

Interview with family: ◉ Yes ○ No ○ N/A Specify:

Did you interview the resident(s) identified in allegation:

○ Yes ◉ No ○ N/A Specify: The client was not interviewable

Did you interview additional residents? ◉ Yes ◉ No

Total number of resident interviews: 1

Interview with staff: ◉ Yes ○ No ○ N/A Specify:

Tennessen Warnings

Tennessen Warning given as required: ◉ Yes ○ No

Facility Name: Camilia Rose Group Home Report Number: HG186007

Total number of staff interviews: 8

Physician Interviewed: ○ Yes ◉ No

Nurse Practitioner Interviewed: ○ Yes ◉ No

Physician Assistant Interviewed: ○ Yes ◉ No

Interview with Alleged Perpetrator(s): ○ Yes ○ No ◉ N/A Specify: _____

Attempts to contact:

Date:	Time:	Date:	Time:	Date:	Time:

If unable to contact was subpoena issued: ○ Yes, date subpoena was issued _____ ○ No

Were contacts made with any of the following:

☐ Emergency Personnel ☐ Police Officers ☐ Medical Examiner ☐ Other: Specify _____

Observations were conducted related to:

☒ Personal Care
☒ Nursing Services
☒ Infection Control
☒ Cleanliness
☒ Dignity/Privacy Issues
☒ Safety Issues
☒ Transfers
☒ Facility Tour
☒ Incontinence

Was any involved equipment inspected: ○ Yes ◉ No ○ N/A

Was equipment being operated in safe manner: ○ Yes ○ No ◉ N/A

Were photographs taken: ○ Yes ◉ No Specify: Shower chair not available

cc:

Health Regulation Division - Licensing & Certification

The Office of Ombudsman for Mental Health and Developmental Disabilities

Coon Rapids Police Department

Anoka County Attorney

Coon Rapids City Attorney

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

PRINTED: 08/03/2016
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
	24G166	A. BUILDING _____ B. WING _____	C 07/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE GROUP HOME	11820 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
W 000	INITIAL COMMENTS A complaint investigation was conducted to investigate case #HG186007. As a result, the following deficiencies are issued.	W 000		
W 104	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to established a system that ensured equipment was maintained for safe use when one of three (C1) clients reviewed had a fall from a shower chair and sustained a head injury because the shower chair broke. The findings include: Client #1's (C1) record revealed C1's diagnoses included cerebral palsy with quadriplegia. The Risk Management Assessment and Plan dated June 25, 2015, identified C1's risk of physical limitations and the approved use of safety straps for torso positioning in the wheelchair and shower chair. In addition, the client had an approved lap tray when seated in the wheelchair for an additional aide in positioning. Review of the Consumer Incident Report dated January 30, 2016, direct support professional (DSP) A pulled C1 backwards while seated in the shower chair over the shower room door threshold when the back handle of the shower chair came apart from the chair frame causing the chair to tip backwards. The client hit his/her	W 104	An Adaptive Equipment Maintenance Protocols has been implemented into the home. Each month an assigned individual will be completing the checklist for each piece of adaptive equipment. The checklist includes checking seatbelts, frames, wheels, brakes, upholstery, seat cushions, footrests, handgrips to ensure they are in proper working condition. Batteries are checked and charged as required. Nuts, bolts, and screws are checked and tightened as needed. Cleaning of equipment is completed weekly by the overnight staff. All staff will be trained at our monthly staff meeting August 16, 2016 on the adaptive equipment maintenance protocols and checklist. The facility LPN will ensure that all staff have received training on each piece of adaptive equipment before they will be allowed to use the equipment. The training will include the procedures for inspecting each piece of equipment to ensure it is in good working order prior to each time they would use the equipment. Continued on next page	9/1/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Julie Costello | TITLE: Program Director/QIDP | (X6) DATE: 8/12/16

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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	24G186	A. BUILDING _____ B. WING _____	C 07/11/2016

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W 104	Continued From page 1 head on the floor and sustained a laceration to the back of his/her head. The client was evaluated in the emergency room and received sutures to the back of the head. The CAT scan revealed no acute intracranial pathology. Direct support professional (DSP)A was interviewed on May 19, 2016, at 2:30 p.m., and stated s/he had put the client in the shower chair, wheeled the client to the shower room and when s/he completed the shower and went to wheel the client in the shower chair back over the shower room door threshold the back handle of the shower chair came off in his/her hand. The chair had been slightly tipped backwards and the momentum caused the chair to continue to fall backwards and C1 hit his/her head on the floor. DSP/A stated s/he had used the chair before, but this was the first s/he had used it for C1 as s/he did not usually work on his/her bath day. C1 stated the chair was fairly new, and had not noticed anything unusual that would have caused concern in the use of the chair prior to him/her putting C1 in the chair for his/her shower. DSP/A stated the first responders who arrived to transport C1 for emergent medical treatment noticed the shower chair handle was missing two screws. DSP/A did not notice that screws were missing from the shower chair handle and did not notice any screws on the floor after the incident. An interview with the program supervisor (PS)A, on May 10, 2016, at 9:35 a.m., verified screws were missing from the shower chair handle, and that the shower chair was immediately removed from use. The PS stated the chair was removed from the premise and thought it had been trashed. PS/A was not aware of regular safety checks for client equipment or who would	W 104	Continued On a quarterly basis the maintenance technician will complete an adaptive equipment maintenance checklist to ensure the equipment is in good working and lubricated if needed. When a new piece of equipment is received at the home the maintenance technician will check the equipment for proper assembly, electrical connections are firmly in place, proper tire pressure, and lubrication if needed. The shower room thresholds have been inspected and replaced as needed to reduce the height of the edge that the shower chairs would roll over. Home supervisors will check the checklists monthly to ensure adaptive equipment has been inspected and identify any needs for repairs or replacements.	9/1/16

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W 104	Continued From page 2 conduct those checks. In addition, the PD was not aware when the shower chair was put into use. The manufactures Operating Instructions for the shower chair dated 09/01/2010 included the following Safety/Maintenance Information; 1. Make certain chair is assembled according to enclosed instructions 2. Check pipe and fittings for hairline fractures monthly 3. Check all junctures to make certain the pipe and fittings do not pull apart 4. Clean and lubricate casters monthly to avoid rust and wheel lock-up 5. Do not subject product to temperatures below 40 or above 140. An interview with the maintenance technician (MT) A on May 20, 2016, at 10:17 a.m., revealed there was no known routine safety checks of client equipment that included the shower chairs. MT/A was not aware who received client equipment that included shower chairs and/or who assembled the equipment. The director of supportive living interviewed on June 1, 2016, at 11:43 a.m., stated there was no known system that included routine safety checks for client equipment which would have included but not limited to shower chairs. The director of supportive living was also not aware of any formal procedure that ensured equipment safety before client use.	W 104		

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	01141	A. BUILDING: _____ B. WING _____	C 07/11/2016

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5 000	Initial Comments In accordance with Minnesota Statute, section 144.56 and/or Minnesota Statute, section 144.653, 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 or MN Statute indicated below. When a rule or statute 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. A complaint investigation was conducted to investigate case #HG186007. As a result, the following correction order is issued.	5 000	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 Supervised Living Facilities (SLF). 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	

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5 000	Continued From page 1	5 000	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 evidenced by." Following the surveyors findings is 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.	
5 700	MN Statute 144.651 Subd. 14. RES. RIGHTS Freedom from maltreatment. Residents shall be free from maltreatment as defined in the Vulnerable Adults Protection Act. "Maltreatment" means conduct described in section 626.5572, subdivision 15, or the intentional and nontherapeutic infliction of physical pain or injury, or any persistent course of conduct intended to produce mental or emotional distress. Every resident shall also be free from nontherapeutic chemical and physical restraints, except in fully documented emergencies, or as authorized in writing after examination by a resident's physician for a specified and limited period of time, and only when necessary to protect the resident from self-injury or injury to	5 700		

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5 700	Continued From page 2 others. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to established a system that ensured equipment was maintained for safe use when one of three (C1) clients reviewed had a fall from a shower chair and sustained a head injury. The findings include: Client #1's (C1) record revealed C1's diagnoses included cerebral palsy with quadriplegia. The Risk Management Assessment and Plan dated June 25, 2015, identified C1's risk of physical limitations and the approved use of safety straps for torso positioning in the wheelchair and shower chair. In addition, the client had an approved lap tray when seated in the wheelchair for an additional aide in positioning. Review of the Consumer Incident Report dated January 30, 2016, direct support professional (DSP) A pulled C1 backwards while seated in the shower chair over the shower room door threshold when the back handle of the shower chair came apart from the chair frame causing the chair to tip backwards. The client hit his/her head on the floor and sustained a laceration to the back of his/her head. The client was evaluated in the emergency room and received sutures to the back of the head. The CAT scan revealed no acute intracranial pathology. Direct support professional (DSP)A was interviewed on May 19, 2016, at 2:30 p.m., and stated s/he had put the client in the shower chair,	5 700	An Adaptive Equipment Maintenance Protocols has been implemented into the home. Each month an assigned individual will be completing the checklist for each piece of adaptive equipment. The checklist includes checking seatbelts, frames, wheels, brakes, upholstery, seat cushions, footrests, handgrips to ensure they are in proper working condition. Batteries are checked and charged as required. Nuts, bolts, and screws are checked and tightened as needed. Cleaning of equipment is completed weekly by the overnight staff. All staff will be trained at our monthly staff meeting August 16, 2016 on the adaptive equipment maintenance protocols and checklist. The facility LPN will ensure that all staff have received training on each piece of adaptive equipment before they will be allowed to use the equipment. The training will include the procedures for inspecting each piece of equipment to ensure it is in good working order prior to each time they would use the equipment. Continued on next page	9/1/16

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5 700	Continued From page 3 wheeled the client to the shower room and when s/he completed the shower and went to wheel the client in the shower chair back over the shower room door threshold the back handle of the shower chair came off in his/her hand. The chair had been slightly tipped backwards and the momentum caused the chair to continue to fall backwards and C1 hit his/her head on the floor. DSP/A stated s/he had used the chair before, but this was the first s/he had used it for C1 as s/he did not usually work on his/her bath day. C1 stated the chair was fairly new, and had not noticed anything unusual that would have caused concern in the use of the chair prior to him/her putting C1 in the chair for his/her shower. DSP/A stated the first responders who arrived to transport C1 for emergent medical treatment noticed the shower chair handle was missing two screws. DSP/A did not notice that screws were missing from the shower chair handle and did not notice any screws on the floor after the incident. An interview with the program supervisor (PS)A, on May 10, 2016, at 9:35 a.m., verified screws were missing from the shower chair handle, and that the shower chair was immediately removed from use. The PS stated the chair was removed from the premise and thought it had been trashed. PS/A was not aware of regular safety checks for client equipment or who would conduct those checks. In addition, the PD was not aware when the shower chair was put into use. The manufactures Operating Instructions for the shower chair dated 09/01/2010 included the following Safety/Maintenance Information; 1. Make certain chair is assembled according to enclosed instructions 2. Check pipe and fittings for hairline fractures	5 700	Continued On a quarterly basis the maintenance technician will complete an adaptive equipment maintenance checklist to ensure the equipment is in good working and lubricated if needed. When a new piece of equipment is received at the home the maintenance technician will check the equipment for proper assembly, electrical connections are firmly in place, proper tire pressure, and lubrication if needed. The shower room thresholds have been inspected and replaced as needed to reduce the height of the edge that the shower chairs would roll over. Home supervisors will check the checklists monthly to ensure adaptive equipment has been inspected and identify any needs for repairs or replacements.	9/1/16

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5 700	Continued From page 4 monthly 3. Check all junctures to make certain the pipe and fittings do not pull apart 4. Clean and lubricate casters monthly to avoid rust and wheel lock-up 5. Do not subject product to temperatures below 40 or above 140. An Interview with the maintenance technician (MT) A on May 20, 2016, at 10:17 a.m., revealed there was no known routine safety checks of client equipment that included the shower chairs. MT/A was not aware who received client equipment that included shower chairs and/or who assembled the equipment. The director of supportive living interviewed on June 1, 2016, at 11:43 a.m., stated there was no known system that included routine safety checks for client equipment which would have included but not limited to shower chairs. The director of supportive living was also not aware of any formal procedure that ensured equipment safety before client use. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	5 700		

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
24G186 (Y1)	A. Building B. Wing (Y2)	10/6/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE GROUP HOME	11820 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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix W0104 Reg. # 483.410(a)(1) LSC	Correction Completed 10/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) AW/mm	DATE 10/17/2016	SIGNATURE OF SURVEYOR 05455	DATE 10/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
01141 Y1	A. Building B. Wing Y2	10/6/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
CAMILIA ROSE GROUP HOME	11820 XEON BOULEVARD COON RAPIDS, MN 55448

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ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 50700 Reg. # MN Statute 144.651 Subd. 14. LSC	Correction Completed 10/06/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
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ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) AW/mm	DATE 10/17/2016	SIGNATURE OF SURVEYOR 05455	DATE 10/06/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO			