DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Emailed November 2, 2020

Administrator
Camilia Rose Group Home
11820 Xeon Boulevard
Coon Rapids, MN 55448

RE: Event ID: WR0011
Project Number: HG186024C

Dear Administrator:

On September 30, 2020 through October 2, 2020 an abbreviated survey was conducted to investigate HG186024C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). A full survey was conducted 10/5/20 through 10/08/2020.

HG186024C was substantiated with deficiencies.

Also at the time of the complaint investigation the survey team noted one or more deficiencies which indicated that a situation of "Immediate Jeopardy" existed for your clients as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567).

During the complaint invesitgation we reviewed your allegation of compliance and determined that your facility had taken appropriate actions to remove the "Immediate Jeopardy" as detailed in the deficiencies cited at on the enclosed "Statement of Deficiencies and Plan of Correction" (Form CMS-2567). Therefore, we removed the immediate jeopardy on October 5, 2020.

One or more of these deficiencies do not meet the requirements of Section 1905(d) of the Social Security Act and the following Condition(s) of Participation (CoP) for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFs/IID): This is listed below.

W318 42 CFR § Health Care Services

Federal certification deficiencies are delineated on the enclosed form CMS-2567 "Statement of Deficiencies and Plan of Correction". Certification deficiencies are listed on the left side of the form. The right side of the form is to be completed with your written plan for corrective action (PoC). Ordinarily, a provider will be expected to take the steps necessary to achieve compliance within 60 days of the exit interview.

A PoC for the deficiencies must be submitted within ten calendar days of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

The PoC must be placed directly on the CMS-2567, signed and dated by the administrator or your authorized official. If possible, please type and return your plan of correction to ensure legibility. Please make a copy of the form for your records and return the original. Additional documentation may be attached to Form CMS-2567, if necessary.

Questions regarding all documents submitted as a response to the client care deficiencies (those preceded by an "W" tag) and emergency preparedness deficiencies (those preceded by an "E" 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
Fax: 320-223-7348

Failure to submit an acceptable written plan of correction of federal deficiencies within ten calendar days may result in decertification and a loss of federal reimbursement.

Upon acceptance of your PoC, we will revisit the facility to verify necessary corrections. If you have not corrected the situation(s) that resulted in the findings of Conditions of Participation being found not met by November 22, 2020, we will have no choice but to recommend to the Minnesota Department of Human Services that your provider agreement be terminated.

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

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121

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Emailed November 2,2020

Administrator
Camilia Rose Group Home
11820 Xeon Boulevard
Coon Rapids, MN 55448

Re: Enclosed State Supervised Living Facility Licensing Orders - Event ID WR0011

Dear Administrator:

On 9/30/20 through 10/2/20, an abbreviated survey was conducted to investigate HG186024C. A full survey was conducted 10/5/20 through 10/08/2020.

The following complaint was found to be substantiated: HG504010C Licensing orders were issued.

Your facility was not in compliance with requirements of Minnesota Rules, Chapter 4665 requirements for Supervised Living Facilities (SLF).

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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 Supervised Living Facilities.

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 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.

When all orders are corrected, the first page of the order form should be signed and returned to:

Susie Haben, Unit Supervisor
St. Cloud B District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 Susie Haben. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121 Fax: 651-215-9697

Enclosure

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
	01141	A. BUILDING: _____ B. WING _____	C 10/08/2020

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) COMPLETE DATE
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. On 9/30/20 through 10/2/20, an abbreviated survey was conducted to investigate HG186024C. A full survey was conducted 10/5/20 through 10/08/2020. The following complaint was found to be substantiated: HG504010C Licensing orders were issued. Your facility was not in compliance with requirements of Minnesota Rules, Chapter 4665	5 000		

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5 000	Continued From page 1 requirements for Supervised Living Facilities (SLF).	5 000		
5 250	MN Rule 4665.1800 Subp. 1 SPACE ARRANGEMENTS AND REQUIREMENTS. Space to meet needs of residents and program licensure requirements. Provision of appropriate space and arrangements thereof for sleeping, dining, recreation, and other common use areas for activities or training shall be in conformance with the residents' mobility needs and with the program licensure requirements of the Department of Human Services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided appropriate equipment storage and prompt removal of broken/soiled furniture for 1 of 4 apartments (Four Leaf Clover) which effected clients and facility staff movement within the apartment. Findings include: Upon entrance to the facility on 9/30/20, at 9:00 a.m., surveyor noted the hall of Four Leaf Clover apartment had been used as a storage area for the following items: -on both side of the staff office were a total of three 3 inch shelves with open front cabinets (approximately 28 inches (in) tall, 36 in long and 12 in deep). - in the same hall on the left (East) side where the bedrooms were located, were stored: two mechanical lifts, four wheelchairs, the two large	5 250		

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5 250	Continued From page 2 "rubber maid style" totes and three bath chairs. On 10/06/20, at 8:47 a.m., area director (AD) mentioned to direct support staff (DSP)-A she wanted the hallway of Four Leaf Clover "de-cluttered", from the staff office down the hall in the sleep area of the unit. Director stated to DSP-A it was to be a priority over the next two days. Upon return the following day, 10/07/20, at 7:30 a.m., the hall in Four Leaf Clover remained the same. During observation 10/7/20, at 7:50 a.m. C7 was noted coming down the hall in his wheelchair. C7 was observed, twice hanging up his wheelchair first on a wheelchair outside his room, and then on one of the mechanical lift legs. During an interview on 10/07/2020, at 10:30 AD stated the facility had a shortage of storage places. AD stated that some of the equipment could be placed in the client rooms, if they were single rooms, however, several items belong to clients that resided in double occupancy rooms. The AD stated that the three wheelchairs were the "2nd" wheelchair for three of the clients and it had been discussed to downsize the census and make the bedrooms single occupancy but the open rooms within the facility are being maintained as potential COVID-19 quarantine rooms. On 10/07/20, at 12:00 p.m., the hallway was noted now to be cleared, with the exception of the three open shelf units. During observation and interview 10/7/20, at 3:15 p.m. with program residential services	5 250		

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5 250	Continued From page 3 coordinator PRSC-A in the facility great room there was a large maroon cloth couch with no seat cushions. The couch was facing backwards against the wall, along with a broken wooden chair on top of it. PRSC-A stated the couch has been there for over a month and they have been waiting for maintenance to pick it up. The cushions have been removed due to a client had been sitting on the couch and had urinated on it. In interview on 10/08/20, at 10:30 a.m., the program supervisor (PS) stated the 3 bath chairs were placed in the shower room, and the wheelchairs and totes were placed in an open room in the Cardinal apartment. A policy on facility storage had been requested but not received. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	5 250		
5 515	MN Rule 4665.4700 FIRST AID. Every facility shall have on the premises a suitable first aid kit approved in writing by a physician for use for residents and staff. Tourniquets shall not be stored in the kit. The kit shall be maintained in a place known to and readily available to all personnel responsible for the health or well-being of residents, and such personnel shall be instructed in acceptable emergency first aid procedures. This MN Requirement is not met as evidenced by: Based on observation and interview the agency failed to ensure first aid kits were available in 2 of 3 client transport vehicles.	5 515		

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5 515	Continued From page 4 Findings include: During a review of the agency's first aid kits on 10/8/20, at 10:27 a.m. the program supervisor stated she looked in the agency's two lift vans used for transporting clients and was unable to locate a first aid kit in either one of the vans. The program supervisor stated a third van was off the premises and she was unable to verify if it contained a first aid kit. The program supervisor stated each of the vehicles should have had a first aid kit. At 10:35 a.m. registered nurse (RN)-A stated the resident services coordinators (RSC) were responsible to ensure each vehicle had a fist aid kit. At 10:55 a.m. RSC- A stated she was not aware she was responsible for the first aid kits. A policy was requested but was not provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	5 515		
5 525	MN Rule 4665.4900 EMERGENCY PROCEDURES MEETING. There shall be a meeting of all employees on each shift at least once every three months to discuss emergency procedures used in the facility. Business of the meetings shall cover: A. assignment of persons to specific tasks and responsibilities in case of emergency situation; B. instructions relating to the use of alarm systems and signals;	5 525		

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5 525	Continued From page 5 C. systems for notification of appropriate persons outside the facility; D. information on the location of emergency equipment in the facility; and E. specification of evacuation routes and procedures. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure facility staff attended the emergency procedure meetings every quarter. This had the potential to affect 23 of 23 clients residing in the facility. Findings include: During interview 10/5/20, with the area director (AD) who stated the program supervisor (PS)-D was in charge of keeping the quarterly meeting minutes and she is currently out on a family/medical leave. AD stated she went through her office and is unable to provide any documentation indicating the quarterly emergency procedure meetings were conducted as required. The facility Emergency Response Policy revised 8/2013, indicated: It is the policy of Mary T Inc. to effectively respond to, report, and review all emergencies to ensure the safety of persons receiving services and to promote the continuity of services until emergencies are resolved. It is imperative that the individuals residing in the home, the staff and the public are protected in case of emergency and that emergency procedures are carried out with the least amount of disruption. The purpose of this policy is to outline measures taken during	5 525		

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5 525	Continued From page 6 emergency situations to ensure homes are prepared to anticipate and respond to those situations. TIME PERIOD FOR CORRECTION: Twenty one (21) days..	5 525		

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	24G186	A. BUILDING _____ B. WING _____	C 10/08/2020

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W 000	INITIAL COMMENTS	W 000		

On 9/30/20 through 10/2/20, an abbreviated survey was conducted to investigate HG186024C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

In addition, the Condition of Participation: Health Care Services 42 CFR 483.460 was found not met.

A full survey was conducted 10/5/20 through 10/08/2020.

HG186024C was substantiated with deficiencies issued at W331.

Immediate Jeopardy situation was identified at W331 on 10/2/20, at 2:04 p.m. .

The Immediate Jeopardy began on 8/28/20, when C1, following an Emergency Department (ED) visit on 8/27/20, was seen by a wound clinic and received treatment orders and interventions for an unstagable pressure ulcer that were never implemented at the facility. Additionally, the facility failed to assess and monitor the pressure ulcer and to assist C1 to attend a follow up visit on 9/4/20, for pressure ulcer debridement and again failed on 9/10/20, which subsequently led to C1's hospitalization on 9/10/20. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m. when applicable staff were re-trained on the appointment protocol, doctor's recommendations and when to clarify physician's orders, as well as wound care management including documentation of size, depth, quality, signs of

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

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W 000	Continued From page 1 infection. Additionally, the registered nurse was directed to review all medical referrals and oversee LPN's follow up and monitor twice a week, re-assessment of all current clients was completed and additional safety position rounds were put into place.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to notify the legal guardian/family timely of a worsening unstageable pressure ulcer that required doctor recommended interventions and hospitalization for debridement for 1 of 1 (C1) client who were hospitalize without family notification for six days. Findings include: C1's Emergency Data Form dated 10/1/20, indicated C1 admitted on 9/14/2007, diagnosed with severe intellectual disabilities An Office Visit dated 8/28/20, at Abbott Northwestern Wound Clinic, indicated C1 was seen for evaluation and treatment of his right hip wound. The report stated, the nurse at the group home felt the wound is worsening and had sent C1 to the emergency department on 8/27/20 and	W 148		

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W 148	Continued From page 2	W 148		

the physician there performed an incision and drainage and prescribed Keflex (antibiotic). The physician visit assessed the wound as a unstageable pressure ulcer with the wound bed covered with necrotic material.

An After Wound Care After Visit Summary dated 8/28/20 indicated the following orders:
- dressing change daily cleanse wound with wound cleanser, pat dry, cover with manuka honey dressing and cover with 1/2 abdominal gauze pad, secure with medipore (adhesive) tape.
- 80-100 grams (G) of protein daily through protein dense foods and protein supplement shakes.
-repositioning while in bed every 2 hours, and every 15- 20 minutes while sitting.
-pressure reduction mattress
-Roho wheelchair cushion (redistribute pressure and prevent skin breakdown caused by long-term wheelchair use).

Record review revealed no indication the POA was contacted following the 8/28/20 appointment and treatment orders.

During interview 10/1/20, at 8:09 a.m. C1's power of attorney (POA) who stated, she was not informed by the facility he was hospitalized until 9/16/20, which was 6 days later from the hospital social worker. She further stated she was not aware of the wound doctor's recommendations for the special mattress, wheelchair cushion, positioning or increased protein diet and she would have approved all of them. In addition she stated she had sent multiple emails to the program supervisor (PS)-D requesting updates on C1 and received not responses and finally at

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W 148	Continued From page 3 the end the emails were just getting sent back to her. POA then stated she finally called the RN and got an updated but this was prior to his hospitalization and that is when she found out PS-D was out on leave. During interview 10/1/20 at 8:30 a.m. RN stated she was aware of C1's POA not receiving responses from her emails sent to PS-D. She indicated that should not have happened and lately there has been a lot of turnover in the facility. RN stated she was not aware the POA was not informed by them of C1's hospitalization and should have been. Record review lacked evidence of any POA notification following C1's hospitalization. A facility policy Health Services Coordination And Care Policy dated 8/2014, indicated "When discovered the program will promptly notify the person's legal representative, if any, and the case manager of changes in a persons physical and mental needs affecting health services." The policy also indicated they must document the notification.	W 148		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.460 Health Care Services, was not met. The facility	W 318		

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W 318	Continued From page 4 failed to provide adequate nursing services to C1 who had a worsening pressure ulcer, did not received treatments and interventions as ordered and missed medical appointments on both 9/4/20 and 9/11/20, which subsequently let to C1's admission to the emergency departement who admitted him to the hospital. C1 then required surgical debridement to his wound at the hospital and then was discharged to skilled nursing facility for twice daily dressing changes and rehab. Findings include: See W331: The facility failed to provide adequate nursing services to prevent a worsening unstageable pressure ulcer 1 of 3 clients (C1) who had a unstageable pressure ulcer that required hospitalization for wound debridement and admission to a skilled nursing facility for twice daily dressing changes and therapy.	W 318		
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor a pressure ulcer, implement physician ordered interventions/recommendations and failed to ensure timely attendance to a critical follow up appointment for 1 of 3 (C1) clients who required care and treatment for a pressure ulcer. This failure resulted in C1's admission to the hospital on 9/10/20 for worsening pressure ulcer of right hip where debridement occurred on 9/11/20 and	W 331		

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C1 received 5 days of intravenous (IV) befooling (antibiotic) before being discharged to a skilled nursing facility for rehab and nursing care on 9/18/20. This resulted in an immediate jeopardy situation for C1.

The Immediate Jeopardy began on 8/28/20, when C1, following an Emergency Department (ED) visit on 8/27/20, was seen by a wound clinic and received treatment orders and interventions for an unstageable pressure ulcer that were never implemented at the facility. Additionally, the facility failed to assess and monitor the pressure ulcer and to assist C1 to attend a follow up visit on 9/4/20, for pressure ulcer debridement and again failed on 9/10/20, which subsequently led to C1's hospitalization on 9/10/20. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m.

Findings include:

C1's Emergency Data Form dated 10/1/20, indicated a diagnosis of severe intellectual disabilities and identified C1 used a wheelchair with a gel cushion for mobility.

C1's Coordinated Service and Support Plan (CSSP) dated 3/4/20, indicated staff monitor his health conditions according to written instructions from his licensed health professional, which included assist with or coordinate medical, dental and other health service appointments, use of medical equipment, devices or adaptive aides. Further the CSSP indicated staff will follow the licensed health professional instructions and staff will help track and schedule appointments that are due, provide or acquire transportation and accompany to all appointments. In addition the CSSP indicated medication/treatments will be

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administered as ordered.

A Minnesota Adult Abuse Reporting Center (MAARC) report dated 9/22/20, indicated C1 was hospitalized from 9/10/20 through 9/18/20, with right hip cellulitis. The report indicated he had missed a medical appointment and was advised to seek care at the emergency room with a right hip wound likely pressure ulcer which had been worsening for the past two weeks prior to the hospitalization. The wound required surgery and he was admitted to skilled nursing facility following his hospitalization. In addition the report indicated some of C1's antibiotics were not administered as ordered.

During observation and interview on 9/30/20, at 3:00 p.m. medical residential services coordinator (RSC)-A and surveyor entered C1's room and observed he had a queen sized bed. When RSC-A-A lifted the sheets on the bed it was observed C1 had a standard mattress. On top of his bed were two regular pillows, with two additional smaller decorative round pillows. RSC-A she stated they would use the one standard pillow and try to place that on C1's back to keep C1 off of his right side but he often would pull it out. Further she stated he liked to lay on his right side and suspected that is why C1 obtained the wound on his right hip.

A Consultation Form dated 7/29/20, indicated C1 was seen by a general practice physician for a protruding bump on his right side thigh, right below his hip. The general practice physician ordered a computed tomography (CT) scan of the pelvis (imaging x-ray of the pelvis) at suburban imaging. A following Consultation Form from Suburban Imagining dated 8/21/20, (23 days

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later) indicated C1 received his CT scan of his right pelvis.

During interview on 9/30/20, at 2:20 p.m. with facility registered nurse (RN)-A stated she was not aware why the CT scan took so long to get ordered. RN-A stated it should only have taken a couple of days to have completed and when they scheduled it something must have happened and the staff should have followed up on this immediately. RN-A further stated in the middle of July 2020 she noticed just a lump on C1's right hip, it was not open, so they had him seen and a CT was ordered. RN-A went on by saying, then sometime in August 2020 the area opened and just started to get worse. It was at that time that they sent him to his primary and then to the wound doctor. RN-A concluded by adding, they knew it was getting bad.

An After Visit Summary dated 8/25/20, from C1's primary physician indicated C1 had mild cellulitis/abscess right hip (3 centimeter fluid collection on recent CT scan). The primary physician ordered an oral antibiotic, dressing change twice daily and follow up with wound clinic.

An Office Visit report dated 8/28/20, Abbott Northwestern Wound Clinic, indicated he was seen for evaluation and treatment of his right hip wound. The note indicated staff noticed the wound in early August 2020 and he prefers to lay on his right side while in bed and they make effort to keep on his right hip by placing pillows behind his back while in bed to keep him on his left side. The note further indicated, the nurse at the group home feels the wound is worsening and C1 was sent to the emergency department on 8/27/20,

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and the physician there performed an incision and drainage and prescribed Keflex (antibiotic). The physician's notes from the visit assessed the wound as an unstageable pressure ulcer with the wound bed covered with necrotic material.

An After Visit Summary dated 8/28/20, for C1's Wound Care Clinic visit indicated orders as follows:
- dressing change daily cleanse wound with wound cleanser, pat dry, cover with Manuka honey (aids in wound healing) dressing and cover with 1/2 abdominal dressing secure with medipore (stretches) tape.
- 80-100 grams (G) of protein daily through protein dense foods and protein supplement shakes.
-Repositioning while in bed every 2 hours, and every 15- 20 minutes while sitting.
-pressure reduction mattress
-Roho wheelchair cushion (redistribute pressure and prevents skin breakdown caused by long-term wheelchair use).
-In addition the wound doctor stated in the report he would like to debride the wound but was unable to get consent from his power of attorney. With instruction to return on 9/4/20 for debridement after received consent.

During interview on 9/30/20, at 2:20 p.m. RN-A stated the staff were completing the dressing changes and repositioning C1 every 2 hours. The RN-A stated she was not aware of the other orders for an increased protein diet, specialty mattress, Roho cushion or every 15 to 20 minute repositioning while sitting and confirmed those orders/treatments were not being done. RN-A stated it was the responsibility of the person who brought the clients to their appointments to inform

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the licensed practical nurses (LPNs) of the orders and then follow through with them.

During interview on 9/30/20, at 2:30 p.m. LPN-A stated she was also not aware of the orders for C1, in addition she stated C1 did not attend his 9/4/20 appointment because there was not enough staff in the building to take him so the appointment was canceled and rescheduled for 9/10/20 (6 days later).

During interview on 9/30/20, at 4:00 p.m. with medical residential services coordinator (MRSC)-A stated she makes the appointments for the clients and on 9/10/20, she was supposed to take C1 to his wound appointment but she over slept that morning so LPN-A took him to his appointment and by then he had arrived late. MRSC-A stated because C1 was late for his appointment and the clinic would not see him, LPN-A was instructed to take him to the emergency department (ED) where he waited in the ED until the hospital decided to admit him.

During interview on 10/1/20, at 8:09 a.m. C1's power of attorney (POA) stated, she was not informed by the facility he was hospitalized until 9/16/20, furthermore she was not made aware of the wound doctor's recommendations for the special mattress, wheelchair cushion, positioning or increased protein diet and she would have approved all of them.

During interview on 10/01/20, at 2:30 p.m. C1's wound clinic medical doctor stated he had seen C1 once on 8/28/20, and had diagnosed him with an unstageable pressure ulcer as well had ordered treatments and interventions for C1's condition. C1's wound clinic medical doctor

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stated he ordered a pressure relieving mattress, Roho cushion and protein shake. He stated he was concerned the orders were not implemented, but was most concern C1 had missed his 9/4/20 appointment and stated, "I think it would have been very unlikely that if he would have made it to that appointment instead of missing it, would have helped in preventing his wound from worsening and prevented his hospitalization that occurred on 9/10/20."

An Allina Health ED to Admission in Abbott Northwestern Hospital Visit dated 9/10/20, indicated Chief Complaint-wound check, pressure injury of skin of right hip and cellulitis, right wound approximately 5 cm in diameter with halo of surrounding erythema (redness of the skin) black eschar (dead tissue) covering the wound, and was admitted from ED to hospital at 9:57 p.m. The note further indicated C1 was admitted with right hip cellulitis due to missing his appointment, he was advised by outpatient wound care to present to ED for further evaluation of progressively worsening right hip wound and was unable to have wound debrided. The visit note indicated he was non-toxic on admission and no evidence of osteomyelitis (bone infection), the debridement occurred on 9/11/20 without complication and received 5 days of intravenous (IV) befooling (antibiotic). The hospital visit notes indicated C1 discharged to a skilled nursing facility for rehab and nursing care on 9/18/20.

Review of C1's T-Log documentation of wound care from 7/1/2020 to 9/10/2020 indicated:
-7/24/20 (First note on area on hip noted as bump on his hip/thigh). Noted as, felt like bone protruding when touched, made MD appointment 7/29/20. Rest of the notes for July 2020

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discussed the bump on hip/thigh.
-8/22/20 (RN note) Late Entry for 7/21/20 directed staff to document "in your shift what the area on the right hip looks like. Any increased redness-bright red, warm to touch, or if he develops a fever take to ED. Please call the on call nurse with questions."
The remainder of the notes from 8/22/20 to 9/10/20, lacked evidence of any documentation regarding the wound area, signs of infection, color, sizing/measurements and/or repositioning completed.

During interview on 10/1/20, at 3:45 p.m. RN-A stated the LPN staff should have been documenting all along the size of the wound so they could monitor if the wound was getting bigger. RN-A stated she will be re-educating the staff on this. Furthermore RN-A stated when the LPNs were hired she had the previous LPNs train them in and next time she will make sure she does the training.

An Annual Nutritional Assessment dated 9/21/20, by the facility's registered dietician (RD) indicated C1 had cellulitis and abscess on his right hip. The reported stated it was suggested from wound clinic on 8/28/20 C1 be on a 80-100 gm protein diet. The assessment indicated RD was not made aware of that and he was receiving an 83 gm diet.

An follow up email received from RD to writer on 10/10/20, indicated she was not notified of the request for the 80-100 gm protein diet until she completed his annual assessment and had she been aware of that on 8/28/20, when it was ordered she would have suggested he receive Arginaid (powder with Vitamin C and E to help

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support with wound healing) twice daily, multivitamin, Vitamin C and zinc to promote in wound healing.

In review of C1's medical record it was noted on 10/15/19, an email was sent from Courage Kenny Rehabilitation Institute Mercy Hospital Outpatient physical therapist (PT) who recommended C1 for a trial stander for 30-60 minutes 7 x a week to reduce spasticity and hypertonia, and to help prevent skin breakdown and improve bone health as he is at risk for decline from lack of ability to ambulate safely now. In addition the email sated he is non-verbal, and he is unable to tell staff if he needs repositioning.

A Demo Request was located in the chart dated 2/4/20, from Rehab Tech and demo set up instruction were given on the stander (assistive standing device) when it was delivered, home assessment was completed.

An additional fax from the facility dated 2/6/20, by LPN-B to Allina PT, requested clarification on the stander orders. There was no follow up on the request in the chart.

During interview 10/07/20, at 8:27 a.m. nurse manager registered nurse (RN)-B for Mary T Inc. stated C1's Easystand is in the hall outside of his room and he has not been using it. RN stated she reviewed his medical record and was unable to figure out what happened after 2/4/20 when they received the stander. RN stated there was no documentation after that anywhere. RN stated they will definitely be looking into this and it should not have been under looked.

A facility policy, Appointments And Tracking

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W 331	Continued From page 13 Procedure revised 10/4/20, indicated it is the person scheduling appointments to look at the tracker to see when appointments need to be scheduled, then the next level supervisor or nurse provide prompts when appointments are not scheduled as needed. In addition the policy stated every effort must be made to avoid cancellation of appointments and appointment follow up needs to be completed. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m. when survey staff verified applicable staff were re-trained on the appointment protocol, doctor's recommendations and when to clarify physician's orders, as well as wound care management including documentation of size, depth, quality, signs of infection. Additionally, the registered nurse was directed to review all medical referrals and oversee LPNs follow up and monitor twice a week, re-assessment of all current clients was completed and additional safety position rounds were put into place.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure client medication (eye drops) were given as ordered for	W 340		

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W 340	Continued From page 14 1 of 1 clients (C7) who was observed receiving prescribed medicated eye drops with improper absorption time of each medication. Findings include: C7's record revealed a mild intellectual disability and diagnosis of conjunctivitis (inflammation or infection of the transparent membrane) of the left eye. A review of C7's physician orders, last signed 1/23/20, noted C7 received three different eye medications which included: Cosopt PF 2-0.5% eye drops (used to reduction of elevated intraocular pressure) one drop in the left eye twice a day, Atropine Sulfate 0.01% eye drops (used to treat inflammation of the iris) one drop in the left eye twice a day, and Prednisolone 1% eye drops (a steroid medication used to treat inflammation of the eye) one drop in the left eye four times a day. During medication pass observations on 10/07/20, at 7:52 a.m., direct support staff (DSP)-A was observed setting up morning medications for C7. Medications included in C7's medication pass were three separate eye drops. At 8:00 a.m., after giving C7 his oral medications, DSP-A began giving C7 his eye drops. The first eye drop given was Atropine 0.01% eye drop to the left eye); at 8:01 a.m., Cosopt PF 2-0.5% eye drops was then given and approximately 30 seconds later DSP-A administered Prednisolone 1% eye drops in C7's left eye. All three eye medications were given over a time span of one minute and 30 seconds.	W 340		

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A review of C7 October 2020 Medication Administration Record (MAR) indicated the following:

> "Atropine Sulfate 0.01% eye drop, instill one drop in left eye twice daily ***WAIT 5 MINUTES IN BETWEEN ADMINISTERING DIFFERENT EYE DROPS"
> Cosopt PF Eye Drops - place 1 drop into the left eye 2 times daily * WAIT A FEW MINUTES BETWEEN DROPS"
> Prednisolone AC 1% Eye Drops - instill 1 drop to left eye four times daily ***WAIT 5 MINUTES IN BETWEEN ADMINISTRATION EYE DROPS***"

During interview on 10/07/20, at 8:24 a.m. DSP-A stated she thought they had wait one minute between eye drops.

An interview on 10/07/20, at 10:33 a.m., the facility's pharmacist consultant (PC) stated, there isn't a "concrete answer" while sometimes physician's will indicate a time between drops and that would depend on the types of eye drops being prescribed. However, PC stated waiting 5 minutes between eye drops was reasonable. This would allow the eye time to absorb the medication between drops.

In an interview on 10/07/2020, at 2:30 PM the facility's nurse manager (registered nurse) (RN)-B stated, C7's MAR indicated 5 minutes, and the staff have been trained to that.

A review of the facility's policy, entitled: Basic Medication Administration - Procedures & Routes (last updated 8/13/2018) indicated in step 5: "allow the eye to gently close. Have the individual

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W 340	Continued From page 16 remain in position for 3-5 minutes. He/she can keep eyes closed or blink gently."	W 340		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure a comprehensive drug regimen of each client was completed quarterly by the Pharmacist with input from the interdisciplinary team for 5 of 5 clients (C1, C2, C3, C4 and C7) in the sample. Findings include: Review of the records C1, C2, C3, C4 and C7 indicated a remote pharmacy review was conducted by Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review Geritom pharmacy consultant (PC) due to COVID-19 pandemic on 5/1/2020 and 8/7/20. C1's Emergency Data Form dated 10/1/20 indicated he had severe intellectual disabilities, hypothyroidism, hyperlipidemia(high cholesterol), seizures, gastro-esophageal reflux disease. C1's Coordinated services and Support Plan (CSSP) dated 3/4/20, indicated he received the following medications: Divalproex (anticonvulsant) 500 milligrams (mg) Lamotrigine 100 mg (anticonvulsant)	W 362		

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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
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Simvastatin 40 mg (for high cholesterol)
Levothyroxine 125 micrograms (mcg) for thyroid disorder
Albutetol inhaler (for shortness of breath)
Aspirin 81 mg
Clonazepam 0.5 mg (behaviors)
Tylenol 500 mg (as needed for pain)
Sudafed 10 mg (as needed for cold symptoms)
Milk of Magnesia (as needed for constipation)
Maalox (as needed for nausea)
Abilify 15 mg (atypical affective disorder)
Cephalexin 500 mg (urinary tract infection)
Vitamin D3 (low vitamin D level)

Review of C1's pharmacy review notes indicated on 5/1/20 and 8/7/20, C1 was reviewed with no irregularities.

A Consultation Form dated 7/16/20, indicated C1 was seen by his psychiatrist via Vidyo (video connect visit) and reviewed his target symptoms and medications. The psychiatrist discussed labs and ordered a fasting lipid panel.

Review of C1's medical chart indicated his last lipid panel was completed 1/14/19, and his cholesterol was 249 which was high (normal range is less than 150 milligrams per deciliter mg/dl. No other fasting lipid panels were located.

During interview 10/5/20, at 11:00 a.m. with (PC) from Geritom pharmacy stated during COVID he reviewed the clients medications remotely from the Geritom medication system and was able to see changes. He did not go on-site due to the facility not allowing him to come in. Prior to COVID-19 he stated he would do his reviews on-site, look through the medical books, look at things from the last time, look at referrals

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document and tracking, look at physicals, neuro psych, dentist, lab sections to check for irregularity or missed labs, psych monitoring, consent and discus (looking for side effects from antipsychotic medications). From there, PC stated he would make his recommendations. PC went on to state that during COVID 19 he was unable follow his normal practice so I would have a note on my form stating the facility is to make sure the above standards are being met, adding, essentially, clients went 6 months without a comprehensive review, so if labs were missed it would not have been caught because I did not have access to the physical chart and was not coordinating with anyone onsite.
C2's Emergency Data Form identified diagnosis that included Profound intellectual disability, epilepsy, cerebral palsy and use of a gastrostomy tube.

C2's CSSP dated 6/5/19, identified the use of the following medications:

Levitracetam 750 milligram (mg) tablet
Vitamin D2 1.25 mg tablet
Baclofen 10 mg table,t 1.5 tablets
Gabapentin 250 mg/ 5 milliliter (ml), 5 ml's
Ranitidine 15 mg/ml, 4 ml's
Calcium 600 mg with vitamin D3, t tab
Diazepam 5 mg/ml, 10 ml's

Review of a document titled Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review dated 8/7/20, indicated C2's medications were reviewed with no irregularities.

C3's record indicated cognitive function at the Mild level of intellectual disability, and had the diagnoses of cerebral palsy, hearing loss, OCD

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(Obsessive-compulsive disorder), degenerative arthritis, and leg length discrepancy.

In review of C3's physician's ordered medications reviewed during last annual physical (12/23/19), noted C3 received risperdal (anti-psychotic medication) 150 milligrams (mg) 1 tablet twice a day, oxcerbazepine (seizure medication) 150 mg 1 tablet TID with 300 mg 1 tablet TID of OCD.

C4's record indicated cognitive function at the Severe level of intellectual disability, and had the diagnoses of kyphosis (increased front-to-back curve of the upper spine, GERD (Gastroesophageal reflux disease), congenital heart lesion (defect is a problem with the structure of the heart), pacemaker, degenerative arthritis of the knees.

In review of C4's physician's ordered medications reviewed during last annual physical (12/20/19), noted C4 received metformin (diabetic medication) 500 mg 3 tablets at bedtime, metoprolol succinate (beta-blocker used to treat chest pain (angina), heart failure, and high blood pressure) 50 mg ER (extended release) 1 tablet everyday, potassium chloride ER 10 milliequivent (meq) 1 tablet with meal, hydralazine (to treat high blood pressure) 1 tablet three times a day.

C7's record indicated cognitive function at the Mild level of intellectual disability, and had the diagnoses of pyogenic arthritis (serious and painful infection of a joint), major depression disorder, hypertension, GERD (Gastroesophageal reflux disease), hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), constipation, chronic pain, lower limb weakness with ambulation

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difficulties, psychotic disorder - schizophrenia, conjunctivitis (inflammation or infection of the transparent membrane) of the left eye, and chronic liver issues.

In review of C7's physician's ordered medications reviewed during last annual physical (12/20/19), noted C7 received Quetiapine (Seroquel: anti-psychotic medication) 250 milligrams each night at bedtime.

A review of C3, C4 and C7's quarterly consultant pharmacist (PharmD) noted their medication regime was last reviewed 10/05/20. However, the last quarterly review was dated 1/29/20 which was eight (8) months prior. The medical record did not include evidence for quarterly reviews for April 2020 nor July 2020.

The facility provided documentation, entitled: Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review (for the months of May 2020 and August 2020) the PharmD performed quarterly pharmacy reviews remotely, due to COVID-19, while the facility did not consider the PharmD an essential care staff. The PharmD documented all clients on the same document, with "no irregularities" document next to each client's initials.

During interview on 10/07/2020, at 9:30 a.m., the facility director (FD) and registered nurse (RN)-A stated the PharmD was not considered essential care staff, which required the PharmD quarterly pharmacy reviews for all clients remotely utilizing only the medication records accessible remotely. RN-A stated PharmD did not have access to any client's paper medical records which included lab / blood work results, physician recommendations,

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W 362	Continued From page 21 and facility behavior monitoring to name a few.	W 362		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided appropriate equipment storage and prompt removal of broken/soiled furniture for 1 of 4 apartments (Four Leaf Clover) which effected clients and facility staff movement within the apartment. Findings include: Upon entrance to the facility on 9/30/20, at 9:00 a.m., surveyor noted the hall of Four Leaf Clover apartment had been used as a storage area for the following items: -on both side of the staff office were a total of three 3 inch shelves with open front cabinets (approximately 28 inches (in) tall, 36 in long and 12 in deep). - in the same hall on the left (East) side where the bedrooms were located, were stored: two mechanical lifts, four wheelchairs, the two large	W 435		

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"rubber maid style" totes and three bath chairs.

On 10/06/20, at 8:47 a.m., area director (AD) mentioned to direct support staff (DSP)-A she wanted the hallway of Four Leaf Clover "de-cluttered", from the staff office down the hall in the sleep area of the unit. Director stated to DSP-A it was to be a priority over the next two days.

Upon return the following day, 10/07/20, at 7:30 a.m., the hall in Four Leaf Clover remained the same.

During observation 10/7/20, at 7:50 a.m. C7 was noted coming down the hall in his wheelchair. C7 was observed, twice hanging up his wheelchair first on a wheelchair outside his room, and then on one of the mechanical lift legs.

During an interview on 10/07/2020, at 10:30 AD stated the facility had a shortage of storage places. AD stated that some of the equipment could be placed in the client rooms, if they were single rooms, however, several items belong to clients that resided in double occupancy rooms. The AD stated that the three wheelchairs were the "2nd" wheelchair for three of the clients and it had been discussed to downsize the census and make the bedrooms single occupancy but the open rooms within the facility are being maintained as potential COVID-19 quarantine rooms.

On 10/07/20, at 12:00 p.m., the hallway was noted now to be cleared, with the exception of the three open shelf units.

During observation and interview 10/7/20, at 3:15

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W 435	Continued From page 23 p.m. with program residential services coordinator PRSC-A in the facility great room there was a large maroon cloth couch with no seat cushions. The couch was facing backwards against the wall, along with a broken wooden chair on top of it. PRSC-A stated the couch has been there for over a month and they have been waiting for maintenance to pick it up. The cushions have been removed due to a client had been sitting on the couch and had urinated on it. In interview on 10/08/20, at 10:30 a.m., the program supervisor (PS) stated the 3 bath chairs were placed in the shower room, and the wheelchairs and totes were placed in an open room in the Cardinal apartment. A policy on facility storage had been requested but not received.	W 435		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency drills were held on the day shift, at least quarterly. This practice had the potential to affect all 23 clients who resided in the facility. Findings include: Review of the fire drills from 6/23/19 to 9/12/20 indicated the following:	W 440		

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W 440	Continued From page 24 A day shift fire drill was ran on 10/09/19, and the following day shift fire drill was conducted on 3/15/20, this was 158 days between fire drills. Review of the 2019/2020 Fire Drill Schedule indicated the fire drills were to be completed monthly, with the time of the drills to be rotated equally between the day, evening and night shifts. During interview 10/6/20, at 11:00 a.m. area director (AD) stated the January 2020 fire drill should have been completed in the day time not the evening shift. The facility Emergency Response Policy revised 8/2013, indicated: It is the policy of Mary T Inc. to effectively respond to, report, and review all emergencies to ensure the safety of persons receiving services and to promote the continuity of services until emergencies are resolved. It is imperative that the individuals residing in the home, the staff and the public are protected in case of emergency and that emergency procedures are carried out with the least amount of disruption. The purpose of this policy is to outline measures taken during emergency situations to ensure homes are prepared to anticipate and respond to those situations.	W 440		

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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. On 9/30/20 through 10/2/20, an abbreviated survey was conducted to investigate HG186024C. A full survey was conducted 10/5/20 through 10/08/2020. The following complaint was found to be substantiated: HG504010C Licensing orders were issued. Your facility was not in compliance with requirements of Minnesota Rules, Chapter 4665	5 000	11/18/20	

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy Hanson, RA
TITLE: Residential Administrator
(X6) DATE: 11/9/2020

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5 000	Continued From page 1 requirements for Supervised Living Facilities (SLF).	5 000		
5 250	MN Rule 4665.1800 Subp. 1 SPACE ARRANGEMENTS AND REQUIREMENTS. Space to meet needs of residents and program licensure requirements. Provision of appropriate space and arrangements thereof for sleeping, dining, recreation, and other common use areas for activities or training shall be in conformance with the residents' mobility needs and with the program licensure requirements of the Department of Human Services. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided appropriate equipment storage and prompt removal of broken/soiled furniture for 1 of 4 apartments (Four Leaf Clover) which effected clients and facility staff movement within the apartment. Findings include: Upon entrance to the facility on 9/30/20, at 9:00 a.m., surveyor noted the hall of Four Leaf Clover apartment had been used as a storage area for the following items: -on both side of the staff office were a total of three 3 inch shelves with open front cabinets (approximately 28 inches (in) tall, 36 in long and 12 in deep). - in the same hall on the left (East) side where the bedrooms were located, were stored: two mechanical lifts, four wheelchairs, the two large	5 250		

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5 250	Continued From page 2 "rubber maid style" totes and three bath chairs. On 10/06/20, at 8:47 a.m., area director (AD) mentioned to direct support staff (DSP)-A she wanted the hallway of Four Leaf Clover "de-cluttered", from the staff office down the hall in the sleep area of the unit. Director stated to DSP-A it was to be a priority over the next two days. Upon return the following day, 10/07/20, at 7:30 a.m., the hall in Four Leaf Clover remained the same. During observation 10/7/20, at 7:50 a.m. C7 was noted coming down the hall in his wheelchair. C7 was observed, twice hanging up his wheelchair first on a wheelchair outside his room, and then on one of the mechanical lift legs. During an interview on 10/07/2020, at 10:30 AD stated the facility had a shortage of storage places. AD stated that some of the equipment could be placed in the client rooms, if they were single rooms, however, several items belong to clients that resided in double occupancy rooms. The AD stated that the three wheelchairs were the "2nd" wheelchair for three of the clients and it had been discussed to downsize the census and make the bedrooms single occupancy but the open rooms within the facility are being maintained as potential COVID-19 quarantine rooms. On 10/07/20, at 12:00 p.m., the hallway was noted now to be cleared, with the exception of the three open shelf units. During observation and interview 10/7/20, at 3:15 p.m. with program residential services	5 250		

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5 250	Continued From page 3 coordinator PRSC-A in the facility great room there was a large maroon cloth couch with no seat cushions. The couch was facing backwards against the wall, along with a broken wooden chair on top of it. PRSC-A stated the couch has been there for over a month and they have been waiting for maintenance to pick it up. The cushions have been removed due to a client had been sitting on the couch and had urinated on it. In interview on 10/08/20, at 10:30 a.m., the program supervisor (PS) stated the 3 bath chairs were placed in the shower room, and the wheelchairs and totes were placed in an open room in the Cardinal apartment. A policy on facility storage had been requested but not received. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	5 250		
5 515	MN Rule 4665.4700 FIRST AID. Every facility shall have on the premises a suitable first aid kit approved in writing by a physician for use for residents and staff. Tourniquets shall not be stored in the kit. The kit shall be maintained in a place known to and readily available to all personnel responsible for the health or well-being of residents, and such personnel shall be instructed in acceptable emergency first aid procedures. This MN Requirement is not met as evidenced by: Based on observation and interview the agency failed to ensure first aid kits were available in 2 of 3 client transport vehicles.	5 515		

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5 515	Continued From page 4 Findings include: During a review of the agency's first aid kits on 10/8/20, at 10:27 a.m. the program supervisor stated she looked in the agency's two lift vans used for transporting clients and was unable to locate a first aid kit in either one of the vans. The program supervisor stated a third van was off the premises and she was unable to verify if it contained a first aid kit. The program supervisor stated each of the vehicles should have had a first aid kit. At 10:35 a.m. registered nurse (RN)-A stated the resident services coordinators (RSC) were responsible to ensure each vehicle had a fist aid kit. At 10:55 a.m. RSC- A stated she was not aware she was responsible for the first aid kits. A policy was requested but was not provided. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	5 515		
5 525	MN Rule 4665.4900 EMERGENCY PROCEDURES MEETING. There shall be a meeting of all employees on each shift at least once every three months to discuss emergency procedures used in the facility. Business of the meetings shall cover: A. assignment of persons to specific tasks and responsibilities in case of emergency situation; B. instructions relating to the use of alarm systems and signals;	5 525		

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5 525	Continued From page 5 C. systems for notification of appropriate persons outside the facility; D. information on the location of emergency equipment in the facility; and E. specification of evacuation routes and procedures. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure facility staff attended the emergency procedure meetings every quarter. This had the potential to affect 23 of 23 clients residing in the facility. Findings include: During interview 10/5/20, with the area director (AD) who stated the program supervisor (PS)-D was in charge of keeping the quarterly meeting minutes and she is currently out on a family/medical leave. AD stated she went through her office and is unable to provide any documentation indicating the quarterly emergency procedure meetings were conducted as required. The facility Emergency Response Policy revised 8/2013, indicated: It is the policy of Mary T Inc. to effectively respond to, report, and review all emergencies to ensure the safety of persons receiving services and to promote the continuity of services until emergencies are resolved. It is imperative that the individuals residing in the home, the staff and the public are protected in case of emergency and that emergency procedures are carried out with the least amount of disruption. The purpose of this policy is to outline measures taken during	5 525		

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	01141	A. BUILDING: _____ B. WING _____	C 10/08/2020

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) COMPLETE DATE
5 525	Continued From page 6 emergency situations to ensure homes are prepared to anticipate and respond to those situations. TIME PERIOD FOR CORRECTION: Twenty one (21) days..	5 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G186	A. BUILDING _____ B. WING _____	C 10/08/2020

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W 000	INITIAL COMMENTS On 9/30/20 through 10/2/20, an abbreviated survey was conducted to investigate HG186024C. The facility was found NOT to be in compliance with the requirements of 42CFR 483 Subpart I, for Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID). In addition, the Condition of Participation: Health Care Services 42 CFR 483.460 was found not met. A full survey was conducted 10/5/20 through 10/08/2020. HG186024C was substantiated with deficiencies issued at W331. Immediate Jeopardy situation was identified at W331 on 10/2/20, at 2:04 p.m. . The Immediate Jeopardy began on 8/28/20, when C1, following an Emergency Department (ED) visit on 8/27/20, was seen by a wound clinic and received treatment orders and interventions for an unstagable pressure ulcer that were never implemented at the facility. Additionally, the facility failed to assess and monitor the pressure ulcer and to assist C1 to attend a follow up visit on 9/4/20, for pressure ulcer debridement and again failed on 9/10/20, which subsequently led to C1's hospitalization on 9/10/20. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m. when applicable staff were re-trained on the appointment protocol, doctor's recommendations and when to clarify physician's orders, as well as wound care management including documentation of size, depth, quality, signs of	W 000	 received 11/8/20 POC 11/18/20 Approved 12/4/20	

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

Cathy Hanson, RA | Residential Administrator | 11/9/2020

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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W 000	Continued From page 1 infection. Additionally, the registered nurse was directed to review all medical referrals and oversee LPN's follow up and monitor twice a week, re-assessment of all current clients was completed and additional safety position rounds were put into place.	W 000		
W 148	COMMUNICATION WITH CLIENTS, PARENTS & CFR(s): 483.420(c)(6) The facility must notify promptly the client's parents or guardian of any significant incidents, or changes in the client's condition including, but not limited to, serious illness, accident, death, abuse, or unauthorized absence. This STANDARD is not met as evidenced by: Based on interview and document review the facility failed to notify the legal guardian/family timely of a worsening unstageable pressure ulcer that required doctor recommended interventions and hospitalization for debridement for 1 of 1 (C1) client who were hospitalize without family notification for six days. Findings include: C1's Emergency Data Form dated 10/1/20, indicated C1 admitted on 9/14/2007, diagnosed with severe intellectual disabilities An Office Visit dated 8/28/20, at Abbott Northwestern Wound Clinic, indicated C1 was seen for evaluation and treatment of his right hip wound. The report stated, the nurse at the group home felt the wound is worsening and had sent C1 to the emergency department on 8/27/20 and	W 148	W148 : Communication with clients and teams Effective immediately and on and ongoing Camilla Rose Group Home will follow notification procedures outlined in the Incident Reporting Policy. This policy indicated that notifications include case manager, guardians, family participants, and physicians as needed. All staff will be training on the GER form and expectations for notifications on 11/18/2020. Nursing staff have been trained to make contacts with IDT's for medical updates as well as worsening of conditions. C1's IDT has been updated on his condition and treatment plan and will be updated weekly until he returns to baseline. Designated Manager will review General Event Repots to assure notifications have been made and documented. In addition, she will chair internal meeting related to quality oversight at the program, which reviews GER's and team communication. Correction date: 11/18/2020	

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W 148	Continued From page 2	W 148		

the physician there performed an incision and drainage and prescribed Keflex (antibiotic). The physician visit assessed the wound as a unstageable pressure ulcer with the wound bed covered with necrotic material.

An After Wound Care After Visit Summary dated 8/28/20 indicated the following orders:
- dressing change daily cleanse wound with wound cleanser, pat dry, cover with manuka honey dressing and cover with 1/2 abdominal gauze pad, secure with medipore (adhesive) tape.
- 80-100 grams (G) of protein daily through protein dense foods and protein supplement shakes.
-repositioning while in bed every 2 hours, and every 15- 20 minutes while sitting.
-pressure reduction mattress
-Roho wheelchair cushion (redistribute pressure and prevent skin breakdown caused by long-term wheelchair use).

Record review revealed no indication the POA was contacted following the 8/28/20 appointment and treatment orders.

During interview 10/1/20, at 8:09 a.m. C1's power of attorney (POA) who stated, she was not informed by the facility he was hospitalized until 9/16/20, which was 6 days later from the hospital social worker. She further stated she was not aware of the wound doctor's recommendations for the special mattress, wheelchair cushion, positioning or increased protein diet and she would have approved all of them. In addition she stated she had sent multiple emails to the program supervisor (PS)-D requesting updates on C1 and received not responses and finally at

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W 148	Continued From page 3 the end the emails were just getting sent back to her. POA then stated she finally called the RN and got an updated but this was prior to his hospitalization and that is when she found out PS-D was out on leave. During interview 10/1/20 at 8:30 a.m. RN stated she was aware of C1's POA not receiving responses from her emails sent to PS-D. She indicated that should not have happened and lately there has been a lot of turnover in the facility. RN stated she was not aware the POA was not informed by them of C1's hospitalization and should have been. Record review lacked evidence of any POA notification following C1's hospitalization. A facility policy Health Services Coordination And Care Policy dated 8/2014, indicated "When discovered the program will promptly notify the person's legal representative, if any, and the case manager of changes in a persons physical and mental needs affecting health services." The policy also indicated they must document the notification.	W 148		
W 318	HEALTH CARE SERVICES CFR(s): 483.460 The facility must ensure that specific health care services requirements are met. This CONDITION is not met as evidenced by: Based on interview and document review, the Condition of Participation at 42 CFR 483.460 Health Care Services, was not met. The facility	W 318		

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W 318	Continued From page 4 failed to provide adequate nursing services to C1 who had a worsening pressure ulcer, did not received treatments and interventions as ordered and missed medical appointments on both 9/4/20 and 9/11/20, which subsequently let to C1's admission to the emergency departement who admitted him to the hospital. C1 then required surgical debridement to his wound at the hospital and then was discharged to skilled nursing facility for twice daily dressing changes and rehab. Findings include: See W331: The facility failed to provide adequate nursing services to prevent a worsening unstageable pressure ulcer 1 of 3 clients (C1) who had a unstageable pressure ulcer that required hospitalization for wound debridement and admission to a skilled nursing facility for twice daily dressing changes and therapy.	W 318	W 318: Health Care Services An ISP for C1 for daily attempts of stander use was implemented 11/9/2020. Physical therapy and speech therapy are currently coming into the program to assess C1's current plans as well as to make recommendations. Any additionally recommendations made through these assessments will be discussed with his team and implemented per team decision. A summary of these discussions will be sent to the IDT via email. Dietary recommendations from the TCU for higher protein are currently being followed. Nursing staff will consult with dietician and the physician and follow recommendations as they are made.	
W 331	NURSING SERVICES CFR(s): 483.460(c) The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess and monitor a pressure ulcer, implement physician ordered interventions/recommendations and failed to ensure timely attendance to a critical follow up appointment for 1 of 3 (C1) clients who required care and treatment for a pressure ulcer. This failure resulted in C1's admission to the hospital on 9/10/20 for worsening pressure ulcer of right hip where debridement occurred on 9/11/20 and	W 331	Previous orders for ROHO cushion and pressure mattress are being discontinued. C1's every 15 minutes reposition order was discontinued. He is currently repositioned every hour. RN will review all medical referrals for appointments related to a change in condition, worsening of a medical condition, or urgent care and hospital visits within 2 weeks to oversee LPN's follow up progress. Completion date: 11/13/2020	

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W 331	Continued From page 5 C1 received 5 days of intravenous (IV) befooling (antibiotic) before being discharged to a skilled nursing facility for rehab and nursing care on 9/18/20. This resulted in an immediate jeopardy situation for C1. The Immediate Jeopardy began on 8/28/20, when C1, following an Emergency Department (ED) visit on 8/27/20, was seen by a wound clinic and received treatment orders and interventions for an unstageable pressure ulcer that were never implemented at the facility. Additionally, the facility failed to assess and monitor the pressure ulcer and to assist C1 to attend a follow up visit on 9/4/20, for pressure ulcer debridement and again failed on 9/10/20, which subsequently led to C1's hospitalization on 9/10/20. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m. Findings include: C1's Emergency Data Form dated 10/1/20, indicated a diagnosis of severe intellectual disabilities and identified C1 used a wheelchair with a gel cushion for mobility. C1's Coordinated Service and Support Plan (CSSP) dated 3/4/20, indicated staff monitor his health conditions according to written instructions from his licensed health professional, which included assist with or coordinate medical, dental and other health service appointments, use of medical equipment, devices or adaptive aides. Further the CSSP indicated staff will follow the licensed health professional instructions and staff will help track and schedule appointments that are due, provide or acquire transportation and accompany to all appointments. In addition the CSSP indicated medication/treatments will be	W 331	W331: Nursing Services missing appointments: Residential Service Coordinators, Program Supervisors, LPNs, and RN will be retrained on the appointment protocol prior on 10/5/2020 or the first shift working after that date. This protocol includes consultation with Designated Manager (or Residential Administrator in her absence) to problem solve transportation and staffing glitches to assure that all efforts are made for clients to attend their scheduled and unscheduled appointments. Follow up on Dr recommendations: [redacted], RN trained [redacted] [redacted], LPN on 10/2/2020 in accurately reviewing and following up on both actual orders on the medical referrals as well as the recommendation. This training included asking for Dr clarification of recommendations if we do not understand or feel that we are unable to accomplish the recommendations. This training included seeking orders for recommendations that require corresponding orders and timely implementation of the orders. This training included steps to ensure follow up, including timelines of accelerating issues of follow up to Designated Manager (Residential Administrator in her absence). This training will be presented to [redacted] LPN by [redacted] RN on 10/5/2020. RN will review all medical referrals for appointments related to a change in condition, worsening of a medical condition, or urgent care and hospital visits within 2 weeks to oversee LPN's follow up progress.	X

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W 331	Continued From page 6 administered as ordered. A Minnesota Adult Abuse Reporting Center (MAARC) report dated 9/22/20, indicated C1 was hospitalized from 9/10/20 through 9/18/20, with right hip cellulitis. The report indicated he had missed a medical appointment and was advised to seek care at the emergency room with a right hip wound likely pressure ulcer which had been worsening for the past two weeks prior to the hospitalization. The wound required surgery and he was admitted to skilled nursing facility following his hospitalization. In addition the report indicated some of C1's antibiotics were not administered as ordered. During observation and interview on 9/30/20, at 3:00 p.m. medical residential services coordinator (RSC)-A and surveyor entered C1's room and observed he had a queen sized bed. When RSC-A-A lifted the sheets on the bed it was observed C1 had a standard mattress. On top of his bed were two regular pillows, with two additional smaller decorative round pillows. RSC-A she stated they would use the one standard pillow and try to place that on C1's back to keep C1 off of his right side but he often would pull it out. Further she stated he liked to lay on his right side and suspected that is why C1 obtained the wound on his right hip. A Consultation Form dated 7/29/20, indicated C1 was seen by a general practice physician for a protruding bump on his right side thigh, right below his hip. The general practice physician ordered a computed tomography (CT) scan of the pelvis (imaging x-ray of the pelvis) at suburban imaging. A following Consultation Form from Suburban Imagining dated 8/21/20, (23 days	W 331	W331 Cont' Pressure ulcers: LPN training: LPN's will receive training on wound care management by Oct 5th, 2020. Wound care management will be added to the LPN orientation and training process going forward. Training will include documentation of size, depth, quality of wound, and signs of infection. Nursing staff will monitor a minimum of twice per week clients with pressure ulcers present. RN will be notified of worsening of any pressure ulcers and will assess visually within 48 hours, or immediately if warranted. If pressure ulcer assessments are completed by LPN, the RN will be reviewing documentation of pressure ulcer management weekly as visually assessing each pressure ulcer monthly. Clients that are at Moderate risk or above on the Braden Scale for Predicting Pressure Sore Risks, will be assessed visually by a nurse monthly. Assessing current client risk: RN and Nursing Manager completed Braden Scale pressure ulcer risk assessments On all current residents on 10/2/2020. Individualized care plans will be developed or revised for each person by 10/5/2020. Staff will receive training on these care plans on their first day worked on or after 10/5/2020.	

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W 331	Continued From page 7 later) indicated C1 received his CT scan of his right pelvis. During interview on 9/30/20, at 2:20 p.m. with facility registered nurse (RN)-A stated she was not aware why the CT scan took so long to get ordered. RN-A stated it should only have taken a couple of days to have completed and when they scheduled it something must have happened and the staff should have followed up on this immediately. RN-A further stated in the middle of July 2020 she noticed just a lump on C1's right hip, it was not open, so they had him seen and a CT was ordered. RN-A went on by saying, then sometime in August 2020 the area opened and just started to get worse. It was at that time that they sent him to his primary and then to the wound doctor. RN-A concluded by adding, they knew it was getting bad. An After Visit Summary dated 8/25/20, from C1's primary physician indicated C1 had mild cellulitis/abscess right hip (3 centimeter fluid collection on recent CT scan). The primary physician ordered an oral antibiotic, dressing change twice daily and follow up with wound clinic. An Office Visit report dated 8/28/20, Abbott Northwestern Wound Clinic, indicated he was seen for evaluation and treatment of his right hip wound. The note indicated staff noticed the wound in early August 2020 and he prefers to lay on his right side while in bed and they make effort to keep on his right hip by placing pillows behind his back while in bed to keep him on his left side. The note further indicated, the nurse at the group home feels the wound is worsening and C1 was sent to the emergency department on 8/27/20,	W 331	W 331 Cont' Staff will receive general training on cause, symptoms, and treatment of pressure ulcers on their next shift worked after 10/3/2020. Additional safety/position rounds have been added to the plans for individuals that are identified to need more than 2-hour changes and repositioning. These plan changes were sent out to staff on 10/3/2020. Staff will be expected to read this material and begin additional safety checks on the overnight of 10/3/2020. Supervisors will call the overnight staff at the beginning of their first shift after these expectations begin, ask them to acknowledge the Scom and talk through the expectations and assure staff understand the additional steps for the overnight. Program Supervisors will make an overnight checklist for overnights to document these additional checks by 10/5/2020.	

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W 331	Continued From page 8 and the physician there performed an incision and drainage and prescribed Keflex (antibiotic). The physician's notes from the visit assessed the wound as an unstageable pressure ulcer with the wound bed covered with necrotic material. An After Visit Summary dated 8/28/20, for C1's Wound Care Clinic visit indicated orders as follows: - dressing change daily cleanse wound with wound cleanser, pat dry, cover with Manuka honey (aids in wound healing) dressing and cover with 1/2 abdominal dressing secure with medipore (stretches) tape. - 80-100 grams (G) of protein daily through protein dense foods and protein supplement shakes. -Repositioning while in bed every 2 hours, and every 15- 20 minutes while sitting. -pressure reduction mattress -Roho wheelchair cushion (redistribute pressure and prevents skin breakdown caused by long-term wheelchair use). -In addition the wound doctor stated in the report he would like to debride the wound but was unable to get consent from his power of attorney. With instruction to return on 9/4/20 for debridement after received consent. During interview on 9/30/20, at 2:20 p.m. RN-A stated the staff were completing the dressing changes and repositioning C1 every 2 hours. The RN-A stated she was not aware of the other orders for an increased protein diet, specialty mattress, Roho cushion or every 15 to 20 minute repositioning while sitting and confirmed those orders/treatments were not being done. RN-A stated it was the responsibility of the person who brought the clients to their appointments to inform	W 331	W331 Cont' For C1, dietary recommendations to provide higher protein, which are being provided currently according to TCU recommendation. Nursing staff will consult with the dietician and the physician and follow recommendations as they are made. Previous orders for ROHO cushion and pressure mattress are being discontinued. C1's 15 minutes reposition order has been discontinued. He is currently repositioned every hour. ISP's will be written for orders or recommendations for ROM or PT. These ISP's will be ran during the day as to provide opportunities for nurses to oversee implementation. Implementation will be observed by Service Coordinator, Nursing staff and Designated Manager and documented in the observation books. Problems with implementation will be addressed in weekly quality oversight meeting as needed. Completion date: 11/9/2020	

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W 331	Continued From page 9	W 331		

the licensed practical nurses (LPNs) of the orders and then follow through with them.

During interview on 9/30/20, at 2:30 p.m. LPN-A stated she was also not aware of the orders for C1, in addition she stated C1 did not attend his 9/4/20 appointment because there was not enough staff in the building to take him so the appointment was canceled and rescheduled for 9/10/20 (6 days later).

During interview on 9/30/20, at 4:00 p.m. with medical residential services coordinator (MRSC)-A stated she makes the appointments for the clients and on 9/10/20, she was supposed to take C1 to his wound appointment but she over slept that morning so LPN-A took him to his appointment and by then he had arrived late. MRSC-A stated because C1 was late for his appointment and the clinic would not see him, LPN-A was instructed to take him to the emergency department (ED) where he waited in the ED until the hospital decided to admit him.

During interview on 10/1/20, at 8:09 a.m. C1's power of attorney (POA) stated, she was not informed by the facility he was hospitalized until 9/16/20, furthermore she was not made aware of the wound doctor's recommendations for the special mattress, wheelchair cushion, positioning or increased protein diet and she would have approved all of them.

During interview on 10/01/20, at 2:30 p.m. C1's wound clinic medical doctor stated he had seen C1 once on 8/28/20, and had diagnosed him with an unstageable pressure ulcer as well had ordered treatments and interventions for C1's condition. C1's wound clinic medical doctor

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stated he ordered a pressure relieving mattress, Roho cushion and protein shake. He stated he was concerned the orders were not implemented, but was most concern C1 had missed his 9/4/20 appointment and stated, "I think it would have been very unlikely that if he would have made it to that appointment instead of missing it, would have helped in preventing his wound from worsening and prevented his hospitalization that occurred on 9/10/20."

An Allina Health ED to Admission in Abbott Northwestern Hospital Visit dated 9/10/20, indicated Chief Complaint-wound check, pressure injury of skin of right hip and cellulitis, right wound approximately 5 cm in diameter with halo of surrounding erythema (redness of the skin) black eschar (dead tissue) covering the wound, and was admitted from ED to hospital at 9:57 p.m. The note further indicated C1 was admitted with right hip cellulitis due to missing his appointment, he was advised by outpatient wound care to present to ED for further evaluation of progressively worsening right hip wound and was unable to have wound debrided. The visit note indicated he was non-toxic on admission and no evidence of osteomyelitis (bone infection), the debridement occurred on 9/11/20 without complication and received 5 days of intravenous (IV) befooling (antibiotic). The hospital visit notes indicated C1 discharged to a skilled nursing facility for rehab and nursing care on 9/18/20.

Review of C1's T-Log documentation of wound care from 7/1/2020 to 9/10/2020 indicated:
-7/24/20 (First note on area on hip noted as bump on his hip/thigh). Noted as, felt like bone protruding when touched, made MD appointment 7/29/20. Rest of the notes for July 2020

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discussed the bump on hip/thigh.
-8/22/20 (RN note) Late Entry for 7/21/20 directed staff to document "in your shift what the area on the right hip looks like. Any increased redness-bright red, warm to touch, or if he develops a fever take to ED. Please call the on call nurse with questions."
The remainder of the notes from 8/22/20 to 9/10/20, lacked evidence of any documentation regarding the wound area, signs of infection, color, sizing/measurements and/or repositioning completed.

During interview on 10/1/20, at 3:45 p.m. RN-A stated the LPN staff should have been documenting all along the size of the wound so they could monitor if the wound was getting bigger. RN-A stated she will be re-educating the staff on this. Furthermore RN-A stated when the LPNs were hired she had the previous LPNs train them in and next time she will make sure she does the training.

An Annual Nutritional Assessment dated 9/21/20, by the facility's registered dietician (RD) indicated C1 had cellulitis and abscess on his right hip. The reported stated it was suggested from wound clinic on 8/28/20 C1 be on a 80-100 gm protein diet. The assessment indicated RD was not made aware of that and he was receiving an 83 gm diet.

An follow up email received from RD to writer on 10/10/20, indicated she was not notified of the request for the 80-100 gm protein diet until she completed his annual assessment and had she been aware of that on 8/28/20, when it was ordered she would have suggested he receive Arginaid (powder with Vitamin C and E to help

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support with wound healing) twice daily, multivitamin, Vitamin C and zinc to promote in wound healing.

In review of C1's medical record it was noted on 10/15/19, an email was sent from Courage Kenny Rehabilitation Institute Mercy Hospital Outpatient physical therapist (PT) who recommended C1 for a trial stander for 30-60 minutes 7 x a week to reduce spasticity and hypertonia, and to help prevent skin breakdown and improve bone health as he is at risk for decline from lack of ability to ambulate safely now. In addition the email sated he is non-verbal, and he is unable to tell staff if he needs repositioning.

A Demo Request was located in the chart dated 2/4/20, from Rehab Tech and demo set up instruction were given on the stander (assistive standing device) when it was delivered, home assessment was completed.

An additional fax from the facility dated 2/6/20, by LPN-B to Allina PT, requested clarification on the stander orders. There was no follow up on the request in the chart.

During interview 10/07/20, at 8:27 a.m. nurse manager registered nurse (RN)-B for Mary T Inc. stated C1's Easystand is in the hall outside of his room and he has not been using it. RN stated she reviewed his medical record and was unable to figure out what happened after 2/4/20 when they received the stander. RN stated there was no documentation after that anywhere. RN stated they will definitely be looking into this and it should not have been under looked.

A facility policy, Appointments And Tracking

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W 331	Continued From page 13 Procedure revised 10/4/20, indicated it is the person scheduling appointments to look at the tracker to see when appointments need to be scheduled, then the next level supervisor or nurse provide prompts when appointments are not scheduled as needed. In addition the policy stated every effort must be made to avoid cancellation of appointments and appointment follow up needs to be completed. The immediate jeopardy was removed on 10/5/20, at 3:10 p.m. when survey staff verified applicable staff were re-trained on the appointment protocol, doctor's recommendations and when to clarify physician's orders, as well as wound care management including documentation of size, depth, quality, signs of infection. Additionally, the registered nurse was directed to review all medical referrals and oversee LPNs follow up and monitor twice a week, re-assessment of all current clients was completed and additional safety position rounds were put into place.	W 331		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure client medication (eye drops) were given as ordered for	W 340	W340: Nursing Services: Immediate retraining was provided by RN to the employee that made this mistake. When multiple eye drops are administered to a resident, all staff will follow the protocol of 3-5 minutes between drops. Nursing will retrain staff on this protocol by 11/12/2020 or prior to them administering eye drops. Eye drop administration will be reviewed at the next staff meeting. Managers and nursing staff will monitor for compliance by randomly twice per month observing medication administration process and documented in observation book including the route of administration. Completion date: 11/18/2020	

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W 340	Continued From page 14 1 of 1 clients (C7) who was observed receiving prescribed medicated eye drops with improper absorption time of each medication. Findings include: C7's record revealed a mild intellectual disability and diagnosis of conjunctivitis (inflammation or infection of the transparent membrane) of the left eye. A review of C7's physician orders, last signed 1/23/20, noted C7 received three different eye medications which included: Cosopt PF 2-0.5% eye drops (used to reduction of elevated intraocular pressure) one drop in the left eye twice a day, Atropine Sulfate 0.01% eye drops (used to treat inflammation of the iris) one drop in the left eye twice a day, and Prednisolone 1% eye drops (a steroid medication used to treat inflammation of the eye) one drop in the left eye four times a day. During medication pass observations on 10/07/20, at 7:52 a.m., direct support staff (DSP)-A was observed setting up morning medications for C7. Medications included in C7's medication pass were three separate eye drops. At 8:00 a.m., after giving C7 his oral medications, DSP-A began giving C7 his eye drops. The first eye drop given was Atropine 0.01% eye drop to the left eye); at 8:01 a.m., Cosopt PF 2-0.5% eye drops was then given and approximately 30 seconds later DSP-A administered Prednisolone 1% eye drops in C7's left eye. All three eye medications were given over a time span of one minute and 30 seconds.	W 340		

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A review of C7 October 2020 Medication Administration Record (MAR) indicated the following:

> "Atropine Sulfate 0.01% eye drop, instill one drop in left eye twice daily ***WAIT 5 MINUTES IN BETWEEN ADMINISTERING DIFFERENT EYE DROPS"
> Cosopt PF Eye Drops - place 1 drop into the left eye 2 times daily * WAIT A FEW MINUTES BETWEEN DROPS"
> Prednisolone AC 1% Eye Drops - instill 1 drop to left eye four times daily ***WAIT 5 MINUTES IN BETWEEN ADMINISTRATION EYE DROPS***"

During interview on 10/07/20, at 8:24 a.m. DSP-A stated she thought they had wait one minute between eye drops.

An interview on 10/07/20, at 10:33 a.m., the facility's pharmacist consultant (PC) stated, there isn't a "concrete answer" while sometimes physician's will indicate a time between drops and that would depend on the types of eye drops being prescribed. However, PC stated waiting 5 minutes between eye drops was reasonable. This would allow the eye time to absorb the medication between drops.

In an interview on 10/07/2020, at 2:30 PM the facility's nurse manager (registered nurse) (RN)-B stated, C7's MAR indicated 5 minutes, and the staff have been trained to that.

A review of the facility's policy, entitled: Basic Medication Administration - Procedures & Routes (last updated 8/13/2018) indicated in step 5: "allow the eye to gently close. Have the individual

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W 340	Continued From page 16 remain in position for 3-5 minutes. He/she can keep eyes closed or blink gently."	W 340		
W 362	DRUG REGIMEN REVIEW CFR(s): 483.460(j)(1) A pharmacist with input from the interdisciplinary team must review the drug regimen of each client at least quarterly. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to assure a comprehensive drug regimen of each client was completed quarterly by the Pharmacist with input from the interdisciplinary team for 5 of 5 clients (C1, C2, C3, C4 and C7) in the sample. Findings include: Review of the records C1, C2, C3, C4 and C7 indicated a remote pharmacy review was conducted by Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review Geritom pharmacy consultant (PC) due to COVID-19 pandemic on 5/1/2020 and 8/7/20. C1's Emergency Data Form dated 10/1/20 indicated he had severe intellectual disabilities, hypothyroidism, hyperlipidemia(high cholesterol), seizures, gastro-esophageal reflux disease. C1's Coordinated services and Support Plan (CSSP) dated 3/4/20, indicated he received the following medications: Divalproex (anticonvulsant) 500 milligrams (mg) Lamotrigine 100 mg (anticonvulsant)	W 362	W362: Drug Regimen Review: A pharmacy review was done on site on 10/5/2020. Going forward, if pharmacy reviews cannot be completed on site, the Pharmacist will provide a full pharmacy review off site with the assistance of nursing to provide information by phone or scans. C1's fasting lipid lab was completed on: 11/6/2020. Correction date: 11/6/2020	

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Simvastatin 40 mg (for high cholesterol)
Levothyroxine 125 micrograms (mcg) for thyroid disorder
Albutetol inhaler (for shortness of breath)
Aspirin 81 mg
Clonazepam 0.5 mg (behaviors)
Tylenol 500 mg (as needed for pain)
Sudafed 10 mg (as needed for cold symptoms)
Milk of Magnesia (as needed for constipation)
Maalox (as needed for nausea)
Abilify 15 mg (atypical affective disorder)
Cephalexin 500 mg (urinary tract infection)
Vitamin D3 (low vitamin D level)

Review of C1's pharmacy review notes indicated on 5/1/20 and 8/7/20, C1 was reviewed with no irregularities.

A Consultation Form dated 7/16/20, indicated C1 was seen by his psychiatrist via Vidyo (video connect visit) and reviewed his target symptoms and medications. The psychiatrist discussed labs and ordered a fasting lipid panel.

Review of C1's medical chart indicated his last lipid panel was completed 1/14/19, and his cholesterol was 249 which was high (normal range is less than 150 milligrams per deciliter mg/dl. No other fasting lipid panels were located.

During interview 10/5/20, at 11:00 a.m. with (PC) from Geritom pharmacy stated during COVID he reviewed the clients medications remotely from the Geritom medication system and was able to see changes. He did not go on-site due to the facility not allowing him to come in. Prior to COVID-19 he stated he would do his reviews on-site, look through the medical books, look at things from the last time, look at referrals

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document and tracking, look at physicals, neuro psych, dentist, lab sections to check for irregularity or missed labs, psych monitoring, consent and discus (looking for side effects from antipsychotic medications). From there, PC stated he would make his recommendations. PC went on to state that during COVID 19 he was unable follow his normal practice so I would have a note on my form stating the facility is to make sure the above standards are being met, adding, essentially, clients went 6 months without a comprehensive review, so if labs were missed it would not have been caught because I did not have access to the physical chart and was not coordinating with anyone onsite.
C2's Emergency Data Form identified diagnosis that included Profound intellectual disability, epilepsy, cerebral palsy and use of a gastrostomy tube.

C2's CSSP dated 6/5/19, identified the use of the following medications:

Levitracetam 750 milligram (mg) tablet
Vitamin D2 1.25 mg tablet
Baclofen 10 mg table,t 1.5 tablets
Gabapentin 250 mg/ 5 milliliter (ml), 5 ml's
Ranitidine 15 mg/ml, 4 ml's
Calcium 600 mg with vitamin D3, t tab
Diazepam 5 mg/ml, 10 ml's

Review of a document titled Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review dated 8/7/20, indicated C2's medications were reviewed with no irregularities.

C3's record indicated cognitive function at the Mild level of intellectual disability, and had the diagnoses of cerebral palsy, hearing loss, OCD

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(Obsessive-compulsive disorder), degenerative arthritis, and leg length discrepancy.

In review of C3's physician's ordered medications reviewed during last annual physical (12/23/19), noted C3 received risperdal (anti-psychotic medication) 150 milligrams (mg) 1 tablet twice a day, oxcerbazepine (seizure medication) 150 mg 1 tablet TID with 300 mg 1 tablet TID of OCD.

C4's record indicated cognitive function at the Severe level of intellectual disability, and had the diagnoses of kyphosis (increased front-to-back curve of the upper spine, GERD (Gastroesophageal reflux disease), congenital heart lesion (defect is a problem with the structure of the heart), pacemaker, degenerative arthritis of the knees.

In review of C4's physician's ordered medications reviewed during last annual physical (12/20/19), noted C4 received metformin (diabetic medication) 500 mg 3 tablets at bedtime, metoprolol succinate (beta-blocker used to treat chest pain (angina), heart failure, and high blood pressure) 50 mg ER (extended release) 1 tablet everyday, potassium chloride ER 10 milliequivent (meq) 1 tablet with meal, hydralazine (to treat high blood pressure) 1 tablet three times a day.

C7's record indicated cognitive function at the Mild level of intellectual disability, and had the diagnoses of pyogenic arthritis (serious and painful infection of a joint), major depression disorder, hypertension, GERD (Gastroesophageal reflux disease), hyperlipidemia (an abnormally high concentration of fats or lipids in the blood), constipation, chronic pain, lower limb weakness with ambulation

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difficulties, psychotic disorder - schizophrenia, conjunctivitis (inflammation or infection of the transparent membrane) of the left eye, and chronic liver issues.

In review of C7's physician's ordered medications reviewed during last annual physical (12/20/19), noted C7 received Quetiapine (Seroquel: anti-psychotic medication) 250 milligrams each night at bedtime.

A review of C3, C4 and C7's quarterly consultant pharmacist (PharmD) noted their medication regime was last reviewed 10/05/20. However, the last quarterly review was dated 1/29/20 which was eight (8) months prior. The medical record did not include evidence for quarterly reviews for April 2020 nor July 2020.

The facility provided documentation, entitled: Geritom Medical Inc. Intermediate Care Facility Quarterly Pharmacy Review (for the months of May 2020 and August 2020) the PharmD performed quarterly pharmacy reviews remotely, due to COVID-19, while the facility did not consider the PharmD an essential care staff. The PharmD documented all clients on the same document, with "no irregularities" document next to each client's initials.

During interview on 10/07/2020, at 9:30 a.m., the facility director (FD) and registered nurse (RN)-A stated the PharmD was not considered essential care staff, which required the PharmD quarterly pharmacy reviews for all clients remotely utilizing only the medication records accessible remotely. RN-A stated PharmD did not have access to any client's paper medical records which included lab / blood work results, physician recommendations,

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W 362	Continued From page 21 and facility behavior monitoring to name a few.	W 362		
W 435	SPACE AND EQUIPMENT CFR(s): 483.470(g)(1) The facility must provide sufficient space and equipment in dining, living, health services, recreation, and program areas (including adequately equipped and sound treated areas for hearing and other evaluations if they are conducted in the facility) to enable staff to provide clients with needed services as required by this subpart and as identified in each client's individual program plan. This STANDARD is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the facility provided appropriate equipment storage and prompt removal of broken/soiled furniture for 1 of 4 apartments (Four Leaf Clover) which effected clients and facility staff movement within the apartment. Findings include: Upon entrance to the facility on 9/30/20, at 9:00 a.m., surveyor noted the hall of Four Leaf Clover apartment had been used as a storage area for the following items: -on both side of the staff office were a total of three 3 inch shelves with open front cabinets (approximately 28 inches (in) tall, 36 in long and 12 in deep). - in the same hall on the left (East) side where the bedrooms were located, were stored: two mechanical lifts, four wheelchairs, the two large	W 435	W435: Space and Equipment: Effective immediately and on an ongoing basis, hallways will remain clear of obstacles. On Oct 28th a storage area for lifts, chairs, and shower chairs was created in the great room area. Staff will access these items for care as needed and then return items to this storage area. Routinely, items will be evaluated for items that can be disposed of or stored elsewhere as needed. Staff will be trained on this expectation to maintain this area and maintain the clear hallways at the staff meeting on 11/18/2020. Service Coordinators will provide weekly checks routinely to assure this expectation is maintained. Completion date: 11/18/2020	

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"rubber maid style" totes and three bath chairs.

On 10/06/20, at 8:47 a.m., area director (AD) mentioned to direct support staff (DSP)-A she wanted the hallway of Four Leaf Clover "de-cluttered", from the staff office down the hall in the sleep area of the unit. Director stated to DSP-A it was to be a priority over the next two days.

Upon return the following day, 10/07/20, at 7:30 a.m., the hall in Four Leaf Clover remained the same.

During observation 10/7/20, at 7:50 a.m. C7 was noted coming down the hall in his wheelchair. C7 was observed, twice hanging up his wheelchair first on a wheelchair outside his room, and then on one of the mechanical lift legs.

During an interview on 10/07/2020, at 10:30 AD stated the facility had a shortage of storage places. AD stated that some of the equipment could be placed in the client rooms, if they were single rooms, however, several items belong to clients that resided in double occupancy rooms. The AD stated that the three wheelchairs were the "2nd" wheelchair for three of the clients and it had been discussed to downsize the census and make the bedrooms single occupancy but the open rooms within the facility are being maintained as potential COVID-19 quarantine rooms.

On 10/07/20, at 12:00 p.m., the hallway was noted now to be cleared, with the exception of the three open shelf units.

During observation and interview 10/7/20, at 3:15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G186	A. BUILDING _____ B. WING _____	C 10/08/2020

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 435	Continued From page 23 p.m. with program residential services coordinator PRSC-A in the facility great room there was a large maroon cloth couch with no seat cushions. The couch was facing backwards against the wall, along with a broken wooden chair on top of it. PRSC-A stated the couch has been there for over a month and they have been waiting for maintenance to pick it up. The cushions have been removed due to a client had been sitting on the couch and had urinated on it. In interview on 10/08/20, at 10:30 a.m., the program supervisor (PS) stated the 3 bath chairs were placed in the shower room, and the wheelchairs and totes were placed in an open room in the Cardinal apartment. A policy on facility storage had been requested but not received.	W 435		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel. This STANDARD is not met as evidenced by: Based on interview and document review, the facility failed to ensure emergency drills were held on the day shift, at least quarterly. This practice had the potential to affect all 23 clients who resided in the facility. Findings include: Review of the fire drills from 6/23/19 to 9/12/20 indicated the following:	W 440	440: Fire Evacuation drills: The designated manager will review fire drill reports for accuracy of time recorded and corresponding shift. If the time the drill was run does not match the shift it was supposed to be on, the designated manager will request drill be re-run. A fire drill form will be created to include all CRGH residents on one form with Program Supervisors trained on 11/18/2020. Designated manager will fill out the fire drill completion form on the drive to provide a running record of completion details. Completion date: 11/18/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	24G186	A. BUILDING _____ B. WING _____	C 10/08/2020

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 440	Continued From page 24 A day shift fire drill was ran on 10/09/19, and the following day shift fire drill was conducted on 3/15/20, this was 158 days between fire drills. Review of the 2019/2020 Fire Drill Schedule indicated the fire drills were to be completed monthly, with the time of the drills to be rotated equally between the day, evening and night shifts. During interview 10/6/20, at 11:00 a.m. area director (AD) stated the January 2020 fire drill should have been completed in the day time not the evening shift. The facility Emergency Response Policy revised 8/2013, indicated: It is the policy of Mary T Inc. to effectively respond to, report, and review all emergencies to ensure the safety of persons receiving services and to promote the continuity of services until emergencies are resolved. It is imperative that the individuals residing in the home, the staff and the public are protected in case of emergency and that emergency procedures are carried out with the least amount of disruption. The purpose of this policy is to outline measures taken during emergency situations to ensure homes are prepared to anticipate and respond to those situations.	W 440		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered Via Email December 29, 2020

Administrator
Camilia Rose Group Home
11820 Xeon Boulevard
Coon Rapids, MN 55448

RE: Event ID: WR0012

Dear Administrator:

On December 15, 2020, the Minnesota Department of Health, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance.

Feel free to contact me with any questions related to this letter.

Sincerely,

Amy Johnson

Amy Johnson, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Telephone: 651-201-4121
Enclosure

cc: Licensing and Certification File