STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245353	A. BUILDING _____ B. WING _____	03/04/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to cover a urinary catheter drainage bag, which was visible from the hallway for 1 of 1 residents (R3) reviewed for dignity. Findings include: R3's Physician order [REDACTED]. R3's significant change Minimum Data Set ((MDS) dated [DATE], indicated R3 had severely impaired cognition, and had an indwelling urinary catheter. R3's care plan dated 10/4/20, indicated R3 had an indwelling urinary catheter related to a [DIAGNOSES REDACTED]. R3's care plan directed staff to not allow tubing or any part of the drainage system to touch the floor. On 3/3/20, at 2:49 p.m. R3 was observed from outside of the room, in bed, with an uncovered urinary drainage bag hanging on the outside of the bed. The drainage bag was half full of urine, and the bottom of the bag was laying on the floor. On 3/4/20, from 9:21 a.m. until 9:45 a.m. R3 was observed from outside of the room, in bed, with the uncovered urinary drainage bag hanging on the outside of the bed. The drainage bag contained urine. On 3/4/20, at 9:45 a.m. R3 stated it bothered him that the catheter bag was visible from the hallway. On 3/4/20, at 9:39 a.m. nursing assistant (NA)-A stated they haven't used catheter bag covers in a while. NA-A stated she had used pillow cases as covers before, but not recently. NA-A also looked in the clean linen closet and confirmed there were no catheter bag covers available on the unit. On 3/4/20, at 11:38 a.m. the director of nursing (DON) stated urinary catheter bags were not typically covered when a resident was in their room. The DON also stated if a resident was in a wheelchair or out of their room, the catheter bag could be covered, but not necessarily. The DON stated it could be a dignity thing, and the bag wouldn't trick anyone, but could be used if it bothered someone to have their catheter bag visible. A policy on dignity and covering catheter bags was requested from the facility. The facility provided an undated Policy Interpretation and Implementation page with no identifying topic area. The page directed staff to promote dignity and assist residents as needed by helping a resident to keep urinary catheter bags covered.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure that family was kept up to date of worsening skin issues for 1 of 3 residents (R1) reviewed for notification of change. Findings include: R1's Face Sheet dated 3/4/20, indicated [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had severely impaired cognition, did not reject cares, was totally dependent upon staff for transfers and toileting, and required extensive assistance with bed mobility. The MDS further indicated R1 was at risk of pressure ulcers, had one unstageable pressure ulcer that was present upon admission, had moisture associated skin damage (MASD), infection of the foot and [MEDICAL CONDITION](s). The MDS indicated interventions were in place for skin care including pressure relieving device for chair, pressure relieving device for bed, turn and repositioning schedule, nutrition or hydration, pressure ulcer care, application of non-surgical dressing, application of ointments and dressings to feet. On 3/3/20, at 4:16 p.m. family member (FM)-A stated when R1 came back from the hospital in December, she was told R1 had a scratch on her leg that occurred in the hospital. FM-A stated when R1 returned from the hospital, FM-A had asked for a meeting to discuss R1's prognosis, but was told there had just been a care conference a month ago, and so another one wasn't needed. FM-A stated when she asked nurses how R1's wounds were doing, she was told to ask the wound doctor. FM-A stated that about two weeks ago FM-A happened to be at the facility when the wound doctor was there, and FM-A saw the wound on R1's leg, and described it as the size of a golf ball. In addition, FM-A stated she had been told that R1 had a small spot on her little toe, but when there in February, it was the whole length of her toe, going into her foot. FM-A stated since that time, she had been getting communication from the wound doctor, but prior to that she had not gotten any updates from the facility about R1's wounds. FM-A stated she was shocked when she saw the leg wound. R1's progress notes lacked indication that FM-A was updated on the deteriorating progress of the right, lower lateral leg wound from the point of discharge to the hospital in December, until 2/3/20, when the wound physician discussed progress with FM-A. On 3/4/20, at 11:22 a.m. social worker (SW)-A stated care conferences were held every three months, and if family wanted more meetings they could ask for them. When asked about a family member (FM)-A asking for a meeting to get a prognosis update, SW-A stated she had been scheduled to be off work at that time. SW-A stated documentation showed that a meeting was planned for 12/31/19, she could not tell by the documentation if the meeting had happened. SW-A stated she had touched base with FM-A periodically, but FM-A usually had nursing questions, so she would pass her off to nursing to get questions answered. On 3/4/20, at 11:38 a.m. the director of nursing (DON) was interviewed and stated a lot of families, including FM-A, were there often, even during wound rounds. The DON stated families were different, and it was hard to know what they all wanted, and if they had questions, they could ask. The DON stated family had been present during many dressing changes for R1, but did not know exactly when. The DON stated that R1's leg wound did start out as a skin tear and later it doubled in size several times. On 3/4/2, at 12:13 p.m. a call was placed to, and a message left for, the wound care physician, but no return call was received. A policy on notification of change was requested, but not received.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to perform hand hygiene between dressing changes, and after perineal cares for 1 of 1 residents (R1) reviewed for dressing changes and activities of daily living (ADLs). Findings include: R1's Face Sheet printed 3/4/20, indicated [DIAGNOSES REDACTED]. R1's quarterly Minimum Data Set ((MDS) dated [DATE], indicated R1 had severely impaired cognition, did not reject cares, and was totally dependent upon staff for transfers and toileting. The MDS indicated R1 required extensive assistance of two staff for bed mobility, and was always incontinent of bladder and bowel. R1's Care Plan dated 9/25/19, directed staff to provide incontinence care after each incontinent episode. On 3/4/20, at 7:46 a.m. nursing assistant (NA)-B entered R1's room to begin morning cares. NA-A entered R1's room at 7:55 a.m. to assist with cares. At 8:04 a.m. NA-A was observed to wipe R1's perineal area from front to back, cleaning bowel movement from R1. NA-A then removed the soiled gloves, and without performing hand hygiene, donned clean gloves. NA-A pulled up R1's pants, assisted with placing a Hoyer (mechanical lift) sling under R1, and assisted with picking up supplies. NA-A removed her soiled gloves, and did not perform hand hygiene until she left R1's room. On 3/3/20, at 8:20 a.m. registered nurse (RN)-A and RN-B entered R1's room to perform wound cares. RN-A provided wound cares on R1's lower leg wound while RN-B assisted. After caring for the leg wound, RN-A removed her soiled gloves, and without performing

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) hand hygiene, donned clean gloves. RN-A provided wound cares and dressings to R1's heel wound. After caring for the heel wound, RN-A removed her soiled gloves, and without performing hand hygiene, donned clean gloves. RN-A then provided cares for R1's toe wounds, and the outside of her foot. RN-A changed gloves between wound sites, but did not perform hand hygiene. After treating and dressing R1's wounds and leaving R1's bedside, RN-A removed her gloves and used hand sanitizer. RN-B removed her gloves, but did not perform hand hygiene. RN-A and RN-B then used a sling and Hoyer lift to transfer R1 to her wheelchair. On 3/4/20, at 9:30 a.m. RN-B confirmed she did not perform hand hygiene after assisting with wound cares and before touching the Hoyer lift, sling, and R1's wheelchair. On 3/4/20, at 9:35 a.m. RN-A confirmed she did not perform hand hygiene between glove changes, and between each wound care. ON 3/4/20, at 9:39 a.m. NA-A confirmed she did not perform hand hygiene after peri-cares, and glove removal. On 3/4/20, at 11:38 a.m. the director of nursing (DON) stated it was a standard of care to change gloves between wounds being cared for, and anytime gloves were taken off. The DON stated staff should also perform hand hygiene to prevent cross contamination. The DON confirmed hand hygiene should be done after glove removal following peri-cares as well. The facility's Handwashing/Hand Hygiene policy, undated, directed staff were to perform hand hygiene before and after direct contact with residents, before handling clean or soiled dressings, gauze pads, etc., before moving from a contaminated body site to a clean body site during resident care, after contact with a resident's intact skin, after contact with blood or bodily fluids, after handling used dressings, and after removing gloves. The facility's Wound Care policy undated, directed staff were to remove disposable gloves, and wash and dry hands thoroughly after wound cares.