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 _____	06/29/2020

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 0880 **Level of harm** - Immediate jeopardy **Residents Affected** - Many	**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 ensure the State Agency (SA) and the Centers for Disease Control (CDC) guidance to prevent/ or minimize the transmission of COVID-19 was fully implemented, which resulted in an ongoing second COVID-19 facility outbreak, where 13 residents including R1, R2, R4, R7, R8, R11 and R12 who contracted COVID-19 during the second facility outbreak. In addition, R2, R3 and R5 were directly exposed to COVID-19 when the facility failed to separate negative residents from positive residents. Further, the facility failed to implement COVID-19 transmission based precautions for 14 days following admission for R6, R9 and R10. The facility also failed to ensure 20 out of 20 employees (E-A, E-B, E-C, E-D, E-F, E-G, E-H, E-I, E-J, E-K, E-L, E-M, E-N, E-O, E-P, E-Q, E-R, E-S, E-T) were appropriately cleared to return to work following positive COVID-19 test results. These deficient practices resulted in a system breakdown resulting in an immediate jeopardy (IJ) situation for all 66 residents residing in the facility. In addition, the facility failed to identify and implement process surveillance as part of their overall infection control program this had the potential to affect all 66 residents residing in the facility during the COVID-19 Focused Infection Control Survey. The IJ began on [DATE], when the facility failed to ensure residents who were negative/asymptomatic for COVID-19 were not housed with residents exposed to COVID-19 or who had been confirmed positive. In addition, the facility failed to quarantine and implement transmission based precautions for 14 days for new admissions, along with ensuring all new admissions received a private room during the quarantine period. The facility failed to ensure return to work criteria for healthcare workers was implemented as well as ensure full symptom screening was completed prior to the start of their shift. Further, the facility failed to ensure all visitation, activities and communal dining was done according to guidance. On [DATE], at 2:42 p.m. the facility owner, administrative assistant and administrator (via telephone) were notified of the IJ. The IJ was removed on [DATE], at 5:22 p.m. when the facility implemented actions to reduce/ prevent the spread of COVID-19 within the facility. However, noncompliance remained at the lower scope and severity, widespread, everity which indicated no actual harm with potential for more than minimal harm that was not IJ (Level F). Findings include: On [DATE], at 12:50 p.m. an entrance conference interview was conducted with the administrator, director of nursing (DON) and assistant administrator. The administrator stated the facility was having a re-outbreak of COVID-19 in the facility on the first floor. The previous outbreak in [DATE] was on the third floor and at one point the facility had up to 25 residents with COVID-19. They were down to one resident on the third floor still testing positive when they had a re-outbreak. Three residents currently in the building had tested positive and the whole first floor had been tested and were awaiting the results. The administrator stated the facility did not have a designated observation area to observe residents for symptoms or a separate COVID-19 area for COVID-19 positive residents. The facility was treating them in place. Since the current outbreak was only on the first floor, they had now closed the unit and were using it as a COVID-19 unit; however, there were positive as well as negative COVID-19 residents residing on the unit. The facility had not considered moving resident rooms to accommodate cohorting. Further, the administrator stated the facility was accepting new admission to the facility. New admissions were admitted to private and shared rooms. Those new admissions were to be quarantined to their rooms; however, the facility was not implementing COVID-19 transmission based precautions, because all admissions were tested for COVID-19 twice prior to admission to the facility. Further, there was a recent admission to the third floor from the company assisted living, and although quarantined to their room, without a roommate, this resident was not placed on transmission based precautions. Further, all the new admissions on the second floor had not been placed on COVID-19 transmission based precautions and was not aware it was required if the facility had the personal protective equipment. The facility provided Master COVID-19 Surveillance Line List dated [DATE], identified the facility had had 40 residents develop COVID-19 from [DATE], through [DATE]. There had been 12 residents who had COVID-19 test results and had expired either at the facility or following transfer to the hospital. The facility currently had three residents with current COVID-19 results, and they resided on the first floor. There were three pending resident tests, two residents resided on the first floor and one resident resided on the second floor. The facility provided an updated Master COVID-19 Surveillance Line List dated [DATE], which identified the facility had thirteen current residents with COVID-19 positive test results. Eleven residents resided on the first floor and two residents were housed on the second floor; however, one of the second floor residents had been discharged to home while their test results were pending. On [DATE], at 12:50 p.m. during the entrance conference the administrator stated they felt the facility had a re-outbreak of COVID-19 because R1 had been exposed to family during end of life outdoor visits. The family did not want to have the visit indoors due to COVID-19. The outdoor visits were allowed. The visits occurred on [DATE] and [DATE] (later identified through record review as [DATE]). The family was screened and educated regarding maintaining social distancing. The facility provided facemasks for the family and R1. Neither of the visits were supervised from a distance to ensure social distancing was maintained and the facemasks remained in place. During the [DATE] visit the administrator happened to glance out of the window and noticed there were a lot of family present including children. They had their facemasks off and were touching and kissing R1. The visit was stopped. The facility then implemented COVID-19 transmission based precautions on R1 and her roommate R2. R1 was tested for COVID-19 on [DATE], and when the test came back positive on [DATE], R1 was moved to a private room on the third floor. R1 subsequently passed away on [DATE]. First Floor R1's significant change Minimum Data Set ((MDS) dated [DATE], identified R1 had moderate cognitive impairment. R1 required extensive assistance with activities of daily living (ADL's) and utilized a wheelchair. [DIAGNOSES REDACTED]. R1 was receiving hospice services. R1's visitor COVID-19 Screening Form identified the following: - R1 had two visitors on [DATE], at an unidentified time. Both visitors were identified to be free of signs and symptoms of COVID-19. - R1 had five visitors on [DATE], at 10:54 a.m. All five visitors were identified to be free of signs and symptoms of COVID-19. R1's progress note(s) identified the following: - [DATE], R1 was admitted to hospice services. - [DATE], R1 had a care conference and family was given visitation parameters, due to the residents decline in condition, to include a limitation of three visitors at a time for up to one hour daily. Family asked if visitation could take place outside, which would be referred to administration for approval. - [DATE], [DATE], and [DATE], identified R1 slept in the media room all night after having an unsupervised outside visit on [DATE]. The progress note(s) did not identify if R1 was wearing a mask. - [DATE], at 5:40 p.m. R1'S O2 stats (oxygen concentration in the blood) was 94 percent on 2 liters (L) of oxygen (O2) and 87% on room air. (,[DATE]% within normal limits under 90% is considered low) Resident denied shortness of breath (SOB), however, the writer identified R1 to have labored breathing when transferring. Resident was oxygen dependent. - [DATE], R1 was identified to have slept all night again in the recliner. R1's nursing assistant reported R1 experienced what they thought was choking while putting R1 to bed. The nurse completed and assessment and determined R1 was not choking but was trying to cough. R1 had bilateral crackles (abnormal lung sounds characterized by discontinuous clicking or rattling sounds) in both lungs. The assistant director of nursing (ADON) performed light suctioning, which helped R1 breathe easier. R1 was on 3 L of continuous O2. Hospice was notified and directed staff to administer a breathing treatment. - [DATE], R1 was identified to

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

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 _____	06/29/2020

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 1) sleep in the media room all night (should have been quarantined to her room) and was symptomatic with a cough and dry secretions. R1 remained in the day room all morning. O2 was on at 2 L and her O2 sats were 92%. R1's temperature was 97.7 Fahrenheit (F) (98.6 F is average normal body temp) and had been very congested that morning. Hospice was called and were making an onsite visit. R1's hospice nurse identified R1 was seated in her Broda (reclining wheelchair) in the media room upon arrival. R1 had respiratory congestion with bilateral rales (abnormal lung sounds characterized by discontinuous clicking or rattling sounds.). R1's congestion had increased overnight and had a breathing treatment and oral suctioning performed. Vital signs were identified as temperature 97.7, pulse 92, respirations 32 and irregular (12 to 20 breaths per minute), O2 sats 92 % on 2 L of oxygen, blood pressure was ,[DATE]. COVID test was directed to be completed that day. Family were informed there would be no family visits pending COVID-19 test results. R1 had a COVID-19 test completed that day and was to be in her room with curtain closed. If out in lounge area she is to wear a mask. R1 had been quiet and sitting in lounge chair all shift. (R1 should have been quarantined to her room and placed on transmission based precautions). R1's COVID-19 results were not in as of the evening shift. She was to be in her room with the curtain closed. If out in the lounge area she is to wear a mask. R1 was observed coughing several times that evening. - [DATE], R1 slept in her recliner in her room all night. R1 received a positive COVID-19 test result. R1's belongings were placed in red bio-hazard bags. R1 was moved to room ,[DATE] with all her belongings after testing positive for COVID-19. - [DATE], R1 passed away at 6:40 a.m. The progress notes did not identify when R1 was placed on COVID-19 transmission based precautions. Nor did the progress notes identify any outdoor family visits. The facility provided Master COVID-19 Surveillance Line List dated [DATE], identified the facility had implemented COVID-19 transmission based precautions, which was two days after R1 displayed the onset of symptoms with labored breathing and five days after having the first outside unsupervised family visit. R1's undated census sheet identified R1 was placed in room ,[DATE] on [DATE], and was transferred to room ,[DATE] on [DATE]. R2's quarterly MDS [DATE], identified R2 had severe cognitive impairment. R2 required extensive assistance with ADL's and utilized a walker. [DIAGNOSES REDACTED]. R2's undated census sheet identified R2 had resided in room ,[DATE] since [DATE], and was roommate with R1. R2's progress note(s) identified the following: - [DATE], family was updated regarding a positive COVID-19 case on the unit and the given resident (R1) was isolated to prevent further spread and R2 was tested for COVID-19. - [DATE], at 10:52 a.m. R1 reported to morning staff R2 had a headache. R2 was given her Tylenol early. R2 continued with a headache after medication. At 11:51 a.m. R2 was informed of a new roommate later that day. Family was notified. At 12:40 p.m. family was notified of R2's new roommate (R3) and reported R2's COVID-19 test results were negative. (a new roommate should not have occurred due to R2's exposure to R1 who was diagnosed with [REDACTED]. Vital signs were identified as blood pressure ,[DATE], temperature 101.1 F, respirations 18, O2 sats 84% on room air. R2 was placed on 2 L of O2. Tylenol was administered at 5:00 a.m. and staff encouraged fluids. Staff to continue to monitor. R2 was re-tested for COVID-19. Family were updated and R2 was placed on isolation precautions. R2 was complaining of chills, however, vital signs were stable and without fever. Staff set up isolation for her, at this time. Administration was informed. - [DATE], R2's COVID-19 test returned as positive the evening of [DATE]. She was placed on isolation and precautions. R2 continued to complain of feeling week and achy. - [DATE], R2 was feeling better, vital signs were unremarkable and R2 continued with an occasional cough. A repeat COVID-19 swab was completed. - [DATE], family was notified of newly-diagnosed positive cases of COVID-19 on the unit. Family was also informed R2's most recent COVID-19 test was positive, and R2 was showing improvement in their symptoms. The facility provided Master COVID-19 Surveillance Line List dated [DATE], identified the facility had implemented COVID-19 transmission based precautions, on [DATE], when her roommate R1 had been tested for COVID-19. (However, the progress notes indicate this did not occur until [DATE], when tested positive for COVID-19.) During observation of the first floor on [DATE], at 2:54 p.m. R2 and R3 were residing in the same room. There was a cart outside the room with personal protective equipment (PPE); however, there was no sign on the door identifying what type of precautions staff were expected to utilize and what resident was on precautions. On [DATE], at 2:55 p.m. RN-A stated he was in the process of placing COVID-19 precaution signs on the doors where residents were positive. The first floor had three confirmed COVID-19 cases and the rest of the residents were negative and or awaiting test results. During interview on [DATE], at 3:34 p.m. the infection preventionist/ADON stated when a resident was placed on any type of precautions it should be reflected in the resident progress notes. R1 was placed on precautions on [DATE], when she was displaying symptoms and they obtained a COVID-19 test per the recommendation of hospice. R1's roommate was also placed on COVID-19 transmission based precautions on [DATE], as well. When R1's test came back positive, all residents on the first floor were placed on COVID-19 precautions and the unit was shut down for 72 hours. Then only the residents that were positive continued with the COVID-19 transmission based precautions. Isolation precautions should have continued as the ADON stated there was a pattern identified where the residents had not been displaying symptoms or testing positive until ,[DATE] days after exposure to COVID-19. In hindsight, R1 should have been placed on COVID-19 transmission based precautions and isolated after the first family visit outside on [DATE], which was not supervised. Anytime a resident was exposed they should be isolated and placed on COVID-19 transmission based precautions and monitored for symptoms. The undated 1st Floor Quarantine Procedure for staff identified the following: all residents on first floor were tested on [DATE], direct contact staff would be tested on [DATE], indirect contact staff would self-monitor for signs and symptoms of COVID-19 and the quarantine would remain 72hrs (sic) or until all COVID test results are made available. During interview on [DATE], at 4:20 p.m. licensed practical nurse (LPN)-C stated all residents were screened daily for signs and symptoms of COVID-19. The screening included temperature check, O2 saturation levels and a screen for signs and symptoms including a cough, SOB, sore throat, sleepiness and loss of appetite. As soon as a resident develops symptoms they are isolated to their bed and the curtain is pulled. Then the administration team was notified and COVID-19 transmission based precautions were to be put into place. LPN-C could not recall when R1 and R2 were placed on COVID-19 transmission based precautions and if R2 remained on the precautions after R1 was moved to a private room. R3's quarterly MDS dated [DATE], identified R3 had severe cognitive impairment. R3 required extensive assistance with ADL's and utilized a walker and wheelchair. [DIAGNOSES REDACTED]. R3's undated census sheet identified R3 resided in room ,[DATE] since [DATE], on [DATE], R3 was moved to room ,[DATE] (admitted to room with a resident who had recent exposure to COVID). R3's progress note(s) identified the following: - [DATE], R3 was tested for COVID-19. - [DATE], R3's COVID-19 test results were identified as negative. - [DATE], R3 along with family was offered a different room (,[DATE]) which would allow the resident to be closer to the media/dayroom. Both parties agreed and the move was planned for later that day. At 4:17 p.m. R3 was moved from ,[DATE] to ,[DATE], R3 was confused about the room change. - [DATE], at R3's family were notified on newly diagnosed positive COVID-19 cases among the residents. - [DATE], at 11:40 a.m. R3 was alert denied feeling ill. A COVID-19 test was completed that morning. - [DATE], at 3:59 p.m. family was notified of new positive COVID-19 cases on the unit. No visitors would be allowed on the unit at that time. All visits would need to be conducted through their personal room windows, or via video/phone. During interview on [DATE], at 4:41 p.m. the DON stated the facility should implement COVID-19 transmission based precautions as soon as a resident developed symptoms and not wait until testing was initiated. During a telephone interview on [DATE], at 9:10 a.m. ADON stated the first floor now had 11 COVID-19 positive residents and the facility was waiting on more resident test results. The facility moved some resident rooms around after disinfecting their rooms. They cohorted their positive residents together, and their negative residents together on the first floor on [DATE]. This was done to ensure negative residents were not housed with known symptomatic/positive residents to prevent any further transmission. The ADON did not identify why residents who were positive were not cohorted together sooner. Further, ADON confirmed he was the one who initiated R1's COVID-19 transmission based precautions on [DATE], because she was coughing. R2 was not tested until R1's COVID-19 test came back. R2's first COVID-19 test came back negative and was not involved in R3's move into R2's room. R2 should have remained in the room alone until she did not display any symptoms for 14 days. The reason for this was identified as because the patient could be asymptomatic and may be shedding [MEDICAL CONDITION] and give it to (their) new roommate. During observation of the first floor unit on [DATE], at 11:10 a.m. it was identified there were 20 residents residing on the first floor unit. Eleven residents were positive for COVID-19. All residents were identified to be on COVID-19 transmission based precautions, via a sign on their doors. All the doors were closed. During interview on [DATE], at 11:22 a.m. trained medication assistant (TMA)-B stated the facility should not have moved R3 into R2's room after she had been exposed to COVID-19 from R1. TMA-B stated R2 started displaying symptoms of COVID-19 the day R3 moved into R2's room. R2 was then re-tested and at that time she tested positive. R3 remained negative and continued to be housed with R2. TMA-B did not recall if R2 was on precautions when R3 moved into her room; however, stated R3 was not on precautions until R2 became positive. The floor currently housed COVID-19 positive and negative residents. R3 was moved out of R2's room. On [DATE], administration moved the residents who resided on the first floor. Residents that were

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 _____	06/29/2020

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 2) positive were moved in together and residents that were negative were moved into rooms together. However, the facility did not move R5 out of her current room. R5 was [MEDICAL TREATMENT] patient, and had not tested positive for COVID-19. She continued to reside with R8 who had tested positive for COVID-19. It was observed at this time R5 and R8 continued to be housed in room [ROOM NUMBER] together. Further, R11 and R12 were moved from the second floor to the first floor after R1's COVID-19 test result came back positive on [DATE], and the first floor had been exposed to COVID-19. TMA-B stated both of those residents were now COVID-19 positive. TMA-B stated she was not sure why those residents were moved to the first floor when residents on the first floor were exposed to COVID-19 from R1. Further, TMA-B stated the facility was holding activities in the media room for residents until the first floor had a positive COVID-19 case. The staff tried to maintain 6 feet distance and held activities like music and bingo. During interview on [DATE], at 12:31 p.m. nursing assistant (NA)-B stated moving R3 into R2's room was a big issue that exposed R3 to COVID-19 and that shouldn't have happened. Things did not happen as they should have and now there was eleven residents positive on the first floor. R5's quarterly MDS [DATE], identified R5 had intact cognition and was independent with ADL's. [DIAGNOSES REDACTED]. Further, the MDS identified R5 was receiving [MEDICAL TREATMENT]. R5's progress note(s) identified the following: - [DATE], R5 was reminded on the visitor protocol as R5 was outside meeting a family member to receive personal items. She was outside already when the family member approached R5. - [DATE], family was updated regarding a positive case of COVID-19 on the unit and how the resident (R1) was isolated. R5 was tested for COVID-19. - [DATE], a call was placed to [MEDICAL TREATMENT] unit to inform them R5 had once again been exposed to COVID-19. - [DATE], R5 was notified of expected new roommate later that day. R5 had no concerns as she was moving to room ,[DATE] the following day at R5's request. R5's COVID-19 test results were negative. - [DATE], R5 transferred to room ,[DATE]. - [DATE], family was notified regarding the newly diagnosed positive case of COVID-19 among the residents. - [DATE], family was notified on newly diagnosed positive cases of COVID-19 on the unit. Mitigation and isolation precautions were described. The [MEDICAL TREATMENT] unit was contacted regarding the new influx of COVID-19 cases on the unit where R5 resided. R5's undated census record identified R5 had been in room ,[DATE] from [DATE], through [DATE], when she was transferred to room ,[DATE]. R8's quarterly MDS dated [DATE], identified R8 had moderate cognitive impairment. R8 required limited assistance with ADL's. [DIAGNOSES REDACTED]. R8's progress note on [DATE], at 7:27 p.m. identified R8 tested positive for COVID-19 and was currently on isolation precautions. R8's undated census report identified R8 transferred to room ,[DATE] on [DATE]. R11's admission MDS dated [DATE], identified R12 had intact cognition. R12 needed limited assistance with ADL's and utilized a walker and wheelchair. [DIAGNOSES REDACTED]. The facility provided an updated Master COVID-19 Surveillance Line List dated [DATE], which identified R11 tested positive on [DATE]. R11's undated census record identified R11 was transferred from room ,[DATE] to ,[DATE] on [DATE]. R12's quarterly MDS dated [DATE], identified had severe cognitive impairment required extensive assistance with ADL's and utilized a wheelchair. [DIAGNOSES REDACTED]. The facility provided an updated Master COVID-19 Surveillance Line List dated [DATE], which identified R12 tested positive on [DATE]. R12's undated census record identified R12 was transferred from room ,[DATE] to room ,[DATE] on [DATE]. Then transferred to room ,[DATE] on [DATE]. During interview on [DATE], at 12:32 p.m. LPN-C stated she knew there would be another outbreak of COVID-19 in the facility. It was not handled correctly. Residents that are symptomatic or positive for COVID-19 should not be housed in the same room as residents without symptoms or who had tested negative. Too many residents being moved around to make room for admissions on the second floor. Second Floor On [DATE], at 2:23 p.m. the second floor was toured. No residents were identified to be on any COVID-19 transmission based precautions. During the observation the facility received a new admission R9 and was moved into a room with an existing roommate R10. There was no PPE available outside the room and there were no COVID-19 transmission based precaution signs placed. Further, two puzzles were displayed on two of the dining room tables. The puzzles were in process of being completed. There was also a notice in the hallway for residents to help themselves to the activities in the activity cabinet. During the observation RN-C stated they are going to add new signs on the doors for the new admissions and they would be put on a 14 day COVID-19 transmission based precautions. RN-C stated this was a new process because of you being here the facility had not been placing COVID-19 transmission based precautions on new admissions. The facility did accept new admissions in with other residents if that was the only room available. R9's entry tracking MDS dated [DATE], identified R9 was admitted to the facility on [DATE], to room [ROOM NUMBER]. R9's medical record did not identify R9 had any symptoms of COVID-19. R10's entry tracking MDS dated [DATE], identified R10 admitted to the facility on [DATE], to room [ROOM NUMBER]. R10's medical record did not identify R10 had any symptoms of COVID-19. During a subsequent observation on the second floor on [DATE], at 2:34 p.m. R13 was admitted to a private room; however, there was no PPE available and no COVID-19 precaution sign on the door. R13's entry tracking MDS dated [DATE], identified R13 admitted to the facility on [DATE], to room [ROOM NUMBER]. R13's medical record did not identify R13 had any symptoms of COVID-19. During interview on [DATE], at 2:10 p.m. NA-A stated earlier that day an unidentified resident had been working on one of the puzzles prior to lunch. Further, NA-A was not aware of any disinfecting process following residents utilizing the puzzles. Further, NA-A was interviewed about the second floor dining room process. NA-A stated residents that needed supervision or who required assistance with eating ate in the dining and they were seated 6 feet (ft) apart from each other. Further, new admissions on 14 day quarantine could go to the dining room so the staff could observe how they ate, before determining if they could eat in their room independently. NA-A demonstrated where residents sat in the dining room. They were seated approximately 4 ft. from each other. NA-A stated the residents were not seated 6 ft away from each other. During interview on [DATE], at 2:35 p.m. RN-A stated there were two residents who resided on the second floor who frequently used the puzzles in the dining room. RN-A did not identify who the two residents were. Further, RN-A was not aware of a process to ensure the puzzles were disinfected to prevent the spread of COVID-19. Following the interview RN-A removed the puzzles from the dining room tables. During interview on [DATE], at 3:34 p.m. the ADON stated the facility administration had talked about implementing 14 day COVID-19 transmission based precautions on new admissions, because there was no way to know what and who they were exposed to prior to admission to the facility, regardless of a negative COVID-19 test result. ADON was not sure why COVID-19 transmission based precautions were not implemented or why new admissions were not consistently provided a private room for a minimum of 14 days following admission. The facility had enough PPE to implement COVID-19 transmission based precautions. During telephone interview on [DATE], at 9:10 a.m. the ADON stated new admissions on 14 day quarantine should not being eating in the dining room during the first fourteen days. Further, any resident eating in the dining room needed to be 6 ft apart from each other. These practices were to help prevent the transmission of COVID-19. On [DATE], at 11:11 a.m. during observation of the second floor it was identified all residents were now in private rooms and on COVID-19 transmission based precautions, per the signs on their doors. During interview on [DATE], at 11:14 a.m. RN- A stated all residents were placed in private rooms and all residents were on COVID-19 transmission based precautions. There were two residents R4 and R7 who had tested positive and who had remained on the second floor and were not transferred to the COVID-19 unit on the first floor. RN-A did not identify why R4 and R7 remained on the second floor when they had been identified as being positive and were currently isolated to their rooms now for activities and dining along with the other residents. R4's PPS 5- day MDS dated [DATE], identified R4 had intact cognition. R4 needed limited assistance with ADL's. [DIAGNOSES REDACTED]. R4's progress note dated [DATE], at 9:02 a.m. identified R4 had tested positive for COVID-19 and was placed on isolation precautions. R7's admission MDS dated [DATE], identified R7 had severe cognitive impairment and required extensive assistance with ADL's. [DIAGNOSES REDACTED]. R7's progress note dated [DATE], at 6:44 p.m. identified R7 was positive for COVID-19 and remained on isolation precautions Third Floor During interview on [DATE], at 3:34 p.m. the ADON stated when he had toured the third floor they have been having group activities in the dining area, usually around six or so people, but less than 10 residents, so they kept their numbers under what was considered a group. Further, independent activities like puzzles should be in the resident's room and should not be shared between residents as puzzles could not be disinfected between resident uses. On [DATE], at 4:10 p.m. the third floor dining area and activity area were observed. There was one large room, half of the room had several tables set up and the other half of the room had a large open space without any tables. There were multiple activity carts in the area with various types of activity materials. There were currently eleven residents in the activity space. The residents were not wearing cloth masks and were not maintaining a 6 ft. distance away from each other. Staff was not attempting to keep the residents socially distanced. Further, there were no markings on the floor identifying six foot spaces for the tables or in the empty space. During interview on [DATE], at 4:20 p.m. RN-B stated the facility continued to have group activities on the third floor. The staff ensure the residents were kept six feet apart. A group activity example provided was trivia. Further RN-B was not aware of how the facility was ensuring proper spacing as there were no marking on the floor, to ensure residents were spaced far enough apart. Further, RN-B stated most residents ate in the third dining room because they required supervision and or

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 _____	**06/29/2020**

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Many	(continued... from page 3) assistance with eating. Further RN-B stated, We try to keep them six feet apart it was hard because the residents had dementia. During observation on [DATE], at 4:20 p.m. R6 was lying on his bed. R6 did not have a roommate. There was no signage identifying R6 was on COVID-19 transmission based precautions. R6's entry tracking MDS dated [DATE], identified R6 was admitted to the facility on [DATE]. R6 was admitted to the facility four days prior. R6's