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 _____	07/31/2020

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 0607 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to develop a comprehensive abuse prevention policy to include how the facility was meeting the required screening, training, prevention, identification, protection and response requirements. This had the potential to affect all 56 residents residing in the facility. Findings include: The facility policy Abuse Prevention Program dated 3/26/20, identified residents had the right to be free from abuse, neglect, misappropriation of resident property and exploitation. The policy identified the facility would conduct employee background checks and would not knowingly employ or otherwise engage any individual who had: been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law, had a finding entered into the State nurse aide registry concerning abuse, neglect, exploitation, mistreatment of [REDACTED]. The screening section lacked how the facility was going to screen volunteers and non-employed staff (i.e. agency staff and contracted), students, consultants etc . Further, the policy did not include attempts at obtaining information from current/ previous employers. The policy identified the facility would require staff training/orientation programs that included such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior. The policy did not identify how often the staff would be trained. In addition, the policy did not include training of volunteers and/or non- employed staff. The policy identified the facility would develop and implement policies and procedures to aid the facility in preventing abuse, neglect, or mistreatment of [REDACTED]. The policy did not provide detail or referrals to additional policies on how the facility was meeting the prevention of abuse component. The policy identified they would identify and assess all possible incidents of abuse. The policy did not identify the different types of abuse such as mental/verbal abuse, sexual abuse, physical abuse, and the deprivation by an individual of goods and services. Further, the policy did not identify how the facility could identify potential abuse in their residents. The policy identified the facility would protect residents from during abuse investigations; however, the policy lacked how the facility would provide protection to the residents. The facility policy Abuse Investigation and Reporting dated 3/26/20, identified all reports of resident abuse, neglect , exploitation, misappropriation of resident property, mistreatment and/or injuries of unknowns source would be reported to local, state and federal agencies and thoroughly investigations by facility management. Findings of abuse investigations would also be reported. The policy identified the administrator would immediately suspend any employee who had been accused of resident abuse, pending the outcome of the abuse. The policy did not identify ways to protect physical and psychosocial harm to include the following: respond immediately to protect the alleged victim and integrity of the investigation; Examine the alleged victim for any sign of injury, including a physical examination or psychosocial assessment if needed; Increased supervision of the alleged victim and residents; Room or staffing changes, if necessary, to protect the resident(s) from the alleged perpetrator; Protection from retaliation; and Providing emotional support and counseling to the resident during and after the investigation, as needed. The policy identified if the abuse allegations were founded, the employee(s) would be terminated. However the policy did not identify the response to include: taking all necessary actions as a result of the investigation, which could include, but are not limited to, the following; Analyzing the occurrence(s) to determine why abuse, neglect, misappropriation of resident property or exploitation occurred, and what changes are needed to prevent further occurrences; Defining how care provision would be changed and/or improved to protect residents receiving services; Training of staff on changes made and demonstration of staff competency after training was implemented ; Identification of staff responsible for implementation of corrective actions; The expected date for implementation; and Identification of staff responsible for monitoring the implementation of the plan. During interview on 7/31/20, at 11:27 a.m. the administrator stated the facility abuse prevention policies were vague and did not contain the detail needed to meet the abuse policy requirement. It was important the policy contained all the requirements on how the facility was implementing the requirements in case the administrator was not available to give direction.
F 0608 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines; (2) post the notice of employee rights; and (3) prohibit and prevent retaliation for reporting.** Based on interview and document review, the facility failed to ensure their Reporting Suspicion of a Crime policy included direction on how to preserve a crime scene and how to obtain a rape kit if required. This had the potential to affect all 56 residents currently residing in the facility. Findings include: The facility policy Reporting Suspicion of a Crime dated 8/21/19, identified the following crimes reported to law enforcement included but were not limited to: murder, manslaughter, rape, assault/battery, sexual abuse, theft/robbery, drug diversion, identity theft and fraud/forgery. The policy identified when and who to report the potential crime to, but did not identify how the staff would maintain a potential crime scene including but not limited to handling materials, laundering of linens/clothing, bathing/cleaning of a resident and obtaining a rape kit as appropriate. During interview on 7/31/20, at p.m. the administrator stated the facility policy on reporting a suspicion of a crime was vague and lacked details on preserving a potential crime scene and obtaining a rape kit. The administrator stated he contacted law enforcement with any concern about a potential crime immediately. The administrator relayed the information directed by law enforcement to staff to ensure the potential crime scene would be maintained and send the resident to the emergency room for a rape kit if directed by law enforcement.
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to ensure allegations of potential abuse were thoroughly investigated to ensure resident protection and well-being for 1 of 2 residents (R2) whose allegations of staff to resident abuse were reviewed. Findings include: R2's admission Minimum Data Set ((MDS) dated [DATE], identified R2 had moderate cognitive impairments. The MDS identified R2 was occasionally incontinent and required extensive assistance of two for bed mobility, transfers and toileting. [DIAGNOSES REDACTED]. R2's Incident Report Summary dated 7/20/20, identified R2 had an allegation of physical abuse by a staff member. R2 stated while attempting to use their side rail in the early morning a nursing assistant slapped their hand and was told not to do that. In addition R2 had requested their diaper be changed and the nursing assistant stated no. The alleged perpetrator was identified as nursing assistant (NA)-A. The report identified NA-A was suspended pending investigation. A body audit and pain assessment would be completed and R2 continued to remain safe with their needs met. R2's Investigation Report Summary dated 7/27/20, identified abuse and neglect of care did not occur. NA-A stated they were providing care to R2 without assistance of a second staff because R2 required immediate

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 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) assistance; however, R2 became fearful of falling off the edge of the bed and was pushing and pulling at the side rail. NA-A stated she asked R2 not to grab or push the bed rail, because she was afraid R2 may cause and injury to her wrist. NA-A patted R2 on the shoulder in an attempt to reassure her she would not fall from the bed. NA-A received re-education on following the resident care plan and providing care with dignity and respect. The report identifed the care plan, skin assessment , pain assessment, physical therapy and team sheet were reviewed as part of the investigation. The report identifed R2 and NA-A were the only ones interviewed regarding the incident. The investigation lacked observations of NA-A providing cares to residents; Interviews with other residents and/or skin audits of residents that could not speak for themselves that NA-A provided care to; Along with interviews with staff that worked with NA-A. During interview on 7/30/20, at R2 stated NA-A slapped her on the hand and told her she would not change her diaper. she was not happy with the way NA-A treated her, but denied NA-A abused her. R2 demonstrated how NA-A slapped her hand. R2 tapped lighly on the surveyors hand. During interview on 7/31/20, at 10:41 a.m. licensed social worker (LSW) stated when completing an investigation into an abuse allegation, she interviewed the resident and the alleged perpretrator if one was identified. Completed skin and pain assessments and reviewed the care plan and progress notes. LSW was not aware if NA-A was observed providing care to residents. Further, LWS was not aware if any residents or staff that interacted with NA-A were interviewed to determine if there were any concerns regarding care and treatment. In addition, non-interviewable residents were not assessed for potential signs of abuse. LSW identifed the assistant director of nursing (ADON) assissed with the abuse allegation investigation. During interview on 7/31/20, at 11:13 a.m. ADON stated he did not complete any observations of NA-A providing resident cares. Nor did he interview any additional residents and staff as part of the abuse investigation. Further, ADON stated abuse did not occur, but neglect of care did when NA-A completed cares by not following the care plan. In hindsight the investigation should include other resident interviews, other staff interviews and skin audits for non-interviwable staff to ensure a complete investigation was done. The facility policy Abuse Investigation and Reporting dated 3/26/20, identified the individual conducting the investigation would include at a minimum: the completed documentation forms; The resident's medical record to determine events leading up to the incident; Interview the person(s) reporting the incident; Interview any witnesses to the incident; Interview the resident (as medically appropriate); Interview the resident's Attending Physician as needed to determine the resident's current level of cognitive function and medical condition; Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident; Interview the resident's roommate, family members, and visitors; Interview other residents to whom the accused employee provides care or services: and Review all events leading up to the alleged incident.