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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02HR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00538

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245255**
2.STATE VENDOR OR MEDICAID NO.
(L2) **044518500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER ON HUMBOLDT**
(L4) **512 HUMBOLDT AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55107**

4. TYPE OF ACTION: **7** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/08/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **117** (L18)

13.Total Certified Beds **117** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A,8*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
X 8. Patient Room Size
__ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	117			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving room size (tag F0458) is recommended.

17. SURVEYOR SIGNATURE Date :
Sue Reuss, Supervisor 12/09/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 12/18/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
09/13/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 12/17/2014 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
11/21/2014
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5255

Electronically Delivered: December 18, 2014 (**REVISED**)

Mr. Ted Schmidt, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 55107

Dear Mr. Schmidt:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective November 24, 2014 the above facility is recommended for:

117 - Skilled Nursing Facility Beds/Nursing Facility Beds

Your facility's Medicare approved area consists of all 117 skilled nursing facility beds.

Your request for waiver of tag F0458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiency or renew your request for waiver in order to continue your participation in the Medicare and Medicaid Program.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
December 9, 2014

Mr. Ted Schmidt, Administrator Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 55107

RE: Project Number S5255024

Dear Mr. Schmidt:

On November 5, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 23, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On December 8, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 23, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 24, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 23, 2014, effective November 24, 2014 and therefore remedies outlined in our letter to you dated November 5, 2014, will not be imposed.

Your request for a continuing waiver involving the deficiency(ies) cited under F0458 at the time of the October 23, 2014 standard survey has been forwarded to CMS for their review and determination.

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 if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245255	A. Building B. Wing	12/8/2014

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix F0241 Reg. # 483.15(a) LSC	11/24/2014	ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	11/24/2014	ID Prefix F0441 Reg. # 483.65 LSC	11/24/2014
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/KFD	12/9/2014	16022	12/8/2014
CMS RO				

Followup to Survey Completed on: 10/23/2014

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 02HR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00538

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(L1) **245255**

2.STATE VENDOR OR MEDICAID NO.
(L2) **044518500**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER ON HUMBOLDT**
(L4) **512 HUMBOLDT AVENUE**
(L5) **SAINT PAUL, MN** (L6) **55107**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/23/2014** (L34)

8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
06/30

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **117** (L18)

13.Total Certified Beds **117** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
_X_ 8. Patient Room Size
___ 9. Beds/Room

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B**, 8* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	117			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving room size (tag F0458) is recommended.

17. SURVEYOR SIGNATURE Date :
Momodou Fatty, HFE NE II 11/17/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 11/19/2014 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
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____ 2. Facility is not Eligible
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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
09/13/1982
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 5, 2014

Mr. Ted Schmidt, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 55107

RE: Project Number S5255024 and Complaint Number H5255037

Dear Mr. Schmidt:

On October 23, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the October 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5255037. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the October 23, 2014 standard survey the Minnesota Department of Health completed an investigation of complaint number H5255037 that was found to be unsubstantiated.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not

attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

<u>Informal Dispute Resolution</u> - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction should be directed to:

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: <u>susanne.reuss@state.mn.us</u>
Telephone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 2, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

FAILURE TO ACHIEVE SUBSTANTIAL COMPLIANCE BY THE THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by January 23, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may

still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 23, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process
Minnesota Department of Health
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questionsabout this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	**512 HUMBOLDT AVENUE SAINT PAUL, MN 55107**

(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
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed for H5255037 at the time of the standard recertification survey and was unsubstantiated.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity during dining for 11 of 93 residents (R50,130, R109, R26, R24, R103, R17, R21, R82, R30, R95) observed during dining. Findings include:	F 241	F000 This credible Allegation of Compliance has been prepared and submitted timely. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission	11/24/14

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

Electronically Signed | 11/14/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

(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
F 241	Continued From page 1 On 10/23/14, staff were observed to pass trays to residents in the 2nd floor dining area from 4:26 p.m. until 5:15 p.m. R50 was observed on 10/23/14, at 4:35 p.m. to be sitting at a table in the dining room on 2nd floor, with plate of food on table in front of resident. A small vase containing artificial flowers was laying across R50's plate. R50 was observed to sit at table with the flowers on her plate until 4:45 p.m. when nursing assistant (NA)-G approached R50 and removed the flowers from the plate. The quarterly minimum data set (MDS) dated 8/12/14 identified R50 had diagnosis of Alzheimer disease, was cognitively impaired and had impaired vision and hearing deficits. On 10/20/14 at 4:00 p.m. a family member (FM)-D verbalized concerns related to the lack of supervision and assistance in the fourth floor dining room. FM-D visited the 4th floor dining room frequently during the evening meals to assist a family member with dining, FM-D stated, "Several residents in this dining room do not receive the help that they need with eating, it is very chaotic, in the dining room." FM-D explained, "Staff put the residents trays in front of them and then walk away without helping them, or even showing them what is on their trays. The food on the residents trays get cold and the staff doesn't even ask to reheat their food. Who would want to eat cold food?" FM-D went on to say that it was, "disheartening" to see this. When asked if FM-D had shared this information with any of the	F 241	against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. F241 Department Directors and Management staff have conducted comprehensive audits of meal service; please see attached example of meal service audit document. Management staff has consistently provided in-time training to employees as indicated, to make certain the understanding of appropriate procedures and approaches that comply	

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	245255	A. BUILDING _____ B. WING _____	10/23/2014

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F 241	Continued From page 2 management staff, FM-D said that the nurses see this all the time, and also the management was aware but nothing is done to improve it. FM-D shared that some of the residents cannot feed themselves and relied on staff to help them eat. FM-D questioned if some of the staff didn't realize this or if staff were too busy to sit down with the folks and help them eat. FM-D stated, "how hard could this be?" FM-D continued to share the disappointment of observing helpless folks not receive needed help with their meals, and added the dining activity on fourth floor is, "not smooth and not organized at all." When asked if there were enough staff members present in the dining room to assist residents with their meals, FM-D replied that it appeared there was enough staff but that staff just, "stand around" in the dining room and don't seem to notice who needs help. During observation of resident dining room on fourth floor during the evening meal on 10/20/14 from 4:00 p.m. through 6:20 p.m. eight residents (R130, R109, R26, R24, R103, R17, R21, R82) were observed seated in the chairs at various tables with their meal trays in front of them and staff did not provide needed assistance for meal consumption and did not provide a positive, dignified dining experience. On 10/20/14 at 4:10 p.m. R130 was sitting in front of the television, eating her meal, another resident picked up R130's cranberry juice glass and drank it. Staff at the nursing station were unaware of this situation as no one was supervising this area. Surveyor alerted the staff, and staff assisted the resident to move away from R130's table; however, no one offered another glass of cranberry juice to R130.	F 241	with facility policies and procedures. These audits will occur at each meal service for a minimum of 60 days and will be reviewed by our Quality Council Committee. Quality Council Committee will have oversight of newly implemented protocols and audits to ensure resident needs, dignity and care plan approaches are followed in a manner consistent with facility□s mission and core values. Quality Council Committee will also ensure random audits will occur throughout the year for continued compliance. Mandatory in-servicing conducted for all dietary and nursing personnel, to ensure understanding of individualized dignified dining experience for each resident. This in-servicing includes verbal, written, and hands-on interactive components; post-test completed to confirm employee comprehension of education provided. Facility developed new schedule specific to meal time duties and location designation; management staff will affirm their presence as indicated by schedule. This will ensure all residents that require feeding assistance, encouragement and all care planned objectives are met to their entirety. Education will continue to be conducted through November 24, 2014 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated based on level of satisfaction and Quality Council□s recommendations; please see	

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F 241	Continued From page 3 On 10/20/14 at 4:10 p.m., 5 staff started serving meals to the residents on fourth floor dining room. Community manager, registered nurse (RN)-A assisted two residents who were sitting in the hallway eating. On 10/20/14 from 4:10 p.m. until 5:20 p.m., no assistance was provided to R109 whose food plate was on the table in front of her in the dining room. R109 only drank her juice from the glass and did not touch her meal. On 10/20/14 from 4:20 p.m. until 6:20 p.m. R26 sat in the dining room with his meal plate in front of him on the table and no one asked if he needed alternative meal nor assisted him with his meal. R26 left the uneaten food on his plate in the dining room at 6:20 p.m. On 10/20/14 from 4:25 p.m. until 6:20 p.m. observed R24, R103, R17 and R21 at table 6. The residents were served their meals at 4:20 p.m. and nursing assistant (NAR)-B started feeding R24. NAR-B fed R24 a couple of bites and than wheeled his chair closer to R103 and fed R103 a few bites, while R24 just sat and watched. NAR-B then started feeding the third resident R17 while R24 and R103 sat with their plates full of food in-front of them and watched NAR-B feed R17. This continued until 5:20 p.m., NAR-B wheeled his chair from resident to resident and fed a few bites to one resident while the other two residents just sat and watched. The fourth resident, R21 used her fingers to dip into her mashed potatoes and licked it repeatedly from 4:20 p.m. to 6:20 p.m. No assistance was provided to R21 during the evening meal on fourth floor.	F 241	attached example of Resident Meal Service Satisfaction Survey Tool. Facility will also incorporate immersion training into annual Hand-In-Hand/dementia training. This includes but not limited to, nursing personnel being fed by other nursing personnel while wearing blinding eye glasses, ear plugs, etc.	

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F 241	Continued From page 4 On 10/20/14 from 4:25 p.m. until 5:15 p.m. R82 was observed sitting in his wheelchair in front of the television next to the dining room and his covered meal tray was in front of him on a table. R82 had a neck travel pillow covering his eyes. At 4:45 p.m. the health unit coordinator (HUC)-E approached R82, rubbed R82's back and asked R82 to wake up and eat his dinner. The resident did not respond and HUC-E walked away stating she would come back once R82 was awake. The meal tray sat in-front of R82 from 4:25 p.m. until 5:15 p.m. (40 minutes) and at 5:15 p.m. RN-A approached R82 and gently took away his neck pillow uncovering his eyes, R82 opened up his eyes and saw his food tray in front of him. RN-A uncovered R82's food tray; however, no one offered or asked to heat up his meal. R82 started feeding himself slowly. On 10/21/14 at 10:45 a.m. observed R26 with his brunch meal untouched in front of him in the dining room. Nursing Assistant (NAR)-F asked R26 if he wanted something else to eat, R26 asked for a cookie and ice cream. NAR-F obtained a high calorie cookie, an ice cream cup and a can of high protein shake. R26 ate the cookie, drank 75% of the shake and ate bites of the ice-cream. At 11:10 a.m. NAR-F stated that when R26 is asked about food preferences R26 generally eats. 10/21/14 at 10:50 a.m. observed R21 sitting in the dining room with meal tray in front of her and not eating. A staff walking by, placed a spoon into R21's left hand and R21 started feeding herself one bite after another. R21 continued to feed herself and ate well over 75% of her meal.	F 241		

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F 241	Continued From page 5 On 10/21/14 at 10:30 a.m, nursing assistant (NAR)-D was interviewed regarding meal time and help available to assist residents with eating, in the dining room. NAR-D stated that when there were only 5 aides it was tough to provide needed help in the dining room, but since one more aide was added, it seemed to be enough to help out everyone in the dining room. NAR-D added, "A lot of residents in the dining room need to be fed, and sometimes things do not go as smoothly." On 10/21/14 at 11:40 a.m., nursing assistant (NAR)-A was interviewed regarding staffing during meal times. NAR-A stated now that they have 6 aides instead of just 5, things are running much more smoothly in the dining room. NAR-A felt there were enough aides helping out in the dining room during meal times. NAR- A indicated because of the residents diagnosis and behavioral issues, it was very unpredictable because of the residents unpredictable behaviors. On 10/21/14, at 12:00 p.m. RN-A was interviewed and RN-A stated that all of residents who had food plates sitting in front of them during Monday evening meal required staff to provide assist. RN-A indicated that staff should interact with residents and offer assistance with feeding, opening cartons, providing alternatives and encouraging the residents to eat. RN-A added that she was busy assisting the residents who ate outside of the dining room and did not supervise the dining room to make sure every resident who needed assistance was helped. On 10/23/14, R130's nutritional plan of care, dated 8/13/14, was reviewed and it directed staff to encourage good intake, pour liquids, remind	F 241		

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F 241	Continued From page 6 R130 the importance of consuming adequate fluids and monitor. On 10/23/14, R109's plan of care, dated 03/05/13, was reviewed and it directed staff to encourage good intake at meal time, open containers, pour liquids, offer preferred fluids and food, hand utensils and encourage to eat throughout the meal. On 10/23/14, R26's plan of care, dated 01/30/13, was reviewed and it directed staff to assist R26 with opening the containers, avoid dislikes, serve preferenced meal, and cue/encourage good intake at meals. On 10/23/14, R24's plan of care, dated 03/28/13, was reviewed and it directed staff to assist R24 with opening containers, setting up meal, helping with utensils/plates, and to cue/encourage with meal consumption. On 10/23/14, R103's plan of care, dated 07/07/14, was reviewed and it directed staff to assist R103 by opening containers, encouraging good food consumption, and serving preferences. On 10/23/14, R17's plan of care, dated 05/05/14, was reviewed and it indicated to encourage R17 to consume good amount, offer assistance with fluid, encourage to self feed, offer preferred fluids and meal items and open containers. On 10/23/14, R21's plan of care, dated 07/16/14, was reviewed and it directed staff to encourage R21 to eat with silverware, encourage putting food on the fork, supervise at each meal, provided assistance with meals, avoid dislikes and serve preferences.	F 241		

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F 241	Continued From page 7 On 10/23/14, R82's plan of care, dated 06/04/13, was reviewed and it indicated to encourage consumption of meal, open containers, offer preferred fluids and meals, and encourage good intake. On 10/23/14 The policy/procedure for fourth floor dining procedure was requested from the director of nursing, however was not provided. On 10/20/14 at 4:00 p.m. the dining service was observed on the 3rd floor. Tables had been pre-set with beverages of milk, juice and water and there were paper meal tickets at each place setting with resident names and diet specifics listed. At 4:12 p.m. dietary staff set up the meal and took temperatures of the food. Clothing protectors were passed around the dining room to residents who chose to have one. At 4:17, R30 got up to leave and staff asked R30 to stay to wait for the food to be served. R30 left and returned at 4:25 as the food was just beginning to be served. R30 asked for the stuffed green pepper and staff told R30, "its coming" but make no attempt to get a plate for her. From 4:31 p.m. until 4:38 p.m. R30 asked for her meal 6 times with the same reply that the meal is coming and to wait. At 4:38 p.m. staff placed a plate of food at the place setting next to R30, where no one was sitting. R30 immediately grabbed the plate of food, began to eat in a hurried manner, finished the meal at 4:46 p.m. and left the dining room. Review of R30's care plan directed staff to assure R30 had positive experiences in daily routine without overly demanding tasks and without	F 241		

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F 241	Continued From page 8 becoming overly stressed. On 10/23/14 at 3:38 p.m. the facility dietitian (FD) was interviewed and stated the plan was to offer R30 well liked items, explaining that R30 preferred to stay in her room, but would come out to meals, eat fast and leave. R95 was observed to have a wet place mat. At 4:40 p.m., R95 did not want the main entree and ordered a chicken pot pie. R95 waited until 5:03 for the chicken pot pie, which was placed in front of R95 on the wet place mat. The care plan for R95, dated 6/4/14, directed staff R95 was vulnerable, had difficulty formulating words to express self related to physical and cognitive impairments.	F 241		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the residents written plan of care (POC) for 8 of 93 residents (R130, R109, R26, R24, R103, R17, R21, R82) who required assistance during dining. Findings include:	F 282	F282 Department Directors and Management staff have conducted comprehensive audits of meal service; please see attached example of meal service audit document. Management staff has consistently provided in-time training to employees as indicated, to make certain the understanding of appropriate	11/24/14

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F 282	Continued From page 9 During observation of resident dining room on fourth floor during the evening meal on 10/20/14 from 4:00 p.m. through 6:20 p.m., eight residents (R130, R109, R26, R24, R103, R17, R21, R82) were observed seated in chairs at various tables with meal trays in front and staff did not provide needed assistance for meal consumption. On 10/23/14, R130's nutritional plan of care, dated 8/13/14, was reviewed and it directed staff to encourage good intake, pour liquids, remind R130 the importance of consuming adequate fluids and monitor. On 10/20/14 at 4:10 p.m. R130 was sitting in front of the television, eating her meal, another resident picked up R130's cranberry juice glass and drank it. The staff were at the nursing station; they were unaware of this situation and no one was supervising this area. Surveyor alerted the staff, and staff assisted the resident to move away from R130's table; however, no one offered another glass of cranberry juice to R130. On 10/23/14, R109's plan of care, dated 03/05/13, was reviewed and it directed staff to encourage good intake at meal time, open containers, pour liquids, offer preferred fluids and food, hand utensils and encourage to eat throughout the meal. On 10/20/14 from 4:10 p.m. until 5:20 p.m. no assistance was provided to R109 whose food plate was on the table in front of her in the dining room. R109 only drank juice from the glass and did not touch her meal.	F 282	procedures and approaches that comply with facility policies and procedures. These audits will occur at each meal service for a minimum of 60 days and will be reviewed by our Quality Council Committee. Quality Council Committee will have oversight of newly implemented protocols and audits to ensure resident needs, dignity and care plan approaches are followed in a manner consistent with facility□s mission and core values. Quality Council Committee will also ensure random audits will occur throughout the year for continued compliance. Mandatory in-servicing conducted for all dietary and nursing personnel, to ensure understanding of individualized dignified dining experience for each resident. This in-servicing includes verbal, written, and hands-on interactive components; post-test completed to confirm employee comprehension of education provided. Facility developed new schedule specific to meal time duties and location designation; management staff will affirm their presence as indicated by schedule. This will ensure all residents that require feeding assistance, encouragement and all care planned objectives are met to their entirety. Education will continue to be conducted through November 24, 2014 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated based on level of satisfaction and Quality	

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F 282	Continued From page 10 On 10/23/14, R26's plan of care, dated 01/30/13, was reviewed and directed staff to assist R26 with opening containers, avoid dislikes, serve preferenced meal, and cue/encourage good intake at meals. On 10/20/14 from 4:20 p.m. until 6:20 p.m. R26 sat in the dining room with meal plate in front of him on the table and no one asked if he needed alternative meal or assisted him with his meal. R26 left uneaten food on the plate at 6:20 p.m. On 10/21/14 at 10:45 a.m. observed R26 with brunch meal untouched in front of him in the dining room, Nursing Assistant (NAR)-F asked R26 if he wanted something else to eat, R26 asked for a cookie and ice cream. NAR-F obtained a high calorie cookie, an ice cream cup and a can of high protein shake. R26 ate the cookie, drank 75% of the shake and ate bites of ice-cream. At 11:10 a.m. NAR-F stated when we ask R26 of his preferences and offer him the food he generally eats. On 10/23/14, R24's plan of care, dated 03/28/13, was reviewed and directed staff to assist R24 with opening containers, setting up meal, helping with utensils/plates, and to cue/encourage with meal consumption. On 10/23/14, R103's plan of care, dated 07/07/14, was reviewed and it directed staff to assist R103 by opening containers, encouraging good food consumption, and serving preferences. On 10/23/14, R17's plan of care, dated 05/05/14, was reviewed anddirected staff to encourage R17 to consume good amount, offer assistance with	F 282	Council□s recommendations; please see attached example of Resident Meal Service Satisfaction Survey Tool. Facility will also incorporate immersion training into annual Hand-In-Hand/dementia training. This includes but not limited to, nursing personnel being fed by other nursing personnel while wearing blinding eye glasses, ear plugs, etc.	

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F 282	Continued From page 11 fluid, encourage to self feed, offer preferred fluids and meal items and open containers. On 10/23/14, R21's plan of care, dated 07/16/14, was reviewed and it directed staff to encourage R21 to eat with silverware, encourage putting food on the fork, supervise at each meal, provided assistance with meals, avoid dislikes and serve preferences. On 10/20/14 from 4:25 p.m. until 6:20 p.m. observed R24, R103, R17 and R21 at table 6. They were served their meals at 4:20 p.m. and nursing assistant (NAR)-B started feeding R24. NAR-B fed R24 couple of bites and then wheeled his chair closer to R103 and fed her a few bites, while R24 just sat and watched. NAR-B then started feeding the third resident R17 while R24 and R103 just sat there with their plates full of food in-front of them and watched NAR-B feed R17. This continued until 5:20 p.m., NAR-B wheeled his chair from resident to resident and fed few bites to one resident while the other two residents just sat and watched. The fourth resident, R21 used her fingers to dip into the mashed potatoes and licked it repeatedly from 4:20 p.m. to 6:20 p.m. No assistance was provided to R21 during the evening meal on fourth floor. 10/21/14 at 10:50 a.m. observed R21 sitting in the dining room with meal tray in front of her and not eating. A staff walking by placed a spoon into R21's left hand and she started feeding herself one bite after another. R21 continued to feed self and ate well over 75% of her meal. On 10/23/14, R82's plan of care, dated 06/04/13, was reviewed and directed staff to encourage	F 282		

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F 282	Continued From page 12 consumption of meal, open containers, offer preferred fluids and meals, and encourage good intake. On 10/20/14 from 4:25 p.m. until 5:15 p.m. R82 was observed sitting in his wheelchair in front of the television next to the dining room. A covered meal tray was in front of him on a table. R82 had a neck travel pillow covering his eyes. At 4:45 p.m. the health unit coordinator (HUC)-E approached R82, rubbed R82's back and asked R82 to wake up and eat his dinner. The resident did not respond and HUC-E walked away stating she would come back once R82 was awake. The meal tray sat in-front of R82 from 4:25 p.m. until 5:15 p.m. (40 minutes) and at 5:15 p.m. RN-A approached R82 and gently took away his neck pillow uncovering his eyes. R82 opened up his eyes and saw the food tray in front of him. RN-A uncovered R82's food tray; however, no one offered or asked to heat up his meal. R82 started feeding himself slowly. During interview, on 10/20/14 at 4:00 p.m. a family member (FM)-D verbalized concerns related to the lack of supervision and assistance in the fourth floor dining room. FM-D visited the 4th floor dining room frequently during the evening meals to assist a family member with dining, FM-D stated, "Several residents in this dining room do not receive the help that they need with eating, it is very chaotic, in the dining room." FM-D explained, "Staff put the residents trays in front of them and then walk away without helping them, or even showing them what is on their trays. The food on the residents trays get cold and the staff doesn't even ask to reheat their food".	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	10/23/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 282	Continued From page 13 On 10/21/4 at 10:30 a.m. nursing assistant (NAR)-D was interviewed regarding residents who required assist with eating, NAR-D reported that a lot of residents in the dining room need to be fed. On 10/21/14 at 11:40 a.m. Nursing Assistant (NAR)-A was interviewed regarding residents who required assist with meals. NAR-A stated because of residents diagnosis and behavioral issues, it was very unpredictable. On 10/21/14, at 12:00 p.m. RN-A was interviewed and stated that all of the residents whose food plates sat in front of them during the Monday evening meal needed assist from staff. RN-A indicated the staff should be interacting with residents and offering assistance with feeding, opening cartons, providing alternative meals and encouraging the residents to eat.	F 282		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		11/24/14

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CERENITY CARE CENTER ON HUMBOLDT	512 HUMBOLDT AVENUE SAINT PAUL, MN 55107

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F 441	Continued From page 14 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to implement infection control practices related to hand washing during cares for 1 of 3 residents (R98) observed for activities of daily living. Findings include: On 10/22/2014, 8:39 a.m. R98 was observed to receive morning cares. NA-A donned gloves, wheeled R98 to the bathroom and using a transfer belt NA-A helped R98 to sit on the toilet and wash her upper torso. NA-a donned another	F 441	F441 Facility conducted mandatory nursing personnel in-servicing of hand washing policy and procedure. This training will be completed by November 24, 2014. Competencies will be obtained to ensure appropriate hand washing techniques. Infection Control Nurse will continue to conduct comprehensive infection control audits throughout the year to ensure affective infection prevention practices. These audits will be reviewed by the	

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F 441	Continued From page 15 pair of gloves over the first pair and helped R97 to stand holding the grab bar as he cleaned R98 of a bowel movement (BM). After cleaning R98, NA-A took off both gloves and did not wash hands before donning new gloves. NA-A continued with cares of brushing R98's hair, donning top, pulling up pants and incontinent product. NA-A then wrapped up the soiled garbage, removed gloves and used hand sanitizer before donning new gloves to help R98 brush her teeth. After all cares were completed NA-A removed gloves and washed hands. A hand washing policy, dated 12/2013, directed staff that hand washing is to be done in a method that is consistent with federal, state and local regulations and codes. The policy indicated that staff must wash/sanitize hands after using toilet facilities or any time hands should become soiled.	F 441	Quality Council.	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for five double resident rooms (221, 222, 223, 226, 326) affecting ten residents of 107 residents who resided in the facility. Findings include:	F 458	Annual Room size waiver request F458 Variance on file	~~11/24/14~~

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F 458	Continued From page 16 Resident double occupancy square footage was observed to be approximately 155 square feet instead of the required 160 square feet for double occupancy in rooms 221, 222, 223, 226 and 326. When interviewed on 10/23/14, at 10:31 a.m. the administrator and DON acknowledged a waiver was in place since July 2001, allowing double occupancy in the 155 square foot double rooms versus the regulation of 160 square feet in double occupancy rooms. Resident's residing in those rooms did not offer complaints regarding the size of their rooms.	F 458		

Cerenity
SENIOR CARE
Humboldt

Care Center
512 Humboldt Ave.
St. Paul, MN 55107
P 651-227-8091
F 651-220-1755
Skilled Nursing
Memory Care

Residence
514 Humboldt Ave.
St. Paul, MN 55107
P 651-220-1700
F 651-220-1724
Assisted Living
Memory Care

Transitional Care
514 Humboldt Ave.
St. Paul, MN 55107
P 651-220-1705
F 651-310-1238
Short-term
Rehabilitation

November 21, 2014

Minnesota Department of Health
1645 Energy Park Drive, Suite 300
St. Paul, MN 55108-2970

To Whom It May Concern:

Cerenity Care Center on Humboldt (provider number 245255) would like to request a waiver for 42 CFR 483.70(d)(1)(ii), F458:

I am requesting that the square footage in rooms 221, 222, 223, 226 and 326 be approved for double occupancy. The rooms are approximately 155 square feet of usable floor area rather than the required 160 square feet. These rooms were originally two-bed resident rooms, and have been approved to be so from a waiver since July 2001.

If you have any questions or concerns feel free to contact me at 651-220-1742 or email me at ted.schmidt@bhshealth.org.

Sincerely,

Ted A. Schmidt

Ted Schmidt
Administrator/CEO
Cerenity Care Center on Humboldt

Cc: Susanne Reuss, Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2014**

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K 000	INITIAL COMMENTS FIRE SAFETY . A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Care Center on Humboldt was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Cerenity Care Center Humboldt is a 4-story building with a no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction.. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is partially fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors,resident rooms, closets and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 125 beds and had a census of 110 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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.

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

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	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2014**

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K 000	Continued From page 1 met.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: November 5, 2014

Mr. Ted Schmidt, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 55107

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5255024 and Complaint Number H5255037

Dear Mr. Schmidt:

The above facility was surveyed on October 20, 2014 through October 23, 2014 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number H5255037 that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. 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 Nursing Homes.

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 are the Suggested Method of Correction and 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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 me.

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.

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A complaint investigation was completed for H5255037 at the time of the standard recertification survey and was unsubstantiated.	F 000		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure dignity during dining for 11 of 93 residents (R50,130, R109, R26, R24, R103, R17, R21, R82, R30, R95) observed during dining. Findings include:	F 241	F000 This credible Allegation of Compliance has been prepared and submitted timely. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission	11/24/14

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

Electronically Signed | 11/14/2014

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F 241	Continued From page 1 On 10/23/14, staff were observed to pass trays to residents in the 2nd floor dining area from 4:26 p.m. until 5:15 p.m. R50 was observed on 10/23/14, at 4:35 p.m. to be sitting at a table in the dining room on 2nd floor, with plate of food on table in front of resident. A small vase containing artificial flowers was laying across R50's plate. R50 was observed to sit at table with the flowers on her plate until 4:45 p.m. when nursing assistant (NA)-G approached R50 and removed the flowers from the plate. The quarterly minimum data set (MDS) dated 8/12/14 identified R50 had diagnosis of Alzheimer disease, was cognitively impaired and had impaired vision and hearing deficits. On 10/20/14 at 4:00 p.m. a family member (FM)-D verbalized concerns related to the lack of supervision and assistance in the fourth floor dining room. FM-D visited the 4th floor dining room frequently during the evening meals to assist a family member with dining, FM-D stated, "Several residents in this dining room do not receive the help that they need with eating, it is very chaotic, in the dining room." FM-D explained, "Staff put the residents trays in front of them and then walk away without helping them, or even showing them what is on their trays. The food on the residents trays get cold and the staff doesn't even ask to reheat their food. Who would want to eat cold food?" FM-D went on to say that it was, "disheartening" to see this. When asked if FM-D had shared this information with any of the	F 241	against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility. F241 Department Directors and Management staff have conducted comprehensive audits of meal service; please see attached example of meal service audit document. Management staff has consistently provided in-time training to employees as indicated, to make certain the understanding of appropriate procedures and approaches that comply	

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F 241	Continued From page 2 management staff, FM-D said that the nurses see this all the time, and also the management was aware but nothing is done to improve it. FM-D shared that some of the residents cannot feed themselves and relied on staff to help them eat. FM-D questioned if some of the staff didn't realize this or if staff were too busy to sit down with the folks and help them eat. FM-D stated, "how hard could this be?" FM-D continued to share the disappointment of observing helpless folks not receive needed help with their meals, and added the dining activity on fourth floor is, "not smooth and not organized at all." When asked if there were enough staff members present in the dining room to assist residents with their meals, FM-D replied that it appeared there was enough staff but that staff just, "stand around" in the dining room and don't seem to notice who needs help. During observation of resident dining room on fourth floor during the evening meal on 10/20/14 from 4:00 p.m. through 6:20 p.m. eight residents (R130, R109, R26, R24, R103, R17, R21, R82) were observed seated in the chairs at various tables with their meal trays in front of them and staff did not provide needed assistance for meal consumption and did not provide a positive, dignified dining experience. On 10/20/14 at 4:10 p.m. R130 was sitting in front of the television, eating her meal, another resident picked up R130's cranberry juice glass and drank it. Staff at the nursing station were unaware of this situation as no one was supervising this area. Surveyor alerted the staff, and staff assisted the resident to move away from R130's table; however, no one offered another glass of cranberry juice to R130.	F 241	with facility policies and procedures. These audits will occur at each meal service for a minimum of 60 days and will be reviewed by our Quality Council Committee. Quality Council Committee will have oversight of newly implemented protocols and audits to ensure resident needs, dignity and care plan approaches are followed in a manner consistent with facility□s mission and core values. Quality Council Committee will also ensure random audits will occur throughout the year for continued compliance. Mandatory in-servicing conducted for all dietary and nursing personnel, to ensure understanding of individualized dignified dining experience for each resident. This in-servicing includes verbal, written, and hands-on interactive components; post-test completed to confirm employee comprehension of education provided. Facility developed new schedule specific to meal time duties and location designation; management staff will affirm their presence as indicated by schedule. This will ensure all residents that require feeding assistance, encouragement and all care planned objectives are met to their entirety. Education will continue to be conducted through November 24, 2014 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated based on level of satisfaction and Quality Council□s recommendations; please see	

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F 241	Continued From page 3 On 10/20/14 at 4:10 p.m., 5 staff started serving meals to the residents on fourth floor dining room. Community manager, registered nurse (RN)-A assisted two residents who were sitting in the hallway eating. On 10/20/14 from 4:10 p.m. until 5:20 p.m., no assistance was provided to R109 whose food plate was on the table in front of her in the dining room. R109 only drank her juice from the glass and did not touch her meal. On 10/20/14 from 4:20 p.m. until 6:20 p.m. R26 sat in the dining room with his meal plate in front of him on the table and no one asked if he needed alternative meal nor assisted him with his meal. R26 left the uneaten food on his plate in the dining room at 6:20 p.m. On 10/20/14 from 4:25 p.m. until 6:20 p.m. observed R24, R103, R17 and R21 at table 6. The residents were served their meals at 4:20 p.m. and nursing assistant (NAR)-B started feeding R24. NAR-B fed R24 a couple of bites and than wheeled his chair closer to R103 and fed R103 a few bites, while R24 just sat and watched. NAR-B then started feeding the third resident R17 while R24 and R103 sat with their plates full of food in-front of them and watched NAR-B feed R17. This continued until 5:20 p.m., NAR-B wheeled his chair from resident to resident and fed a few bites to one resident while the other two residents just sat and watched. The fourth resident, R21 used her fingers to dip into her mashed potatoes and licked it repeatedly from 4:20 p.m. to 6:20 p.m. No assistance was provided to R21 during the evening meal on fourth floor.	F 241	attached example of Resident Meal Service Satisfaction Survey Tool. Facility will also incorporate immersion training into annual Hand-In-Hand/dementia training. This includes but not limited to, nursing personnel being fed by other nursing personnel while wearing blinding eye glasses, ear plugs, etc.	

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	245255	A. BUILDING _____ B. WING _____	10/23/2014

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F 241	Continued From page 4 On 10/20/14 from 4:25 p.m. until 5:15 p.m. R82 was observed sitting in his wheelchair in front of the television next to the dining room and his covered meal tray was in front of him on a table. R82 had a neck travel pillow covering his eyes. At 4:45 p.m. the health unit coordinator (HUC)-E approached R82, rubbed R82's back and asked R82 to wake up and eat his dinner. The resident did not respond and HUC-E walked away stating she would come back once R82 was awake. The meal tray sat in-front of R82 from 4:25 p.m. until 5:15 p.m. (40 minutes) and at 5:15 p.m. RN-A approached R82 and gently took away his neck pillow uncovering his eyes, R82 opened up his eyes and saw his food tray in front of him. RN-A uncovered R82's food tray; however, no one offered or asked to heat up his meal. R82 started feeding himself slowly. On 10/21/14 at 10:45 a.m. observed R26 with his brunch meal untouched in front of him in the dining room. Nursing Assistant (NAR)-F asked R26 if he wanted something else to eat, R26 asked for a cookie and ice cream. NAR-F obtained a high calorie cookie, an ice cream cup and a can of high protein shake. R26 ate the cookie, drank 75% of the shake and ate bites of the ice-cream. At 11:10 a.m. NAR-F stated that when R26 is asked about food preferences R26 generally eats. 10/21/14 at 10:50 a.m. observed R21 sitting in the dining room with meal tray in front of her and not eating. A staff walking by, placed a spoon into R21's left hand and R21 started feeding herself one bite after another. R21 continued to feed herself and ate well over 75% of her meal.	F 241		

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F 241	Continued From page 5 On 10/21/14 at 10:30 a.m, nursing assistant (NAR)-D was interviewed regarding meal time and help available to assist residents with eating, in the dining room. NAR-D stated that when there were only 5 aides it was tough to provide needed help in the dining room, but since one more aide was added, it seemed to be enough to help out everyone in the dining room. NAR-D added, "A lot of residents in the dining room need to be fed, and sometimes things do not go as smoothly." On 10/21/14 at 11:40 a.m., nursing assistant (NAR)-A was interviewed regarding staffing during meal times. NAR-A stated now that they have 6 aides instead of just 5, things are running much more smoothly in the dining room. NAR-A felt there were enough aides helping out in the dining room during meal times. NAR- A indicated because of the residents diagnosis and behavioral issues, it was very unpredictable because of the residents unpredictable behaviors. On 10/21/14, at 12:00 p.m. RN-A was interviewed and RN-A stated that all of residents who had food plates sitting in front of them during Monday evening meal required staff to provide assist. RN-A indicated that staff should interact with residents and offer assistance with feeding, opening cartons, providing alternatives and encouraging the residents to eat. RN-A added that she was busy assisting the residents who ate outside of the dining room and did not supervise the dining room to make sure every resident who needed assistance was helped. On 10/23/14, R130's nutritional plan of care, dated 8/13/14, was reviewed and it directed staff to encourage good intake, pour liquids, remind	F 241		

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F 241	Continued From page 6 R130 the importance of consuming adequate fluids and monitor. On 10/23/14, R109's plan of care, dated 03/05/13, was reviewed and it directed staff to encourage good intake at meal time, open containers, pour liquids, offer preferred fluids and food, hand utensils and encourage to eat throughout the meal. On 10/23/14, R26's plan of care, dated 01/30/13, was reviewed and it directed staff to assist R26 with opening the containers, avoid dislikes, serve preferenced meal, and cue/encourage good intake at meals. On 10/23/14, R24's plan of care, dated 03/28/13, was reviewed and it directed staff to assist R24 with opening containers, setting up meal, helping with utensils/plates, and to cue/encourage with meal consumption. On 10/23/14, R103's plan of care, dated 07/07/14, was reviewed and it directed staff to assist R103 by opening containers, encouraging good food consumption, and serving preferences. On 10/23/14, R17's plan of care, dated 05/05/14, was reviewed and it indicated to encourage R17 to consume good amount, offer assistance with fluid, encourage to self feed, offer preferred fluids and meal items and open containers. On 10/23/14, R21's plan of care, dated 07/16/14, was reviewed and it directed staff to encourage R21 to eat with silverware, encourage putting food on the fork, supervise at each meal, provided assistance with meals, avoid dislikes and serve preferences.	F 241		

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F 241	Continued From page 7 On 10/23/14, R82's plan of care, dated 06/04/13, was reviewed and it indicated to encourage consumption of meal, open containers, offer preferred fluids and meals, and encourage good intake. On 10/23/14 The policy/procedure for fourth floor dining procedure was requested from the director of nursing, however was not provided. On 10/20/14 at 4:00 p.m. the dining service was observed on the 3rd floor. Tables had been pre-set with beverages of milk, juice and water and there were paper meal tickets at each place setting with resident names and diet specifics listed. At 4:12 p.m. dietary staff set up the meal and took temperatures of the food. Clothing protectors were passed around the dining room to residents who chose to have one. At 4:17, R30 got up to leave and staff asked R30 to stay to wait for the food to be served. R30 left and returned at 4:25 as the food was just beginning to be served. R30 asked for the stuffed green pepper and staff told R30, "its coming" but make no attempt to get a plate for her. From 4:31 p.m. until 4:38 p.m. R30 asked for her meal 6 times with the same reply that the meal is coming and to wait. At 4:38 p.m. staff placed a plate of food at the place setting next to R30, where no one was sitting. R30 immediately grabbed the plate of food, began to eat in a hurried manner, finished the meal at 4:46 p.m. and left the dining room. Review of R30's care plan directed staff to assure R30 had positive experiences in daily routine without overly demanding tasks and without	F 241		

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F 241	Continued From page 8 becoming overly stressed. On 10/23/14 at 3:38 p.m. the facility dietitian (FD) was interviewed and stated the plan was to offer R30 well liked items, explaining that R30 preferred to stay in her room, but would come out to meals, eat fast and leave. R95 was observed to have a wet place mat. At 4:40 p.m., R95 did not want the main entree and ordered a chicken pot pie. R95 waited until 5:03 for the chicken pot pie, which was placed in front of R95 on the wet place mat. The care plan for R95, dated 6/4/14, directed staff R95 was vulnerable, had difficulty formulating words to express self related to physical and cognitive impairments.	F 241		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the residents written plan of care (POC) for 8 of 93 residents (R130, R109, R26, R24, R103, R17, R21, R82) who required assistance during dining. Findings include:	F 282	F282 Department Directors and Management staff have conducted comprehensive audits of meal service; please see attached example of meal service audit document. Management staff has consistently provided in-time training to employees as indicated, to make certain the understanding of appropriate	11/24/14

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F 282	Continued From page 9 During observation of resident dining room on fourth floor during the evening meal on 10/20/14 from 4:00 p.m. through 6:20 p.m., eight residents (R130, R109, R26, R24, R103, R17, R21, R82) were observed seated in chairs at various tables with meal trays in front and staff did not provide needed assistance for meal consumption. On 10/23/14, R130's nutritional plan of care, dated 8/13/14, was reviewed and it directed staff to encourage good intake, pour liquids, remind R130 the importance of consuming adequate fluids and monitor. On 10/20/14 at 4:10 p.m. R130 was sitting in front of the television, eating her meal, another resident picked up R130's cranberry juice glass and drank it. The staff were at the nursing station; they were unaware of this situation and no one was supervising this area. Surveyor alerted the staff, and staff assisted the resident to move away from R130's table; however, no one offered another glass of cranberry juice to R130. On 10/23/14, R109's plan of care, dated 03/05/13, was reviewed and it directed staff to encourage good intake at meal time, open containers, pour liquids, offer preferred fluids and food, hand utensils and encourage to eat throughout the meal. On 10/20/14 from 4:10 p.m. until 5:20 p.m. no assistance was provided to R109 whose food plate was on the table in front of her in the dining room. R109 only drank juice from the glass and did not touch her meal.	F 282	procedures and approaches that comply with facility policies and procedures. These audits will occur at each meal service for a minimum of 60 days and will be reviewed by our Quality Council Committee. Quality Council Committee will have oversight of newly implemented protocols and audits to ensure resident needs, dignity and care plan approaches are followed in a manner consistent with facility□s mission and core values. Quality Council Committee will also ensure random audits will occur throughout the year for continued compliance. Mandatory in-servicing conducted for all dietary and nursing personnel, to ensure understanding of individualized dignified dining experience for each resident. This in-servicing includes verbal, written, and hands-on interactive components; post-test completed to confirm employee comprehension of education provided. Facility developed new schedule specific to meal time duties and location designation; management staff will affirm their presence as indicated by schedule. This will ensure all residents that require feeding assistance, encouragement and all care planned objectives are met to their entirety. Education will continue to be conducted through November 24, 2014 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated based on level of satisfaction and Quality	

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F 282	Continued From page 10 On 10/23/14, R26's plan of care, dated 01/30/13, was reviewed and directed staff to assist R26 with opening containers, avoid dislikes, serve preferenced meal, and cue/encourage good intake at meals. On 10/20/14 from 4:20 p.m. until 6:20 p.m. R26 sat in the dining room with meal plate in front of him on the table and no one asked if he needed alternative meal or assisted him with his meal. R26 left uneaten food on the plate at 6:20 p.m. On 10/21/14 at 10:45 a.m. observed R26 with brunch meal untouched in front of him in the dining room, Nursing Assistant (NAR)-F asked R26 if he wanted something else to eat, R26 asked for a cookie and ice cream. NAR-F obtained a high calorie cookie, an ice cream cup and a can of high protein shake. R26 ate the cookie, drank 75% of the shake and ate bites of ice-cream. At 11:10 a.m. NAR-F stated when we ask R26 of his preferences and offer him the food he generally eats. On 10/23/14, R24's plan of care, dated 03/28/13, was reviewed and directed staff to assist R24 with opening containers, setting up meal, helping with utensils/plates, and to cue/encourage with meal consumption. On 10/23/14, R103's plan of care, dated 07/07/14, was reviewed and it directed staff to assist R103 by opening containers, encouraging good food consumption, and serving preferences. On 10/23/14, R17's plan of care, dated 05/05/14, was reviewed anddirected staff to encourage R17 to consume good amount, offer assistance with	F 282	Council□s recommendations; please see attached example of Resident Meal Service Satisfaction Survey Tool. Facility will also incorporate immersion training into annual Hand-In-Hand/dementia training. This includes but not limited to, nursing personnel being fed by other nursing personnel while wearing blinding eye glasses, ear plugs, etc.	

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F 282	Continued From page 11 fluid, encourage to self feed, offer preferred fluids and meal items and open containers. On 10/23/14, R21's plan of care, dated 07/16/14, was reviewed and it directed staff to encourage R21 to eat with silverware, encourage putting food on the fork, supervise at each meal, provided assistance with meals, avoid dislikes and serve preferences. On 10/20/14 from 4:25 p.m. until 6:20 p.m. observed R24, R103, R17 and R21 at table 6. They were served their meals at 4:20 p.m. and nursing assistant (NAR)-B started feeding R24. NAR-B fed R24 couple of bites and then wheeled his chair closer to R103 and fed her a few bites, while R24 just sat and watched. NAR-B then started feeding the third resident R17 while R24 and R103 just sat there with their plates full of food in-front of them and watched NAR-B feed R17. This continued until 5:20 p.m., NAR-B wheeled his chair from resident to resident and fed few bites to one resident while the other two residents just sat and watched. The fourth resident, R21 used her fingers to dip into the mashed potatoes and licked it repeatedly from 4:20 p.m. to 6:20 p.m. No assistance was provided to R21 during the evening meal on fourth floor. 10/21/14 at 10:50 a.m. observed R21 sitting in the dining room with meal tray in front of her and not eating. A staff walking by placed a spoon into R21's left hand and she started feeding herself one bite after another. R21 continued to feed self and ate well over 75% of her meal. On 10/23/14, R82's plan of care, dated 06/04/13, was reviewed and directed staff to encourage	F 282		

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F 282	Continued From page 12 consumption of meal, open containers, offer preferred fluids and meals, and encourage good intake. On 10/20/14 from 4:25 p.m. until 5:15 p.m. R82 was observed sitting in his wheelchair in front of the television next to the dining room. A covered meal tray was in front of him on a table. R82 had a neck travel pillow covering his eyes. At 4:45 p.m. the health unit coordinator (HUC)-E approached R82, rubbed R82's back and asked R82 to wake up and eat his dinner. The resident did not respond and HUC-E walked away stating she would come back once R82 was awake. The meal tray sat in-front of R82 from 4:25 p.m. until 5:15 p.m. (40 minutes) and at 5:15 p.m. RN-A approached R82 and gently took away his neck pillow uncovering his eyes. R82 opened up his eyes and saw the food tray in front of him. RN-A uncovered R82's food tray; however, no one offered or asked to heat up his meal. R82 started feeding himself slowly. During interview, on 10/20/14 at 4:00 p.m. a family member (FM)-D verbalized concerns related to the lack of supervision and assistance in the fourth floor dining room. FM-D visited the 4th floor dining room frequently during the evening meals to assist a family member with dining, FM-D stated, "Several residents in this dining room do not receive the help that they need with eating, it is very chaotic, in the dining room." FM-D explained, "Staff put the residents trays in front of them and then walk away without helping them, or even showing them what is on their trays. The food on the residents trays get cold and the staff doesn't even ask to reheat their food".	F 282		

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F 282	Continued From page 13 On 10/21/4 at 10:30 a.m. nursing assistant (NAR)-D was interviewed regarding residents who required assist with eating, NAR-D reported that a lot of residents in the dining room need to be fed. On 10/21/14 at 11:40 a.m. Nursing Assistant (NAR)-A was interviewed regarding residents who required assist with meals. NAR-A stated because of residents diagnosis and behavioral issues, it was very unpredictable. On 10/21/14, at 12:00 p.m. RN-A was interviewed and stated that all of the residents whose food plates sat in front of them during the Monday evening meal needed assist from staff. RN-A indicated the staff should be interacting with residents and offering assistance with feeding, opening cartons, providing alternative meals and encouraging the residents to eat.	F 282		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		11/24/14

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F 441	Continued From page 14 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and document review, the facility failed to implement infection control practices related to hand washing during cares for 1 of 3 residents (R98) observed for activities of daily living. Findings include: On 10/22/2014, 8:39 a.m. R98 was observed to receive morning cares. NA-A donned gloves, wheeled R98 to the bathroom and using a transfer belt NA-A helped R98 to sit on the toilet and wash her upper torso. NA-a donned another	F 441	F441 Facility conducted mandatory nursing personnel in-servicing of hand washing policy and procedure. This training will be completed by November 24, 2014. Competencies will be obtained to ensure appropriate hand washing techniques. Infection Control Nurse will continue to conduct comprehensive infection control audits throughout the year to ensure affective infection prevention practices. These audits will be reviewed by the	

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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
F 441	Continued From page 15 pair of gloves over the first pair and helped R97 to stand holding the grab bar as he cleaned R98 of a bowel movement (BM). After cleaning R98, NA-A took off both gloves and did not wash hands before donning new gloves. NA-A continued with cares of brushing R98's hair, donning top, pulling up pants and incontinent product. NA-A then wrapped up the soiled garbage, removed gloves and used hand sanitizer before donning new gloves to help R98 brush her teeth. After all cares were completed NA-A removed gloves and washed hands. A hand washing policy, dated 12/2013, directed staff that hand washing is to be done in a method that is consistent with federal, state and local regulations and codes. The policy indicated that staff must wash/sanitize hands after using toilet facilities or any time hands should become soiled.	F 441	Quality Council.	
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for five double resident rooms (221, 222, 223, 226, 326) affecting ten residents of 107 residents who resided in the facility. Findings include:	F 458	F458 Variance on file	11/24/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	10/23/2014

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F 458	Continued From page 16 Resident double occupancy square footage was observed to be approximately 155 square feet instead of the required 160 square feet for double occupancy in rooms 221, 222, 223, 226 and 326. When interviewed on 10/23/14, at 10:31 a.m. the administrator and DON acknowledged a waiver was in place since July 2001, allowing double occupancy in the 155 square foot double rooms versus the regulation of 160 square feet in double occupancy rooms. Resident's residing in those rooms did not offer complaints regarding the size of their rooms.	F 458		