DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEE	DICARE &	MEDICAID SERV	ICES
	MEDIC	ARE/MEDICAL	D CERTIFIC	CATION A	AND TRANSMITTAL		ID: 02HR	
	PART I -	TO BE COMPI	LETED BY T	THE STAT	FE SURVEY AGENCY		Facility ID: 005	538
1. MEDICARE/MEDICAID PROVIDER (L1) 245255	NO.	3. NAME AND AI (L3) CERENITY	CARE CENT	ER ON HU	UMBOLDT	4. TYPE	OF ACTION: <u>7(</u> L8) 2. Recertif	fication
2.STATE VENDOR OR MEDICAID NO (L2) 044518500		(L4) 512 HUMBO (L5) SAINT PAU		E	(L6) 55107	3. Termi 5. Valida	ination 4. CHOW ation 6. Complai	
5. EFFECTIVE DATE CHANGE OF OW (L9)	/NERSHIP	7. PROVIDER/SU 01 Hospital	JPPLIER CATEG 05 HHA	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Si 8. Full S	te Visit 9. Other urvey After Complaint	
6. DATE OF SURVEY 12/08/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	014 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		CAR ENDING DATE: 6/30	(L35)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 	117 (L18)	Complianc	nce With equirements e Based On: cceptable POC		And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code	$ \begin{array}{c} - 6. \text{ So} \\ - 7. \text{ M} \\ - 8. \text{ P} \end{array} $	<u>Requirements:</u> cope of Services Limit Iedical Director atient Room Size 3eds/Room	
13.Total Certified Beds	117 (L17)		npliance with Prog ents and/or Appli		* Code: A,8 *	(L12)		
14. LTC CERTIFIED BED BREAKDOW	N				15. FACILITY MEETS			
18 SNF 18/19 SNF 117	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMAR Facility's request for a con				· · · ·	s recommended.			
17. SURVEYOR SIGNATURE		Date :	_		18. STATE SURVEY AGENCY	APPROVAL	Date:	
Sue Reuss, Supervisor		1	2/09/2014	(L19)	Anne Kleppe, Enforcer	nent Specia	alist 12/1	8/2014 (L20)
PART	II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	COFFICE OR SINGLE S	TATE AGE		
 DETERMINATION OF ELIGIBILIT _X_ 1. Facility is Eligible to Part 2. Facility is not Eligible 			IPLIANCE WITH HTS ACT:	H CIVIL	 Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above : 			
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:		(L30)	<u> </u>
OF PARTICIPATION 09/13/1982	BEGINNING		ENDING DA		VOLUNTARY 00 01-Merger, Closure	_	INVOLUNTARY 05-Fail to Meet Health/Sa	fety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse		06-Fail to Meet Agreemen	ıt
25. LTC EXTENSION DATE: 2 (L27)	A. Suspension	VE SANCTIONS n of Admissions: uspension Date:	(L44)		03-Risk of Involuntary Terminatio 04-Other Reason for Withdrawal		OTHER 07-Provider Status Chang 00-Active	ze
	D. Resente S	ispension Date.	(L45)					
28. TERMINATION DATE:	29	. INTERMEDIARY/			30. REMARKS			
		03001						
	(L28)			(L31)	Uploaded 12/	17/2014	ML	
31. RO RECEIPT OF CMS-1539	32	DETERMINATION	OF APPROVAL	DATE				
	(L32)	11/21/2014		(L33)	DETERMINATION APPI	ROVAL		



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.

Cerenity Care Center on Humboldt December 18, 2014 (REVISED) Page 2

Sincerely,

Are Klegge

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



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,

Kumalu 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

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245255	(Y2) Multiple Construction A. Building B. Wing	A. Building	
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	(Y4) Item		(Y5) Date	(Y4) Item	(Y	'5) E	Date
ID Prefix Reg. # LSC	F0241 483.15(a)	Correction Completed 11/24/2014	ID Prefix Reg. # LSC	F0282 483.20(k)(3)(ii)	Correction Completed 11/24/2014		F0441 483.65		Correction Completed _11/24/2014
ID Prefix Reg. #		Correction Completed	ID Prefix Reg. #		Correction Completed	Reg. #			Correction Completed
Reg. #									Correction Completed
ID Prefix Reg. # LSC									Correction Completed
Reg. #			D "			D			
Reviewed E	By Rev	viewed By	Date:	Signature	of Surveyor:		[Date:	
State Agen	cy S	SR/KFD	12/9/201	4]	6022		12	2/8/2014
Reviewed E CMS RO	3y Rev	viewed By	Date:	Signature	of Surveyor:		1	Date:	
Followup to Survey Completed on: 10/23/2014				Uncorrected Deficed Deficed Deficiencies (CM		the Feelliter	YES	NO	

DEPARTMENT OF HEALTH ANI	D HUMA	N SERVICES			CENTERS FOR MED	DICARE & MEDICAID	SERVICES	
					AND TRANSMITTAL	ID: 0	2HR	
	PART I -	TO BE COMPL	ETED BY T	THE STAT	TE SURVEY AGENCY	Facili	ty ID: 00538	
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245255 2.STATE VENDOR OR MEDICAID NO. (L2) 044518500		3. NAME AND AD (L3) CERENITY (L4) 512 HUMBO (L5) SAINT PAU	CARE CENT OLDT AVENU	ER ON H	UMBOLDT (L6) 55107	1. Initial 2. 3. Termination 4.	<u>2 (</u> L8) . Recertification . CHOW . Complaint	
			,				. Other	
5. EFFECTIVE DATE CHANGE OF OWNEF (L9)		7. PROVIDER/SU 01 Hospital	05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 10/23/201 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	4 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE	FISCAL YEAR ENDING D 06/30	ATE: (L35)	
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	ΔS·		I		
From (a):		A. In Complian			And/Or Approved Waivers Of	The Following Requirements:		
To (b):		Program Re	equirements		2. Technical Personnel	6. Scope of Services	Limit	
12.Total Facility Beds 11'	7 (L18)	Compliance Based On: 1. Acceptable POC			3. 24 Hour RN7. Medical Director 4. 7-Day RN (Rural SNF) X8. Patient Room Size			
13.Total Certified Beds 11'	7 (L17)	X B. Not in Com Requireme	pliance with Prog ents and/or Appli		5. Life Safety Code * Code: B , 8*	9. Beds/Room (L12)		
14. LTC CERTIFIED BED BREAKDOWN		1			15. FACILITY MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY REMARKS (Facility's request for a continuing				,	commended.			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:	
Momodou Fatty, HFE NE II		1	1/17/2014	(L19)	Anne Kleppe, Enforcement Specialist 11/19/2014			
PARTI	- TO BE	COMPLETED B	BY HCFA RF	· · /	L OFFICE OR SINGLE S	TATE AGENCY	(L20)	
19. DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Participat		20. COM	PLIANCE WITH		 21. 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 			
2. Facility is not Eligible	(L21)							
22. ORIGINAL DATE 23. L	TC AGREE	MENT 24	. LTC AGREEN	IENT	26. TERMINATION ACTION:	(L30)		
OF PARTICIPATION F 09/13/1982	BEGINNINC	G DATE	ENDING DA	ГЕ	VOLUNTARY 00 01-Merger, Closure			
(L24) (L41)		(L25)		02-Dissatisfaction W/ Reimburse		Agreement	
25. LTC EXTENSION DATE: 27. A	ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminatio	n <u>OTHER</u>		
А	. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Stat	tus Change	
(L27) B	B. Rescind S	uspension Date:	(L44)			00-Active		
			(L45)					
28. TERMINATION DATE:	29	9. INTERMEDIARY/	CARRIER NO.		30. REMARKS			
		03001						
(L2	28)			(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	DATE				
(L3	32)			(L33)	DETERMINATION APPI	ROVAL		



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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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: <u>pat.sheehan@state.mn.us</u> Telephone: (651) 201-7205 Fax: (651) 215-0525

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

Sincerely,

Are Klegge

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		ON	<u>/B NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY IPLETED
		245255	B. WING		10/:	23/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENII	Y CARE CENTER ON			512 HUMBOLDT AVENUE		
				SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000			
F 241 SS=E	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificant Upon receipt of an a on-site revisit of your validate that substat regulations has beet your verification. A complaint investig H5255037 at the tim recertification surver 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each res full recognition of his This REQUIREMEN by: Based on observant review, the facility fa dining for 11 of 93 r	acceptable electronic POC, an ur facility may be conducted to initial compliance with the en attained in accordance with gation was completed for ne of the standard ay and was unsubstantiated. AND RESPECT OF omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced tion, interview, and document ailed to ensure dignity during esidents (R50,130, R109, 17, R21, R82, R30, R95)	F 24	F000 This credible Allegation of Complian has been prepared and submitted ti Submission of this Credible Allegatio Compliance is not a legal admission deficiency exists or that the Statement	imely. on of n that a	11/24/14
	Findings include:			Deficiencies were correctly cited, ar also not to be construed as an admi		
LABORATOR	/ DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
Electron	ically Signed					11/14/2014

Electronically Signed

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.

PRINTED: 11/17/2014

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	MB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	O CORRECTION	DENTIFICATION NUMBER.	A. BUILDING	3	
		245255			10/23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENI	TY CARE CENTER ON	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIO
F 241	Continued From pa	ae 1	F 24′	1	
	residents in the 2nd p.m. until 5:15 p.m. R50 was observed be sitting at a table floor, with plate of f resident. A small va was laying across F observed to sit at ta plate until 4:45 p.m (NA)-G approached flowers from the pla The quarterly minin 8/12/14 identified R	on 10/23/14, at 4:35 p.m. to in the dining room on 2nd ood on table in front of ase containing artificial flowers R50's plate. R50 was able with the flowers on her . when nursing assistant d R50 and removed the ate. num data set (MDS) dated S50 had diagnosis of Alzheimer tively impaired and had		 against interest of the Facility, its Administrator or any employees, a other individuals who draft or may discussed in this Credible Allegatic Compliance. In addition, preparatic submission of this Credible Allegat Compliance does not constitute ar admission or agreement of any kin Facility of the truth of any facts alle the correctness of any conclusions forth in this allegation by the surve agency. Accordingly, we are submitting this Credible Allegation of Compliance because state and federal law man submission of a Credible Allegation Compliance within ten (10) days of of the Statement of deficiencies as condition to participate in the Medi and Medical Assistance programs. submission of the Credible Allegation 	be on of on and ion of id by eged or s set y solely ndate n of receipt s a care The
	(FM)-D verbalized of supervision and as- dining room. FM-D room frequently du assist a family men "Several residents receive the help that very chaotic, in the explained, "Staff put them and then walk or even showing th food on the residen doesn't even ask to want to eat cold foot	D p.m. a family member concerns related to the lack of sistance in the fourth floor o visited the 4th floor dining ring the evening meals to her with dining, FM-D stated, in this dining room do not at they need with eating, it is dining room." FM-D at the residents trays in front of c away without helping them, em what is on their trays. The test trays get cold and the staff o reheat their food. Who would od?" FM-D went on to say that ng" to see this. When asked if		Compliance within this time frame in no way be considered or constru- agreement with the allegations of non-compliance or admissions by facility. F241 Department Directors and Manage staff have conducted comprehensi- audits of meal service; please see attached example of meal service document. Management staff has consistently provided in-time training employees as indicated, to make of the understanding of appropriate	should ued as the ement ve audit ng to

Facility ID: 00538

If continuation sheet Page 2 of 17

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	
ID PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMF	PLETED
		245255	B. WING _			10/2	23/2014
IAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
ERENII	TY CARE CENTER O	N HUMBOLDT		-	12 HUMBOLDT AVENUE AINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 241	Continued From pa	age 2	F 24	11			
	-	FM-D said that the nurses see			with facility policies and procedures	S.	
	this all the time, an	d also the management was			These audits will occur at each me		
		is done to improve it. FM-D			service for a minimum of 60 days a		
		of the residents cannot feed lied on staff to help them eat.			be reviewed by our Quality Council Committee. Quality Council Comm		
		f some of the staff didn't realize			will have oversight of newly implem		
		too busy to sit down with the			protocols and audits to ensure resid		
		n eat. FM-D stated, "how hard			needs, dignity and care plan approa		
		I-D continued to share the			are followed in a manner consisten		
		observing helpless folks not lp with their meals, and added			facility s mission and core values. Council Committee will also ensure	ire	
		on fourth floor is, "not smooth			random audits will occur throughou		
	and not organized	at all." When asked if there members present in the dining			year for continued compliance.		
	room to assist resid	dents with their meals, FM-D			Mandatory in-servicing conducted f		
		ared there was enough staff			dietary and nursing personnel, to e		
		stand around" in the dining			understanding of individualized dig		
	room and don't see	em to notice who needs help.			dining experience for each resident in-servicing includes verbal, written		
	During observation	of resident dining room on			hands-on interactive components;	, and	
	fourth floor during t	he evening meal on 10/20/14			post-test completed to confirm emp	oloyee	
	(R130, R109, R26,	ough 6:20 p.m. eight residents R24, R103, R17, R21, R82)			comprehension of education provid	led.	
		ted in the chairs at various			Facility developed new schedule sp	pecific	
		eal trays in front of them and e needed assistance for meal			to meal time duties and location	offirm	
		lid not provide a positive,			designation; management staff will their presence as indicated by sche		
	dignified dining exp				This will ensure all residents that re		
	J				feeding assistance, encouragemen	t and	
					all care planned objectives are met		
		0 p.m. R130 was sitting in front			their entirety. Education will continu		
	-	ating her meal, another R130's cranberry juice glass			conducted through November 24, 2 and will be mandatory prior to staff		
		at the nursing station were			working on any unit.		
		uation as no one was					
		ea. Surveyor alerted the staff,			Resident Meal Service Satisfaction		
		he resident to move away from ever, no one offered another			surveys will be conducted as indicated based on level of satisfaction and C		
	ERIGINATION POWE						

Facility ID: 00538

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245255	B. WING _		10	/23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
CERENI	TY CARE CENTER ON	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIC DATE
F 241	Continued From page 3			41		
meals to the reside	0 p.m., 5 staff started serving		attached example of Resid Service Satisfaction Surve			
	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.		Facility will also incorporate training into annual Hand-In-Hand/dementia tra includes but not limited to,	aining. This		
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 dinin room. R109 only drank her juice from the glass and did not touch her meal.		personnel being fed by oth personnel while wearing bl glasses, ear plugs, etc.	er nursing			
	On 10/20/14 from 4:20 p.m. until 6:20 p.m sat in the dining room with his meal plate of him on the table and no one asked if he needed alternative meal nor assisted him meal. R26 left the uneaten food on his pl the dining room at 6:20 p.m.	om with his meal plate in front and no one asked if he meal nor assisted him with his uneaten food on his plate in				
C F f f f r r r r	observed R24, R10 The residents were p.m. and nursing as feeding R24. NAR- and than wheeled h fed R103 a few bite watched. NAR-B the resident R17 while plates full of food in NAR-B feed R17. NAR-B wheeled his	4:25 p.m. until 6:20 p.m. 93, R17 and R21 at table 6. 93 served their meals at 4:20 95 sistant (NAR)-B started 95 fed R24 a couple of bites 96 nis chair closer to R103 and 97 es, while R24 just sat and 98 hen started feeding the third 98 R24 and R103 sat with their 91 of them and watched 92 This continued until 5:20 p.m., 93 chair from resident to				
	the other two reside fourth resident, R2 her mashed potato from 4:20 p.m. to 6	ew bites to one resident while ents just sat and watched. The 1 used her fingers to dip into es and licked it repeatedly :20 p.m. No assistance was ring the evening meal on				

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		AND HUMAN SERVICES			FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245255	B. WING		10/:	23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENI	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 4	F 241			
	was observed sittin the television next to covered meal tray w R82 had a neck tra At 4:45 p.m. the her approached R82, ru R82 to wake up and did not respond and she would come ba meal tray sat in-from 5:15 p.m. (40 minut approached R82 ar pillow uncovering h eyes and saw his for uncovered R82's for offered or asked to feeding himself slow On 10/21/14 at 10:4 brunch meal untour dining room. Nursin R26 if he wanted so asked for a cookie a obtained a high cale and a can of high p cookie, drank 75% the ice-cream. At when R26 is asked generally eats. 10/21/14 at 10:50 at the dining room with not eating. A staff y into R21's left hand herself one bite after	4:25 p.m. until 5:15 p.m. R82 g in his wheelchair in front of to the dining room and his was in front of him on a table. vel pillow covering his eyes. alth unit coordinator (HUC)-E ubbed R82's back and asked d eat his dinner. The resident d HUC-E walked away stating ack once R82 was awake. The nt of R82 from 4:25 p.m. until tes) and at 5:15 p.m. RN-A nd gently took away his neck is eyes, R82 opened up his bod tray in front of him. RN-A bod tray; however, no one heat up his meal. R82 started wiy. 45 a.m. observed R26 with his ched in front of him in the ng Assistant (NAR)-F asked omething else to eat, R26 and ice cream. NAR-F orie cookie, an ice cream cup rotein shake. R26 ate the of the shake and ate bites of 11:10 a.m. NAR-F stated that about food preferences R26				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245255	B. WING		10	10/23/2014	
	PROVIDER OR SUPPLIER	N HUMBOLDT	STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR	HOULD BE	(X5) COMPLETIC DATE	
F 241	On 10/21/14 at 10: (NAR)-D was intern and help available in the dining room. were only 5 aides help in the dining ro was added, it seem everyone in the din lot of residents in the and sometimes thin On 10/21/14 at 11:- (NAR)-A was intern during meal times. have 6 aides instea much more smooth felt there were eno dining room during because of the res behavioral issues, because of the res On 10/21/14, at 12 and RN-A stated th food plates sitting i evening meal requ RN-A indicated tha residents and offer opening cartons, p encouraging the re that she was busy outside of the dinin the dining room to needed assistance	30 a.m, nursing assistant viewed regarding meal time to assist residents with eating, NAR-D stated that when there it was tough to provide needed bom, but since one more aide ned to be enough to help out ing room. NAR-D added, "A ne dining room need to be fed, ngs do not go as smoothly." 40 a.m., nursing assistant viewed regarding staffing NAR-A stated now that they ad of just 5, things are running hly in the dining room. NAR-A ugh aides helping out in the meal times. NAR- A indicated idents diagnosis and it was very unpredictable idents unpredictable behaviors. :00 p.m. RN-A was interviewed hat all of residents who had n front of them during Monday ired staff to provide assist. t staff should interact with assistance with feeding, roviding alternatives and sidents to eat. RN-A added assisting the residents who ate ig room and did not supervise make sure every resident who		41			

If continuation sheet Page 6 of 17

STATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED
				NG		
	PROVIDER OR SUPPLIER	245255	B. WING	STREET ADDRESS, CITY, STATE, ZIP COE		/23/2014
		IHUMBOLDT				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 241	R130 the importance fluids and monitor. On 10/23/14, R109 03/05/13, was revie encourage good int containers, pour liq food, hand utensils throughout the mea On 10/23/14, R26's was reviewed and if with opening the co preferenced meal, a intake at meals. On 10/23/14, R24's was reviewed and if with opening contai with opening contai with opening contai with utensils/plates, meal consumption. On 10/23/14, R103' 07/07/14, was revie assist R103 by oper good food consump On 10/23/14, R17's was reviewed and if to consume good a fluid, encourage to and meal items and On 10/23/14, R21's was reviewed and if R21 to eat with silve food on the fork, su	e of consuming adequate s plan of care, dated wed and it directed staff to ake at meal time, open uids, offer preferred fluids and and encourage to eat and encourage good plan of care, dated 03/28/13, t directed staff to assist R24 ners, setting up meal, helping and to cue/encourage with s plan of care, dated wed and it directed staff to ning containers, encouraging otion, and serving preferences. plan of care, dated 05/05/14, t indicated to encourage R17 mount, offer assistance with self feed, offer preferred fluids d open containers. plan of care, dated 07/16/14, t directed staff to encourage erware, encourage putting pervise at each meal, e with meals, avoid dislikes	F 2	41		

		AND HUMAN SERVICES				FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245255	B. WING	i		10/	23/2014
NAME OF I	PROVIDER OR SUPPLIER	-	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER ON	N HUMBOLDT			512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 7	F2	241			
	was reviewed and i consumption of me	plan of care, dated 06/04/13, t indicated to encourage al, open containers, offer meals, and encourage good					
		olicy/procedure for fourth floor as requested from the director r was not provided.					
	observed on the 3rd pre-set with bevera and there were paper	D p.m. the dining service was d floor. Tables had been ges of milk, juice and water per meal tickets at each place t names and diet specifics					
	temperatures of the were passed aroun who chose to have leave and staff ask food to be served. If as the food was jus asked for the stuffe R30, "its coming" b plate for her. From asked for her meal that the meal is con staff placed a plate next to R30, where immediately grabbe eat in a hurried man p.m. and left the dir	v staff set up the meal and took e food. Clothing protectors d the dining room to residents one. At 4:17, R30 got up to ed R30 to stay to wait for the R30 left and returned at 4:25 at beginning to be served. R30 ed green pepper and staff told ut make no attempt to get a 4:31 p.m. until 4:38 p.m. R30 6 times with the same reply ning and to wait. At 4:38 p.m. of food at the place setting no one was sitting. R30 ed the plate of food, began to nner, finished the meal at 4:46 hing room. re plan directed staff to assure					
	R30 had positive ex	xperiences in daily routine anding tasks and without					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245255 B. WING 10/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 8 F 241 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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 11/24/14 PERSONS/PER CARE PLAN SS=E 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 bv: Based on observation, interview and document F282 review, the facility failed to provide services in **Department Directors and Management** accordance with the residents written plan of care staff have conducted comprehensive (POC) for 8 of 93 residents (R130, R109, R26, audits of meal service; please see attached example of meal service audit R24, R103, R17, R21, R82) who required assistance during dining. document. Management staff has consistently provided in-time training to Findings include: employees as indicated, to make certain the understanding of appropriate

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:02HR11

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PRINTED: 11/17/2014

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				_			
		245255	B. WING _			10/2	23/2014
	PROVIDER OR SUPPLIER	N HUMBOLDT		51	TREET ADDRESS, CITY, STATE, ZIP CODE 12 HUMBOLDT AVENUE AINT PAUL, MN 55107	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 282	During observation fourth floor during t from 4:00 p.m. thro (R130, R109, R26, were observed sea with meal trays in fineeded assistance On 10/23/14, R130 dated 8/13/14, was to encourage good R130 the important fluids and monitor. On 10/20/14 at 4:10 of the television, ear resident picked up and drank it. The s station; they were un no one was superv alerted the staff, an move away from R offered another gla On 10/23/14, R109 03/05/13, was revise encourage good infi containers, pour liq food, hand utensils throughout the mean On 10/20/14 from 4 assistance was pro- plate was on the ta	of resident dining room on he evening meal on 10/20/14 ugh 6:20 p.m., eight residents R24, R103, R17, R21, R82) ted in chairs at various tables ront and staff did not provide for meal consumption. 's nutritional plan of care, reviewed and it directed staff intake, pour liquids, remind ce of consuming adequate 0 p.m. R130 was sitting in front atting her meal, another R130's cranberry juice glass staff were at the nursing unaware of this situation and ising this area. Surveyor id staff assisted the resident to 130's table; however, no one ss of cranberry juice to R130. 's plan of care, dated ewed and it directed staff to take at meal time, open uids, offer preferred fluids and and encourage to eat al. 4:10 p.m. until 5:20 p.m. no vvided to R109 whose food ble in front of her in the dining rank juice from the glass and	F 2	82	procedures and approaches that co with facility policies and procedures These audits will occur at each me- service for a minimum of 60 days a be reviewed by our Quality Council Committee. Quality Council Comm will have oversight of newly implem protocols and audits to ensure residen facility is mission and core values. Council Committee will also ensure random audits will occur throughou year for continued compliance. Mandatory in-servicing conducted f dietary and nursing personnel, to ef- understanding of individualized dig dining experience for each resident in-servicing includes verbal, written hands-on interactive components; post-test completed to confirm emp comprehension of education provid Facility developed new schedule sp to meal time duties and location designation; management staff will their presence as indicated by sche This will ensure all residents that re- feeding assistance, encouragemen all care planned objectives are met their entirety. Education will continu- conducted through November 24, 2 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated	al ind will ittee ented dent aches t with Quality t the or all nsure hified t. This , and bloyee led. becific affirm edule. equire t and to le to be 2014	

Facility ID: 00538

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STATEMEN	F OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED
		245255	B. WING _			23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER O	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 282	was reviewed and with opening conta preferenced meal, intake at meals. On 10/20/14 from 4 sat in the dining roch him on the table and alternative meal or R26 left uneaten for On 10/21/14 at 10:- brunch meal untour dining room, Nursin R26 if he wanted se asked for a cookie obtained a high cal and a can of high p cookie, drank 75% ice-cream. At 11:1 ask R26 of his pref he generally eats. On 10/23/14, R24's was reviewed and 6 with opening conta with utensils/plates meal consumption. On 10/23/14, R103 07/07/14, was revie assist R103 by ope good food consumption.	 a plan of care, dated 01/30/13, directed staff to assist R26 iners, avoid dislikes, serve and cue/encourage good 4:20 p.m. until 6:20 p.m. R26 om with meal plate in front of d no one asked if he needed assisted him with his meal. od on the plate at 6:20 p.m. 45 a.m. observed R26 with ched in front of him in the ng Assistant (NAR)-F asked omething else to eat, R26 and ice cream. NAR-F orie cookie, an ice cream cup orotein shake. R26 ate the of the shake and ate bites of 0 a.m. NAR-F stated when we erences and offer him the food a plan of care, dated 03/28/13, directed staff to assist R24 iners, setting up meal, helping, and to cue/encourage with 	F 28	Council s recommendations; attached example of Resident Service Satisfaction Survey To Facility will also incorporate im training into annual Hand-In-Hand/dementia trainin includes but not limited to, nurs personnel being fed by other n personnel while wearing blindin glasses, ear plugs, etc.	Meal ol. mersion ig. This sing ursing	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245255	B. WING		10/23/2014		
	PROVIDER OR SUPPLIER	N HUMBOLDT	STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 282	and meal items and On 10/23/14, R21's was reviewed and i R21 to eat with silv food on the fork, su provided assistance and serve preferen On 10/20/14 from 4 observed R24, R10 They were served t nursing assistant (N NAR-B fed R24 con his chair closer to F while R24 just sat a started feeding the and R103 just sat food in-front of ther R17. This continue wheeled his chair fif fed few bites to one residents just sat a resident, R21 used mashed potatoes a 4:20 p.m. to 6:20 p provided to R21 du fourth floor. 10/21/14 at 10:50 a the dining room wit not eating. A staff R21's left hand and	self feed, offer preferred fluids d open containers. a plan of care, dated 07/16/14, t directed staff to encourage erware, encourage putting upervise at each meal, e with meals, avoid dislikes ces. 4:25 p.m. until 6:20 p.m. 03, R17 and R21 at table 6. their meals at 4:20 p.m. and NAR)-B started feeding R24. uple of bites and then wheeled R103 and fed her a few bites, and watched. NAR-B then third resident R17 while R24 there with their plates full of m and watched NAR-B feed ed until 5:20 p.m., NAR-B rom resident to resident and e resident while the other two nd watched. The fourth her fingers to dip into the and licked it repeatedly from .m. No assistance was ring the evening meal on	F 282	2			

Facility ID: 00538

If continuation sheet Page 12 of 17

		AND HUMAN SERVICES			FORM	: 11/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245255	B. WING _		10/	23/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	consumption of me preferred fluids and intake. On 10/20/14 from 4 was observed sittin the television next t meal tray was in fro a neck travel pillow p.m. the health unit approached R82, ru R82 to wake up and did not respond and she would come ba meal tray sat in-fror 5:15 p.m. (40 minut approached R82 ar pillow uncovering h eyes and saw the four uncovered R82's for offered or asked to feeding himself slow During interview, or family member (FM related to the lack of in the fourth floor di 4th floor dining roor evening meals to as dining, FM-D stated dining room do not need with eating, it room." FM-D expla trays in front of ther helping them, or ev their trays. The food	4:25 p.m. until 5:15 p.m. R82 g in his wheelchair in front of to the dining room. A covered ont of him on a table. R82 had covering his eyes. At 4:45 coordinator (HUC)-E ubbed R82's back and asked d eat his dinner. The resident d HUC-E walked away stating ack once R82 was awake. The nt of R82 from 4:25 p.m. until tes) and at 5:15 p.m. RN-A nd gently took away his neck is eyes. R82 opened up his pood tray in front of him. RN-A bod tray; however, no one heat up his meal. R82 started	F 28			

If continuation sheet Page 13 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY PLETED
		245255	B. WING	;		10/2	23/2014
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	Y CARE CENTER ON	HUMBOLDT			512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 13	F 2	282			
	(NAR)-D was interv who required assist	a.m. nursing assistant iewed regarding residents with eating, NAR-D reported ts in the dining room need to					
	(NAR)-A was intervi required assist with	0 a.m. Nursing Assistant lewed regarding residents who meals. NAR-A stated as diagnosis and behavioral unpredictable.					
F 441 SS=D	and stated that all o plates sat in front of evening meal need indicated the staff s residents and offeri opening cartons, pr encouraging the res	00 p.m. RN-A was interviewed f the residents whose food them during the Monday ed assist from staff. RN-A hould be interacting with ng assistance with feeding, oviding alternative meals and sidents to eat. CONTROL, PREVENT	F 4	441			11/24/14
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction.					
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr	tablish an Infection Control					

Facility ID: 00538

If continuation sheet Page 14 of 17

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION			
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	IPLETED	
		245255	B. WING _			23/2014	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE		
CERENI	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 441	Continued From pa (3) Maintains a reco actions related to in	ord of incidents and corrective	F 44	1			
	determines that a reprevent the spread isolate the resident (2) The facility mus communicable dise from direct contact direct contact will tr (3) The facility mus hands after each di hand washing is ind professional practic (c) Linens Personnel must have	tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ease or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					
	by: Based on observat facility failed to imp practices related to for 1 of 3 residents of daily living. Findings include: On 10/22/2014, 8:3	NT is not met as evidenced tion and document review, the lement infection control hand washing during cares (R98) observed for activities		F441 Facility conducted mandator personnel in-servicing of har policy and procedure. This ti completed by November 24, Competencies will be obtain appropriate hand washing te Infection Control Nurse will o conduct comprehensive infe audits throughout the year to	nd washing raining will be 2014. ed to ensure echniques. continue to ction control		

Facility ID: 00538

If continuation sheet Page 15 of 17

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245255	B. WING		10/2	23/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
CERENI	Y CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	COMPLETION DATE
F 441	Continued From pa	ge 15	F 441			
	pair of gloves over to stand holding the of a bowel moveme NA-A took off both hands before donni continued with care donning top, pulling product. NA-A then garbage, removed sanitizer before dor brush her teeth. Af NA-A removed glow A hand washing po staff that hand was that is consistent w	the first pair and helped R97 e grab bar as he cleaned R98 ent (BM). After cleaning R98, gloves and did not wash ng new gloves. NA-A is of brushing R98's hair, i up pants and incontinent wrapped up the soiled gloves and used hand ning new gloves to help R98 ter all cares were completed res and washed hands. hicy, dated 12/2013, directed hing is to be done in a method ith federal, state and local		Quality Council.		
F 458 SS=B	staff must wash/sau facilities or any time 483.70(d)(1)(ii) BEI LEAST 80 SQ FT/F Bedrooms must me per resident in mult least 100 square fe	easure at least 80 square feet iple resident bedrooms, and at et in single resident rooms.	F 458	Annual Room size waiver req	uest	11/24/14
	by: Based on observat failed to provide at resident in multiple double resident roo	NT is not met as evidenced tion, and interview, the facility least 80 square feet per resident bedrooms for five ms (221, 222, 223, 226, 326) nts of 107 residents who y.		F458 Variance on file		

Facility ID: 00538

If continuation sheet Page 16 of 17

		AND HUMAN SERVICES				FORM	: 11/17/2014 APPROVED : 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245255	B. WING			10/	23/2014
NAME OF I	PROVIDER OR SUPPLIER	•			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	TY CARE CENTER ON	N HUMBOLDT			12 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROV DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 458	observed to be app instead of the requi occupancy in room When interviewed of administrator and E was in place since occupancy in the 19 versus the regulation occupancy rooms. Resident's residing	age 16 coupancy square footage was proximately 155 square feet ired 160 square feet for double s 221, 222, 223, 226 and 326. on 10/23/14, at 10:31 a.m. the DON acknowledged a waiver July 2001, allowing double 55 square foot double rooms on of 160 square feet in double in those rooms did not offer ng the size of their rooms.	F	458			

Facility ID: 00538

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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 <u>ted.schmidt@bhshealth.org</u>.

Sincerely,

Tel A. Gchmidt

Ted Schmidt Administrator/CEO Cerenity Care Center on Humboldt

Cc: Susanne Reuss, Minnesota Department of Health

Cerenity Senior Care -Humboldt Cerenity Senior Care -Marian of Saint Paul Cerenity Senior Care -White Bear Lake



	MENT OF HEALTH			1	5255023	FORM	10/27/2014 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SI COMPLE	JRVEY
		245255		B. WING _		10/2	1/2014
	ROVIDER OR SUPPLIER	ON HUMBOLDT	512 HU	RESS, CITY, S MBOLDT PAUL, MN			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	(EACH DEFICIENCY MUST			PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
	FIRE SAFETY						
	- 191						
	Minnesota Departm time of this survey, Humboldt was foun compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National F	Survey was conduct ent of Public Safety. Cerenity Care Center d to be in substantia requirements for pa id at 42 CFR, Subpa ety from Fire, and the Fire Protection Assoc D1, Life Safety Code Health Care.	At the er on al articipation art 2000 siation				
	building with a no ba constructed at 2 diff building was constru- determined to be of 1970, an addition w side of the building Type II(222) constru- building and the add	er Humboldt is a 4-s asement. The buildir ferent times. The orig ucted in 1960 and wa Type II(222) constru- as constructed to the that was determined uction Because the dition meet the const sting buildings, the fa- ilding.	ng was ginal as iction. In e South to be of original ruction				
	The facility has a co smoke detection in closets and spaces monitored for autom notification. The fac	ally fire sprinkler pro omplete fire alarm sy the corridors,residen open to the corridor, natic fire department ility has a licensed c a census of 110 at the	stem with t rooms, that is apacity of				
		42 CFR Subpart 483					(Ye) DATE
LABORATOR	RY DIRECTOR'S OR PROVI	UER/SUPPLIER REPRESE	NIAI IVE'S SIGN	NATURE	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.

DEPART	MENT OF HEALTH	AND HUMAN SERV	ICES	8		FORM	10/27/2014 APPROVED 0.0938-0391
STATEMEN	S FOR MEDICARE	(X1) PROVIDER/SUPPLIE	R/CLIA		PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE S COMPLI	URVEY
		245255		B. WING		10/2	1/2014
	ROVIDER OR SUPPLIER	ON HUMBOLDT	512 HU	RESS, CITY, S IMBOLDT PAUL, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI BE PRECEDED BY FULL NTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	Continued From par met.	age 1		K 000			
	7						



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 <u>only a suggestion</u> 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,

Ane Klasse

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

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		ON	<u>ИВ NO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		245255	B. WING		10/:	23/2014
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENII	Y CARE CENTER ON			512 HUMBOLDT AVENUE		
				SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 00	ס		
F 241 SS=E	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the form. Your electron be used as verificant Upon receipt of an a on-site revisit of your validate that substat regulations has beet your verification. A complaint investig H5255037 at the tim recertification surver 483.15(a) DIGNITY INDIVIDUALITY The facility must pro- manner and in an e enhances each res full recognition of his This REQUIREMEN by: Based on observant review, the facility fa dining for 11 of 93 r	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with gation was completed for ne of the standard ey and was unsubstantiated. AND RESPECT OF omote care for residents in a invironment that maintains or ident's dignity and respect in is or her individuality. NT is not met as evidenced tion, interview, and document ailed to ensure dignity during esidents (R50,130, R109, 17, R21, R82, R30, R95)	F 24	F000 This credible Allegation of Complian has been prepared and submitted ti Submission of this Credible Allegatio Compliance is not a legal admission deficiency exists or that the Statement	imely. on of n that a	11/24/14
	Findings include:			Deficiencies were correctly cited, an also not to be construed as an adm		
		ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE		(X6) DATE
	ically Signed			···· ==		11/14/2014

Electronically Signed

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.

PRINTED: 11/17/2014

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	MB NO. 0938-03 (X3) DATE SURVEY COMPLETED
	O CORRECTION	DENTIFICATION NUMBER.	A. BUILDING	3	
		245255			10/23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
CERENI	TY CARE CENTER ON	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIO
F 241	Continued From pa	ae 1	F 24′	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.			 against interest of the Facility, its Administrator or any employees, a other individuals who draft or may discussed in this Credible Allegatic Compliance. In addition, preparatic submission of this Credible Allegat Compliance does not constitute ar admission or agreement of any kin Facility of the truth of any facts alle the correctness of any conclusions forth in this allegation by the surve agency. Accordingly, we are submitting this Credible Allegation of Compliance because state and federal law man submission of a Credible Allegation Compliance within ten (10) days of of the Statement of deficiencies as condition to participate in the Medi and Medical Assistance programs. submission of the Credible Allegation 	be on of on and ion of id by eged or s set y solely ndate n of receipt s a care The
	(FM)-D verbalized of supervision and as- dining room. FM-D room frequently du assist a family men "Several residents receive the help that very chaotic, in the explained, "Staff put them and then walk or even showing th food on the residen doesn't even ask to want to eat cold foot	D p.m. a family member concerns related to the lack of sistance in the fourth floor o visited the 4th floor dining ring the evening meals to her with dining, FM-D stated, in this dining room do not at they need with eating, it is dining room." FM-D at the residents trays in front of c away without helping them, em what is on their trays. The test trays get cold and the staff o reheat their food. Who would od?" FM-D went on to say that ng" to see this. When asked if		Compliance within this time frame in no way be considered or constru- agreement with the allegations of non-compliance or admissions by facility. F241 Department Directors and Manage staff have conducted comprehensi- audits of meal service; please see attached example of meal service document. Management staff has consistently provided in-time training employees as indicated, to make of the understanding of appropriate	should ued as the ement ve audit ng to

Facility ID: 00538

If continuation sheet Page 2 of 17
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	E CONSTRUCTION	(X3) DATE	0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG _		COMF	PLETED
		245255	B. WING _			10/2	23/2014
NAME OF	PROVIDER OR SUPPLIER	•		ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER O	N HUMBOLDT		-	2 HUMBOLDT AVENUE AINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 241	Continued From pa	age 2	F 24	41			
		FM-D said that the nurses see			with facility policies and procedures	5.	
	this all the time, an	d also the management was			These audits will occur at each mea	al	
aware but nothing is done to improve it. FM-D shared that some of the residents cannot feed				service for a minimum of 60 days a			
					be reviewed by our Quality Council		
		lied on staff to help them eat. f some of the staff didn't realize			Committee. Quality Council Commi will have oversight of newly implem		
		too busy to sit down with the			protocols and audits to ensure resid		
	folks and help then	n eat. FM-D stated, "how hard			needs, dignity and care plan approa		
		I-D continued to share the			are followed in a manner consisten		
		observing helpless folks not			facility s mission and core values.		
		Ip with their meals, and added on fourth floor is, "not smooth			Council Committee will also ensure random audits will occur throughou		
		at all." When asked if there			year for continued compliance.	t the	
	were enough staff	members present in the dining					
		dents with their meals, FM-D			Mandatory in-servicing conducted f		
		ared there was enough staff stand around" in the dining			dietary and nursing personnel, to en understanding of individualized digr		
		em to notice who needs help.			dining experience for each resident		
					in-servicing includes verbal, written		
	During observation	of resident dining room on			hands-on interactive components;		
		the evening meal on 10/20/14			post-test completed to confirm emp		
		ough 6:20 p.m. eight residents R24, R103, R17, R21, R82)			comprehension of education provid	led.	
		Ited in the chairs at various			Facility developed new schedule sp	ecific	
	tables with their me	eal trays in front of them and			to meal time duties and location		
	staff did not provide	e needed assistance for meal			designation; management staff will		
		lid not provide a positive,			their presence as indicated by sche		
	dignified dining exp	berience.			This will ensure all residents that re feeding assistance, encouragemen		
					all care planned objectives are met		
	On 10/20/14 at 4:1	0 p.m. R130 was sitting in front			their entirety. Education will continu		
	of the television, ea	ating her meal, another			conducted through November 24, 2	2014	
		R130's cranberry juice glass			and will be mandatory prior to staff		
		at the nursing station were uation as no one was			working on any unit.		
		ea. Surveyor alerted the staff,			Resident Meal Service Satisfaction		
		he resident to move away from			surveys will be conducted as indica		
	R130's table; howe	ever, no one offered another			based on level of satisfaction and C	Quality	
	glass of cranberry	ining to D100		1	Council s recommendations; pleas	0000	

Facility ID: 00538

If continuation sheet Page 3 of 17

	OF DEFICIENCIES	& MEDICAID SERVICES		IPLE CONSTRUCTION). 0938-039 TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245255	B. WING _			/23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
CERENI	TY CARE CENTER ON	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 241	Continued From pa	ige 3	F 24	41		
		0 p.m., 5 staff started serving		attached example of Reside Service Satisfaction Survey		
	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		Facility will also incorporate training into annual Hand-In-Hand/dementia trai includes but not limited to, n	ning. This		
	assistance was pro plate was on the tal	vided to R109 whose food ble in front of her in the dining ank her juice from the glass		personnel being fed by othe personnel while wearing blir glasses, ear plugs, etc.	r nursing	
	sat in the dining roc of him on the table needed alternative	4:20 p.m. until 6:20 p.m. R26 om with his meal plate in front and no one asked if he meal nor assisted him with his uneaten food on his plate in 6:20 p.m.				
obs The p.m feed and fed wat resi plat	observed R24, R10 The residents were p.m. and nursing as feeding R24. NAR- and than wheeled h fed R103 a few bite watched. NAR-B th resident R17 while plates full of food in	4:25 p.m. until 6:20 p.m. 93, R17 and R21 at table 6. 9 served their meals at 4:20 9 sistant (NAR)-B started 9 fed R24 a couple of bites 10 nis chair closer to R103 and 10 es, while R24 just sat and 10 nen started feeding the third R24 and R103 sat with their 10-front of them and watched This continued until 5:20 p.m.,				
	NAR-B wheeled his resident and fed a f the other two reside fourth resident, R2 ² her mashed potatoo from 4:20 p.m. to 6	s chair from resident to few bites to one resident while ents just sat and watched. The 1 used her fingers to dip into es and licked it repeatedly :20 p.m. No assistance was ring the evening meal on				

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		AND HUMAN SERVICES			FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245255	B. WING		10/:	23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENI	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 4	F 241			
	was observed sittin the television next to covered meal tray w R82 had a neck tra At 4:45 p.m. the her approached R82, ru R82 to wake up and did not respond and she would come ba meal tray sat in-from 5:15 p.m. (40 minut approached R82 ar pillow uncovering h eyes and saw his for uncovered R82's for offered or asked to feeding himself slow On 10/21/14 at 10:4 brunch meal untour dining room. Nursin R26 if he wanted so asked for a cookie a obtained a high cale and a can of high p cookie, drank 75% the ice-cream. At when R26 is asked generally eats. 10/21/14 at 10:50 at the dining room with not eating. A staff y into R21's left hand herself one bite after	4:25 p.m. until 5:15 p.m. R82 g in his wheelchair in front of to the dining room and his was in front of him on a table. vel pillow covering his eyes. alth unit coordinator (HUC)-E ubbed R82's back and asked d eat his dinner. The resident d HUC-E walked away stating ack once R82 was awake. The nt of R82 from 4:25 p.m. until tes) and at 5:15 p.m. RN-A nd gently took away his neck is eyes, R82 opened up his bod tray in front of him. RN-A bod tray; however, no one heat up his meal. R82 started wiy. 45 a.m. observed R26 with his ched in front of him in the ng Assistant (NAR)-F asked omething else to eat, R26 and ice cream. NAR-F orie cookie, an ice cream cup rotein shake. R26 ate the of the shake and ate bites of 11:10 a.m. NAR-F stated that about food preferences R26				

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION		E SURVEY	
		245255		-		10	23/2014	
NAME OF	PROVIDER OR SUPPLIER	_ 10_00			TREET ADDRESS, CITY, STATE, ZIP CODE	10/	23/2014	
CERENI	TY CARE CENTER ON	I HUMBOLDT		-	12 HUMBOLDT AVENUE SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIC DATE	
F 241	(NAR)-D was interv and help available t in the dining room. were only 5 aides i help in the dining ro was added, it seem everyone in the dini lot of residents in th and sometimes thin On 10/21/14 at 11:4 (NAR)-A was interv during meal times. have 6 aides instea much more smooth felt there were enou dining room during because of the resi behavioral issues, i because of the resi behavioral issues, i because of the resi con 10/21/14, at 12: and RN-A stated that food plates sitting in evening meal requi RN-A indicated that residents and offer opening cartons, pr encouraging the resi that she was busy a outside of the dining the dining room to r needed assistance	30 a.m, nursing assistant iewed regarding meal time o assist residents with eating, NAR-D stated that when there t was tough to provide needed oom, but since one more aide ed to be enough to help out ing room. NAR-D added, "A he dining room need to be fed, ngs do not go as smoothly." 40 a.m., nursing assistant iewed regarding staffing NAR-A stated now that they d of just 5, things are running ly in the dining room. NAR-A ugh aides helping out in the meal times. NAR- A indicated dents diagnosis and t was very unpredictable dents unpredictable behaviors. 00 p.m. RN-A was interviewed at all of residents who had n front of them during Monday red staff to provide assist. c staff should interact with assistance with feeding, oviding alternatives and sidents to eat. RN-A added assisting the residents who ate g room and did not supervise make sure every resident who was helped.	F2	241				
	dated 8/13/14, was	's nutritional plan of care, reviewed and it directed staff intake, pour liquids, remind						

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STATEMEN	F OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED	
				NG			
	PROVIDER OR SUPPLIER	245255	B. WING	STREET ADDRESS, CITY, STATE, ZIP COE		/23/2014	
		IHUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE	
F 241	R130 the importance fluids and monitor. On 10/23/14, R109 03/05/13, was revie encourage good int containers, pour liq food, hand utensils throughout the mea On 10/23/14, R26's was reviewed and if with opening the co preferenced meal, a intake at meals. On 10/23/14, R24's was reviewed and if with opening contai with opening contai with opening contai with utensils/plates, meal consumption. On 10/23/14, R103' 07/07/14, was revie assist R103 by oper good food consump On 10/23/14, R17's was reviewed and if to consume good a fluid, encourage to and meal items and On 10/23/14, R21's was reviewed and if R21 to eat with silve food on the fork, su	e of consuming adequate s plan of care, dated wed and it directed staff to ake at meal time, open uids, offer preferred fluids and and encourage to eat and encourage good plan of care, dated 03/28/13, t directed staff to assist R24 ners, setting up meal, helping and to cue/encourage with s plan of care, dated wed and it directed staff to ning containers, encouraging otion, and serving preferences. plan of care, dated 05/05/14, t indicated to encourage R17 mount, offer assistance with self feed, offer preferred fluids d open containers. plan of care, dated 07/16/14, t directed staff to encourage erware, encourage putting pervise at each meal, e with meals, avoid dislikes	F 2	41			

		AND HUMAN SERVICES				FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245255	B. WING	i		10/	23/2014
NAME OF I	PROVIDER OR SUPPLIER	-	-	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER ON	N HUMBOLDT			512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 241	Continued From pa	ige 7	F2	241			
	was reviewed and i consumption of me	plan of care, dated 06/04/13, t indicated to encourage al, open containers, offer meals, and encourage good					
		olicy/procedure for fourth floor as requested from the director r was not provided.					
	observed on the 3rd pre-set with bevera and there were paper	D p.m. the dining service was d floor. Tables had been ges of milk, juice and water per meal tickets at each place t names and diet specifics					
	temperatures of the were passed aroun who chose to have leave and staff ask food to be served. If as the food was jus asked for the stuffe R30, "its coming" b plate for her. From asked for her meal that the meal is con staff placed a plate next to R30, where immediately grabbe eat in a hurried man p.m. and left the dir	v staff set up the meal and took e food. Clothing protectors d the dining room to residents one. At 4:17, R30 got up to ed R30 to stay to wait for the R30 left and returned at 4:25 at beginning to be served. R30 ed green pepper and staff told ut make no attempt to get a 4:31 p.m. until 4:38 p.m. R30 6 times with the same reply ning and to wait. At 4:38 p.m. of food at the place setting no one was sitting. R30 ed the plate of food, began to nner, finished the meal at 4:46 hing room. re plan directed staff to assure					
	R30 had positive ex	xperiences in daily routine anding tasks and without					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 245255 B. WING 10/23/2014 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **512 HUMBOLDT AVENUE CERENITY CARE CENTER ON HUMBOLDT** SAINT PAUL, MN 55107 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PRÉFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 241 Continued From page 8 F 241 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 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED F 282 11/24/14 PERSONS/PER CARE PLAN SS=E 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 bv: Based on observation, interview and document F282 review, the facility failed to provide services in **Department Directors and Management** accordance with the residents written plan of care staff have conducted comprehensive (POC) for 8 of 93 residents (R130, R109, R26, audits of meal service; please see attached example of meal service audit R24, R103, R17, R21, R82) who required assistance during dining. document. Management staff has consistently provided in-time training to Findings include: employees as indicated, to make certain the understanding of appropriate

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:02HR11

Facility ID: 00538

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PRINTED: 11/17/2014

TATEMEN	OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	0938-039 SURVEY PLETED
				_			
		245255	B. WING _			10/2	23/2014
	PROVIDER OR SUPPLIER	N HUMBOLDT	STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIC DATE
F 282	During observation fourth floor during t from 4:00 p.m. thro (R130, R109, R26, were observed sea with meal trays in fineeded assistance On 10/23/14, R130 dated 8/13/14, was to encourage good R130 the important fluids and monitor. On 10/20/14 at 4:10 of the television, ear resident picked up and drank it. The s station; they were un no one was superv alerted the staff, an move away from R offered another gla On 10/23/14, R109 03/05/13, was revise encourage good infi containers, pour liq food, hand utensils throughout the mean On 10/20/14 from 4 assistance was pro- plate was on the ta	of resident dining room on he evening meal on 10/20/14 ugh 6:20 p.m., eight residents R24, R103, R17, R21, R82) ted in chairs at various tables ront and staff did not provide for meal consumption. 's nutritional plan of care, reviewed and it directed staff intake, pour liquids, remind ce of consuming adequate 0 p.m. R130 was sitting in front atting her meal, another R130's cranberry juice glass staff were at the nursing unaware of this situation and ising this area. Surveyor id staff assisted the resident to 130's table; however, no one ss of cranberry juice to R130. 's plan of care, dated ewed and it directed staff to take at meal time, open uids, offer preferred fluids and and encourage to eat al. 4:10 p.m. until 5:20 p.m. no vvided to R109 whose food ble in front of her in the dining rank juice from the glass and	F 2	82	procedures and approaches that co with facility policies and procedures These audits will occur at each me- service for a minimum of 60 days a be reviewed by our Quality Council Committee. Quality Council Comm will have oversight of newly implem protocols and audits to ensure residen facility is mission and core values. Council Committee will also ensure random audits will occur throughou year for continued compliance. Mandatory in-servicing conducted f dietary and nursing personnel, to ef- understanding of individualized dig dining experience for each resident in-servicing includes verbal, written hands-on interactive components; post-test completed to confirm emp comprehension of education provid Facility developed new schedule sp to meal time duties and location designation; management staff will their presence as indicated by sche This will ensure all residents that re- feeding assistance, encouragemen all care planned objectives are met their entirety. Education will continu- conducted through November 24, 2 and will be mandatory prior to staff working on any unit. Resident Meal Service Satisfaction surveys will be conducted as indicated	al ind will ittee ented dent aches t with Quality t the or all nsure hified t. This , and bloyee led. becific affirm edule. equire t and to le to be 2014	

Facility ID: 00538

If continuation sheet Page 10 of 17

STATEMEN	F OF DEFICIENCIES	KMEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · ·	E SURVEY
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	IPLETED
		245255	B. WING _			23/2014
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENI	TY CARE CENTER O	N HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 282	was reviewed and with opening conta preferenced meal, intake at meals. On 10/20/14 from 4 sat in the dining roc him on the table and alternative meal or R26 left uneaten for On 10/21/14 at 10:- brunch meal untour dining room, Nursin R26 if he wanted se asked for a cookie obtained a high cal and a can of high p cookie, drank 75% ice-cream. At 11:1 ask R26 of his pref he generally eats. On 10/23/14, R24's was reviewed and 6 with opening conta with utensils/plates meal consumption. On 10/23/14, R103 07/07/14, was revie assist R103 by ope good food consumption.	 a plan of care, dated 01/30/13, directed staff to assist R26 iners, avoid dislikes, serve and cue/encourage good 4:20 p.m. until 6:20 p.m. R26 om with meal plate in front of d no one asked if he needed assisted him with his meal. od on the plate at 6:20 p.m. 45 a.m. observed R26 with ched in front of him in the ng Assistant (NAR)-F asked omething else to eat, R26 and ice cream. NAR-F orie cookie, an ice cream cup orotein shake. R26 ate the of the shake and ate bites of 0 a.m. NAR-F stated when we erences and offer him the food a plan of care, dated 03/28/13, directed staff to assist R24 iners, setting up meal, helping, and to cue/encourage with 	F 28	Council s recommendations; attached example of Resident Service Satisfaction Survey To Facility will also incorporate im training into annual Hand-In-Hand/dementia trainin includes but not limited to, nurs personnel being fed by other n personnel while wearing blindin glasses, ear plugs, etc.	Meal ol. mersion ig. This sing ursing	

If continuation sheet Page 11 of 17

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	0. 0938-039 TE SURVEY MPLETED	
		245255	B. WING		10	/23/2014	
	PROVIDER OR SUPPLIER	N HUMBOLDT	STREET ADDRESS, CITY, STATE, ZIP CODE 512 HUMBOLDT AVENUE SAINT PAUL, MN 55107				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 282	and meal items and On 10/23/14, R21's was reviewed and i R21 to eat with silv food on the fork, su provided assistance and serve preferen On 10/20/14 from 4 observed R24, R10 They were served t nursing assistant (N NAR-B fed R24 con his chair closer to F while R24 just sat a started feeding the and R103 just sat food in-front of ther R17. This continue wheeled his chair fif fed few bites to one residents just sat a resident, R21 used mashed potatoes a 4:20 p.m. to 6:20 p provided to R21 du fourth floor. 10/21/14 at 10:50 a the dining room wit not eating. A staff R21's left hand and	self feed, offer preferred fluids d open containers. a plan of care, dated 07/16/14, t directed staff to encourage erware, encourage putting upervise at each meal, e with meals, avoid dislikes ces. 4:25 p.m. until 6:20 p.m. 03, R17 and R21 at table 6. their meals at 4:20 p.m. and NAR)-B started feeding R24. uple of bites and then wheeled R103 and fed her a few bites, and watched. NAR-B then third resident R17 while R24 there with their plates full of m and watched NAR-B feed ed until 5:20 p.m., NAR-B rom resident to resident and e resident while the other two nd watched. The fourth her fingers to dip into the and licked it repeatedly from .m. No assistance was ring the evening meal on	F 282	2			

Facility ID: 00538

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		AND HUMAN SERVICES			FORM	: 11/17/2014 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245255	B. WING _		10/	23/2014
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
CERENIT	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 282	consumption of me preferred fluids and intake. On 10/20/14 from 4 was observed sittin the television next t meal tray was in fro a neck travel pillow p.m. the health unit approached R82, ru R82 to wake up and did not respond and she would come ba meal tray sat in-fror 5:15 p.m. (40 minut approached R82 ar pillow uncovering h eyes and saw the four uncovered R82's for offered or asked to feeding himself slow During interview, or family member (FM related to the lack of in the fourth floor di 4th floor dining roor evening meals to as dining, FM-D stated dining room do not need with eating, it room." FM-D expla trays in front of ther helping them, or ev their trays. The food	4:25 p.m. until 5:15 p.m. R82 g in his wheelchair in front of to the dining room. A covered ont of him on a table. R82 had covering his eyes. At 4:45 coordinator (HUC)-E ubbed R82's back and asked d eat his dinner. The resident d HUC-E walked away stating ack once R82 was awake. The nt of R82 from 4:25 p.m. until tes) and at 5:15 p.m. RN-A nd gently took away his neck is eyes. R82 opened up his pood tray in front of him. RN-A bod tray; however, no one heat up his meal. R82 started	F 28			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	11/17/2014 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DAT	E SURVEY PLETED
		245255	B. WING	;		10/2	23/2014
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
CERENIT	Y CARE CENTER ON	HUMBOLDT			512 HUMBOLDT AVENUE SAINT PAUL, MN 55107		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 13	F 2	282			
	(NAR)-D was interv who required assist	a.m. nursing assistant iewed regarding residents with eating, NAR-D reported ts in the dining room need to					
	(NAR)-A was intervi required assist with	0 a.m. Nursing Assistant lewed regarding residents who meals. NAR-A stated as diagnosis and behavioral unpredictable.					
F 441 SS=D	and stated that all o plates sat in front of evening meal need indicated the staff s residents and offeri opening cartons, pr encouraging the res	00 p.m. RN-A was interviewed f the residents whose food them during the Monday ed assist from staff. RN-A hould be interacting with ng assistance with feeding, oviding alternative meals and sidents to eat. CONTROL, PREVENT	F 4	441			11/24/14
	Infection Control Pr safe, sanitary and c	tablish and maintain an ogram designed to provide a omfortable environment and development and transmission ction.					
	Program under whit (1) Investigates, con in the facility; (2) Decides what pr	tablish an Infection Control					

Facility ID: 00538

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION		<u>. 0938-039</u> E SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED	
		245255	B. WING		10/	23/2014	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	P CODE		
CERENI	TY CARE CENTER ON	I HUMBOLDT		512 HUMBOLDT AVENUE SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTIV PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)		ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE	
F 441	Continued From pa	ge 14	F4	41			
		ord of incidents and corrective					
	determines that a re prevent the spread isolate the resident. (2) The facility must communicable dise from direct contact direct contact will tr (3) The facility must hands after each di hand washing is inc professional practic (c) Linens Personnel must har	ion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. t require staff to wash their rect resident contact for which dicated by accepted					
	by: Based on observat facility failed to impl practices related to	NT is not met as evidenced ion and document review, the lement infection control hand washing during cares (R98) observed for activities		F441 Facility conducted manda personnel in-servicing of policy and procedure. Th completed by November Competencies will be obt appropriate hand washin	hand washing is training will be 24, 2014. tained to ensure		
	receive morning ca wheeled R98 to the transfer belt NA-A h	39 a.m. R98 was observed to res. NA-A donned gloves, bathroom and using a helped R98 to sit on the toilet r torso. NA-a donned another		Infection Control Nurse w conduct comprehensive audits throughout the yea affective infection preven These audits will be revie	infection control ar to ensure tion practices.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCUA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A BUILDING (X3) DATE SUMP A BUILDING NAME OF CORRECTION 245255 B. WING 10/23/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITV, STATE, ZIP CODE S12 HUMBOLDT AVENUE SAINT PAUL, MN 55107 10/23/20 CERENTY CARE CENTER ON HUMBOLDT SIMMARY STATEMENT OF DEFICIENCES INCLOSE OF DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDER'S PLAN OF CORRECTION (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY 000000000000000000000000000000000000	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 093										
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2IP CODE CERENITY CARE CENTER ON HUMBOLDT STREET ADDRESS, CITY, STATE, 2IP CODE (X4, ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OP PREFIX 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. IN-A-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 washed hands. F 441 Quality Council. 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 abclub decome soiled. F 458 11/24 F 458 EAST 80 SQ FT/RESIDENT F 458 11/24 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. F 458 This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility F458	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X2)			(X3) DATE SURVEY COMPLETED				
CERENITY CARE CENTER ON HUMBOLDT 512 HUMBOLDT AVENUE SAINT PAUL, M 55107 (X4) ID 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 HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) OC PREFIX TAG 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 tech. After all cares were completed NA-A removed gloves and used hands. F 458 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 458 F 458 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. F 458 This REQUIREMENT is not met as evidenced by: Based on observation, and interview, the facility F458	245255		B. WING		10/23/2014						
SAINT PAUL, MN 55107 (W10) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WIST 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) COMP COMPACE (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PREFIX (EACH DEFICIENCY) COMPACE (EACH CORRECTIVE ACTION BOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Could be cross-REFERENCED TO THE APPROPRIATE DEFICIENCY Could be cros	NAME OF F	PROVIDER OR SUPPLIER									
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH DEFICIENCY) COMPARING COMPARING Construct and comparing the precedence of the preced	CERENIT	Y CARE CENTER ON	I HUMBOLDT								
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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	pair of gloves over to stand holding the of a bowel moveme NA-A took off both hands before donni continued with care donning top, pulling product. NA-A then garbage, removed g sanitizer before dor brush her teeth. Af NA-A removed glov A hand washing pol staff that hand wash that is consistent w regulations and coo staff must wash/sar facilities or any time 483.70(d)(1)(ii) BEI LEAST 80 SQ FT/F Bedrooms must me per resident in mult least 100 square fe This REQUIREMEN by: Based on observat failed to provide at resident in multiple double resident roo affecting ten reside resided in the facilit	the first pair and helped R97 e grab bar as he cleaned R98 ent (BM). After cleaning R98, gloves and did not wash ing new gloves. NA-A es of brushing R98's hair, g up pants and incontinent wrapped up the soiled gloves and used hand nning new gloves to help R98 ter all cares were completed ves and washed hands. licy, dated 12/2013, directed hing is to be done in a method ith federal, state and local des. The policy indicated that nitize hands after using toilet e hands should become soiled. DROOMS MEASURE AT RESIDENT easure at least 80 square feet tiple resident bedrooms, and at tet in single resident rooms. NT is not met as evidenced tion, and interview, the facility least 80 square feet per resident bedrooms for five oms (221, 222, 223, 226, 326) nts of 107 residents who		Quality Council.		11/24/14				

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		AND HUMAN SERVICES				FORM	11/17/2014 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245255	B. WING			10/	23/2014	
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
CERENI	TY CARE CENTER ON	N HUMBOLDT			512 HUMBOLDT AVENUE SAINT PAUL, MN 55107			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 458	observed to be app instead of the requi occupancy in room When interviewed of administrator and D was in place since occupancy in the 19 versus the regulation occupancy rooms. Resident's residing	age 16 coupancy square footage was proximately 155 square feet red 160 square feet for double s 221, 222, 223, 226 and 326. on 10/23/14, at 10:31 a.m. the DON acknowledged a waiver July 2001, allowing double 55 square foot double rooms on of 160 square feet in double in those rooms did not offer ng the size of their rooms.	F	458				

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