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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XNG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00538

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245255**

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

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

4. TYPE OF ACTION: **7** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/10/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **125** (L18)

13.Total Certified Beds **125** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 05/11/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 06/07/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Uploaded 06/07/12 DB

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/20/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN # 24-5255

At the time of the standard survey completed March 8, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections are required. The facility was given an opportunity to correct before remedies were imposed.

On April 23, 2012, the Minnesota Department of Health and, on May 10, 2012, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) by review of the plan of correction and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on March 8, 2012, effective April 17, 2012. Therefore, the remedies outlined in our letter dated May 11, 2012, will not be imposed. See attached CMS-2567B forms for the results of the April 23, 2012 revisit and May 10, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5255 June 7, 2012

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 April 17, 2012 the above facility is certified for:

125 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 125 skilled nursing facility beds.

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.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 11, 2012

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

RE: Project Number S5255021

Dear Mr. Schmidt:

On March 22, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 8, 2012. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 23, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 10, 2012 the Minnesota Department of Public Safety completed a 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 March 8, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 17, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 8, 2012, effective April 17, 2012 and therefore remedies outlined in our letter to you dated March 22, 2012, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5255r112.rtf

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245255	A. Building B. Wing	4/23/2012

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	(Y5) Date
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(t** LSC	Correction Completed **04/17/2012**	ID Prefix **F0176** Reg. # **483.10(n)** LSC	Correction Completed **04/17/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/17/2012**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/17/2012**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **04/17/2012**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **04/17/2012**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/17/2012**	ID Prefix **F0458** Reg. # **483.70(d)(1)(ii)** LSC	Correction Completed **04/17/2012**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/sd	05/11/12	16022	04/23/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
3/8/2012			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245255	A. Building B. Wing 01 - MAIN BUILDING 01	5/10/2012

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

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0050	04/17/2012	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/sd	05/11/12	12424	05/10/12
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
3/8/2012	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5XNG

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00538

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245255**

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/08/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

12.Total Facility Beds **125** (L18)

13.Total Certified Beds **125** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	125			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the standard survey completed on March 8, 2012, the facility was not in substantial compliance and the most serious deficiencies were widespread deficiencies that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F) whereby corrections are required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Robyn Woolley, HFE NE II 04/09/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Susan N. Leppke, Program Specialist 04/18/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS
Posted 4/20/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 1060 0002 3051 4143

March 22, 2012

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

RE: Project Number S5255021

Dear Mr. Schmidt:

On March 8, 2012, 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.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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>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;

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

Informal Dispute Resolution - 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:

Suzanne Reuss
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

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 April 17, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 17, 2012 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

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

- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 June 8, 2012 (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 September 8, 2012 (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 a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Suzanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5255S12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	03/08/2012

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY'S PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPIANCE. UPON RECEIPT OF AN ACCEPTABLE POC AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANIAL COMPLAINCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATON.	F 000	**F000** This credible Allegation of Compliance has been prepared and submitted timely. Submission of this Credible Allegation of Compliance is not a legal admission that a deficiency exists or that the Statement of Deficiencies were correctly cited, and is also not to be construed as an admission against interest of the Facility, its Administrator or any employees, agents or other individuals who draft or may be discussed in this Credible Allegation of Compliance. In addition, preparation and submission of this Credible Allegation of Compliance does not constitute an admission or agreement of any kind by Facility of the truth of any facts alleged or the correctness of any conclusions set forth in this allegation by the survey agency. Accordingly, we are submitting this Credible Allegation of Compliance solely because state and federal law mandate submission of a Credible Allegation of Compliance within ten (10) days of receipt of the Statement of deficiencies as a condition to participate in the Medicare and Medical Assistance programs. The submission of the Credible Allegation of Compliance within this time frame should in no way be considered or construed as agreement with the allegations of non-compliance or admissions by the facility.	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those	F 156	4/5/12 SER	

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

Ted A. Schmitt | Administrator | 4/4/12

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	03/08/2012

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F 156	Continued From page 1 other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control	F 156	**F156** Residents are presented with the resident bill of rights upon admission into the facility. This is documented in their medical record. The resident bill of rights is reviewed with all residents during the admission/orientation process with a social worker. Residents will sign an acknowledgement form to prove receipt and understanding of the resident bill of rights no later than 3 business days after initial admission. Director of Social Services will audit acknowledgement of resident bill of rights on a bi-weekly basis for 2 months and monthly thereafter until compliance is achieved. These audit results will be shared and monitored via the facility QA process.	04/17/12

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F 156	Continued From page 2 unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on family interview, staff interview, and document review, the facility did not ensure 1 of 3 residents (R161) or resident representatives were	F 156		

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F 156	Continued From page 3 notified of resident's rights or Medicare benefits upon admission. Findings include: R161 was admitted on 2/27/12 with diagnosis including pressure ulcer stage IV - sacral/coccyx, dementia, rehabilitation procedures, and diabetes. Interview with R161's spouse on 3/5/12 (7 days later) at 6:30 p.m. revealed no facility staff had approached the spouse regarding admission paper work, including residents rights and specific Medicare benefits. Interview with Nurse Manager (NM) A on 3/8/12 at 11:00 a.m. indicated the admission paperwork would be scanned into the computer, and verified there was no admission paperwork in the computer (10 days after admission). Interview with the Social Service Director on 3/8/12 at 12:15 p.m. indicated she tries to touch base with the family to sign the admission paperwork within the first three days. The facility policy dated 2005 indicated "admission paperwork is completed by social worker with resident or responsible party. If arrangements cannot be made for responsible party to meet with the social worker in person, papers can be mailed or faxed for completion. Admission paperwork to be completed includes: 1. Admission Agreement 2. Medicare Secondary Payer Form." The federal regulation indicated " The facility must inform the resident both orally and in writing in a language that the resident	F 156		

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F 156	Continued From page 4 understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing."	F 156		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and document review the facility did not assess 1 of 3 residents (R 122) with a nebulizer, for self administration of medications. Findings include: At 7:30 a.m. on 3/7/12, licensed practical nurse (LPN)-A was observed to set up and give R122 a DuoNeb nebulizer treatment via a mask. LPN-A advised R122 that she would be back in about 7 minutes. LPN -A indicated R122 would leave the mask on. At 7:40 a.m. LPN-A took R122's mask off. Review of R122's record on 3/7/12 at 2:00 p.m. indicated a self administration of medication	F 176	**F176** Self administration of medication assessment specific to duo-neb conducted on 03/08/2012. Self administration of medication order for duo-neb obtained 03/08/2012. Facility conducted audit of all resident's receiving nebulizer to ensure self administration medication (SAM) orders and assessements were present and complete. Facility will review SAM assessments and orders upon admit and quarterly. Community manager will audit for appropriate SAM assessments and orders post admission and quarterly for 6 months.	04/17/12

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F 176	Continued From page 5 assessment dated 2/29/12 for R122 to self administer Oxycodone (pain medication) at dialysis. The assessment indicated R122 was independent with daily decisions. No assessment for R122 to self administer the nebulizer was found in R122's record. No physician order for R122 to self administer the nebulizer was found. Interview with nurse manager (NM) - A on 3/8/12 at 11:15 a.m., verified R122 did not have an assessment to self administer the nebulizer.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced	F 279	**F279** Facility social worker or designee will develop a discharge care plan for all residents with a length of stay order that does not indicate long term care or for residents who voice a desire to discharge as indicated in their MDS. Director of Social Services will audit for presence of discharge care plans on a bi-weekly basis for 2 months and monthly thereafter until compliance is achieved. These audit results will be shared and monitored via the facility QA process.	04/17/12

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F 279	Continued From page 6 by: Based on document review and staff interview the facility did not develop a comprehensive plan of care for discharge for 1 of 3 residents (R122) in the sample reviewed for discharge planning. Findings include: Review of R122's record indicated R122 was admitted on 11/7/11 with diagnosis including end stage renal disease, chronic kidney disease, spleen injury w/o (without) open wound, diabetes, diabetic peripheral neuropathy, bronchitis, fistula, and bilateral below the knee amputations. Social service assessment dated 11/11/11 indicated R122 had minor forgetfulness, showed symptoms of depression, expresses feelings openly, copes well, no behaviors, adjusted to physical limitations, and discharge potential was short term. The assessment indicated the resident expressed preferences toward discharge. Progress note dated 11/11/11 indicated "resident was pleasant during assessment, dtr (daughter) also present. Score of 13 on BIMS, res (resident) feels her STM (short term memory) is bad and states she forgets things all the time. Score of 10 on PHQ - 9 indicated moderate depression. Res seems to be in good spirits most of the time and has no dx (diagnosis) of depression, but states her mood has not been good lately d/t (due to) her room being too small, not having her normal routine,etc. Family visits often and is very supportive. Goal is for LTC (long term care), but family would like res transferred to a care center closer to their homes. SS (social service) assisting with this. Low risk of elopement, VA plan of care will be initiated." Review of 122's	F 279		

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F 279	Continued From page 7 record indicated no plan of care for resident's discharge or vulnerability. Review of R122's CAA (care area assessment) report dated 11/18/11 indicated Return to Community Referral was triggered from the initial Minimal Data Set (MDS). The summary report indicated the section was triggered due to the resident reporting interest in returning to her independent apartment. Res was admitted to CCH (Cerenty Care Center) for what family hoped to be LTC, but res. has expressed interest in returning home. IDT (inter disciplinary team) has not yet determined if this is feasible or not. No referral make to local county agency: not needed at this point. Care Plan Decision was checked yes. Interview with Social Worker (SW) A on 3/8/12 at 12:10 p.m. indicated R122 discharge plans had changed during R122's stay. SW A indicated another social worker was R122's primary and was not available. SW A indicated R122 had a care conference on 3/7/12 and that it is expected after a care conference that a care plan with the discharge would be started and the every resident is different. Record review revealed R122 had a care conference on 11/23/11. Care conference note indicated " DNR/DNI (Do not resuscitate, do not intubate). Res (resident) medically stable. Requested female caregivers as she is more comfortable with them. Res has eye appt (appointment) next week out of building. Cont (continue) dialysis 3 days/ week. Res wants to move to ALF (assisted living facility), wants one where she can smoke, family suggested XXX Hi-Rise, SS (Social Service) to f/u (follow-up). Working with PT/OT (physical therapy and	F 279		

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F 279	Continued From page 8 occupational therapy)..." Review of record indicated no care plan for discharge. Interview with SW A verified R122 had been admitted on 11/7/11, and no discharge plan was in the current plan of care.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, document review and staff interview, the facility failed to follow the plan of care for repositioning for 1 of 2 residents (R161) observed for repositioning. Findings include: Review of R 161's plan of care indicated an alteration in skin D/T (due to) sacral coccyx pressure ulcer upon admission R/T (related to) non -ambulatory, total assist with transfers,and extensive assist with bed mobility. Approaches included turn and reposition every hour while sitting and lying. Observation on 3/7/12 revealed R 161 was not repositioned from 7:30 a.m. until 9:20 a.m. (1 hour 50 minutes). On 3/7/12 at 7:30 a.m. R 161 was observed in bed resting on his back, at 8:28 a.m., Licensed Practical Nurse (LPN) - A entered the room to check the wound vacuum machine which was beeping, talked to R161 and left the room. At	F 282	**F282** Education was immediately provided regarding this specific resident's (re-positioning) care plan to all staff responsible for his care. To ensure care plan awareness, nursing staff/community manager will color code on care sheets if any procedure is different from the usual re-positioning protocol. This will be done to alert staff that the procedure or order has been enhanced with individualized characteristics. D.O.N. will periodically monitor process to ensure implementation is successful.	04/17/12

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F 282	Continued From page 9 8:42 a.m. nursing assistant (NA) A entered the room, elevated the bed approximately 30 degrees and gave R 161 a doughnut and two 4 ounce containers of apple juice. At 9:00, R161 was still lying on his back. At 9:03 a.m. NA-A entered the room and completed R161's morning activities of daily living (adls). At 9:20 a.m. R161 was assisted to roll onto his right side, and a dri-pride (incontinent product) was applied. Interview with NA-A at 9:40 a.m. indicated R161 was turned and repositioned every two hours, and NA-A did not know why R161 wore an incontinent product. The nursing assistant assignment sheet indicated R161 was "S1-L1", which was a repositioning plan of "S1 reposition q (every) 1 hour when sitting...L1 q 1 hour when laying" Interview with nurse manager A (NM-A) on 3/8/12 at 11:00 a.m. verified R161's plan of care indicated R161 was to be turned and repositioned every 1 hour.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	**F314** Education was immediately provided regarding this specific resident's (re-positioning) care plan to all staff responsible for his care. To ensure care plan awareness, nursing staff/community manager will color code on care sheets if any procedure is different from the usual re-positioning protocol. This will be done to alert staff that the procedure or order has been enhanced with individualized characteristics. D.O.N. will periodically monitor process to ensure implementation is successful.	04/17/12

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F 314	Continued From page 10 Based on observation, document review and staff interview, the facility failed to ensure care and services were provided to prevent the worsening of pressure ulcers for 1 of 2 residents (R161) with pressure ulcers. Findings include: Review of R161's plan of care indicated an alteration in skin D/T (due to) sacral, coccyx pressure ulcer upon admission R/T (related to) non -ambulatory, total assist with transfers, and extensive assist with bed mobility. Approaches included turn and reposition every hour while sitting and lying. Observation on 3/7/12 revealed R161 was not repositioned from 7:30 a.m. until 9:20 a.m. (1 hour 50 minutes). R161 was admitted on 2/27/12 with diagnosis including pressure ulcer state IV - sacral/coccyx(skin breakdown that extends into the muscle and can extend as far down as the bone), dementia, and diabetes. On 3/7/12 at 7:30 a.m. R161 was observed in bed resting on his back, at 8:28 a.m., Licensed Practical Nurse (LPN) - A entered the room to check the wound vacuum machine which was beeping, talked to R161 and left the room. At 8:42 a.m. nursing assistant (NA) A entered the room, elevated the bed approximately 30 degrees and gave R161 a doughnut and two 4 ounce containers of apple juice. At 9:00, R161 was still lying on his back. At 9:03 a.m., NA-A entered the room and completed R161's morning activities of daily living (adls). At 9:20 a.m. R161 was assisted to roll onto his right side, and a dri-pride (incontinent product) was applied.	F 314		

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F 314	Continued From page 11 Interview with NA-A at 9:40 a.m. indicated R161 was turned and repositioned every two hours. The nursing assistant assignment sheet indicated R161 was "S1-L1", which was a repositioning plan of "S1 reposition q (every) 1 hour when sitting...L1 q 1 hour when laying" Interview with nurse manager A (NM-A) on 3/8/12 at 11:00 a.m. verified R161's plan of care indicated R161 was to be turned and repositioned every 1 hour. Review of R161's record revealed a Braden scale (determines skin risk of breakdown) of 11, which indicated the resident was at high risk of skin breakdown. Interventions include LAL /AP air mattress, pressure reducing device for bed and for chair, turning and repositioning program, ulcer care, and application of ointments /medications other that to feet. The Skin Risk Summary reviewed on 3/8/12, indicated" wound assessment, stage 4 sacral coccygeal pressure area assessed. 11 cm x 7.4 cm x 1.8 cm wound base 60 % slough, 40 % granulation tissue, Undermining present from 1-6 o'clock, Tunneling at 8 and 12 o'clock. wound edges macerated. moderate amount of sersanguinous drainage noted. no foul odor, no necrosis, slight resistant during dressing, no verbal s/sx (signs and symptoms) of pain or discomfort. wife present during dressing change and states that resident right hand will shake more vigorously if he is having increased pain, but he will not verbalize. Primary MD (physician) updated r/t (related to) residents status. new orders as follows: 1) hold wound vac until 2/28/12	F 314		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12 CM to apply and 2) continue wet to dry dressing change to coccyx at this time. 3) administer prn (as needed) oxycodone 30 minutes prior to dressing change to coccyx. 4) LAL /AP mattress setting to be on 3 instead of 6. Resident and wife aware of new orders. Resident does have LAL/AP mattress to further promote wound healing. Receiving vitamin c as dietary supplement, alb/pre alb (laboratory test to check albumin and prealbumin levels) to further address dietary intervention to assist with wound healing. ROHO cushion applied to w/c to also further prevent. Review of the "weekly wound document progress sheet" initiated 2/27/12 indicated the following interventions: wound/ air LAL/AP (low air loss/ alternating pressure) air mattress set at 3 at all times, vitamin C per MD (physician) order, reposition every 1 hour, ROHO (air cushion) cushion to w/c (wheelchair), Oxycodone (narcotic pain medication) 30 minutes prior to dressing change. The progress sheet also revealed on 2/27/12 the wound measurements were "11 cm (centimeters) length, 7.4 cm width, 1.8 cm depth". On 2/29/12 the wound had increased in size to "11 cm length, 8 cm width, and 2 cm depth." On 3/5/12 the wound had decreased in size to " 8.7 cm, 6.1 cm width, and 1.7 cm depth."	F 314		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		

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F 425	Continued From page 13 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation , document review and staff interview, the facility failed to ensure medications were given according to manufacturers recommendation for 1 or 3 residents (R 41) in the sample who received inhalers. Findings include: During medication observation on 3/8/12 at 7:40 a.m., Licence Practical Nurse (LPN) A administered R 41's Combivent inhaler. LPN A informed R 41 to breathe out and then gave R41 a puff of the inhaler. Five seconds later LPN A administered another dose of the inhaler. LPN A indicated R41 does not do his own inhaler and the staff has to give it . Review of R41's chart indicated a physician	F 425	**F425** Immediate education was provided to LPN who did not follow manufacture guidelines for administration of a resident's inhaler. LPN demonstrated a clear and concise understanding of the facility policy and protocol immediately after education. Facility staff re-educated regarding following manufacture guidelines of all medications prior to administration. Competency of metered dose inhaler conducted and LPN demonstrated competency of procedure. In addition the contracted facility pharmacy provides all staff in-service regarding personalized medication administration on an annual basis. This years in-service is scheduled to take place on May 21, 2012.	04/17/12

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F 425	Continued From page 14 order for albuterol-ipratropium (Combivent) inhaler 2 puffs four times a day. The inhaler had a sticker on it which indicated " avoid if allergic to peanuts. Shake well before using, may cause dizziness. wait 2 minutes between puffs." LPN A offered no explanation when questioned about the timing of the puffs. Interview with Nurse Manager A on 3/8/12 at 11:00 a.m. indicated puffs of an inhaler should be at least 2 minutes apart.	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions	F 441	**F441** Immediate education was provided to LPN who did not follow infection control protocols during insulin administration. LPN demonstrated a clear and concise understanding of the facility policy and protocol immediately after education. Competency of infection control performance was tested on 03/08/2012 at which time the LPN successfully performed the infection control technique. Competency was again tested by Staff Development on 4/3/2012 and LPN demonstrated competency with procedure. A memo was provided to all facility staff regarding the specific infection prevention techniques used to ensure compliance of facility policies. In addition infection control training is given to all staff on an annual basis via Silverchair Learning Systems.	04/17/12

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F 441	Continued From page 15 from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, document review, and staff interview, the facility failed to ensure proper infection control was followed during insulin administration for 2 of 2 residents (R 41 and R161) observed to receive insulin. Finding include: Observation of a medication administration on 3/7/12 at 7:45 a.m., License Practical Nurse (LPN) A drew up R 41's insulin and administered the insulin without wearing gloves. During observation of R161, at 8:53 a.m. LPN A was observed to administer a subcutaneous injection without wearing gloves. When questioned, LPN A revealed she had given R161 insulin. Interview with LPN A at that time indicated she does not wear gloves to give insulin. Review of the facility undated policy for injection (subcutaneous) medication administration - insulin, indicated 21 steps, with step number 13	F 441		

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F 441	Continued From page 16 indicating to apply gloves. Interview with Nurse Manager A on 3/8/12 at 11:00 a.m. indicated staff are to wear gloves when administering insulin.	F 441		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide at least 160 square feet of usable floor space for 9 residents in the sample who were in double rooms. Findings include: Resident rooms 221, 222, 223, 226, and 326 did not meet the required 80 square feet per resident living in a multiple resident bedroom. This was confirmed in an interview with the facility administrator and director of nursing on 3/12/12 at 2:00 p.m. Residents residing in those rooms did not offer complaints regarding the size of their rooms.	F 458	**F458** Variance on file	04/17/12

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

F5255020

PRINTED: 03/22/2012
FORM APPROVED
OMB NO. 0938-0391

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	245255	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	03/08/2012

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC 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. UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Cerenity Care Center on Humboldt was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar St., Suite 145 St. Paul, MN 55101- 5145	K 000	POC ok PS 4-9-12 RECEIVED APR - 5 2012 MN DEPT. OF PUBLIC SAFETY STATE FIRE MARSHAL DIVISION	

Exit: 3-8-12
Dc: 4-17-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Ted A. Schultz	Administrator	4/4/12

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

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K 000	Continued From page 1 Pat.Sheehan@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Cerenity Care Center Humboldt is a 4-story building with a no basement. The building was constructed at 2 different times. The original building was constructed in 1960 and was determined to be of Type II(222) construction. In 1970, an addition was constructed to the South side of the building that was determined to be of Type II(222) construction.. Because the original building and the addition meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is partially fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors,resident rooms, closets and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 125 beds and had a census of 116 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on review of available reports and records, it was determined that the facility has failed to properly conduct fire drills in accordance with NFPA 101 (00), Chapter 19, Section 19.7.1.2.. This deficient practice could affect how staff react in a fire emergency and could adversely affect the safety of all patients, staff and visitors. FINDINGS INCLUDE: On facility tour between 09:00 AM and 02:00 PM on 03/08/2012, during a review of fire drill reports provided by the facility. it was noted that the facility did have documentation that fire drills were conducted during all shifts for the last 12 months, however the fire drills were not varied throughout the shift during the night shift. 3 of 4 drills were conducted between 2:20 AM and 2:30 AM. This deficiency was verified by the facility Administrator (TS).	K 050	**K050** Facility will create a fire drill schedule that ensures that all fire drills are performed at staggered times. Director of Maintenance will review fire drill schedules for a time period of six months or until compliance is maintained.	04/17/12

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K 050	Continued From page 3 *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 050		