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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6QUQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00354

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245365**

2.STATE VENDOR OR MEDICAID NO.
(L2) **723816900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - MARIAN**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

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 **09/18/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	90			
(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):

17. SURVEYOR SIGNATURE — Date :
Susanne Reuss, Unit Supervisor 09/18/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 09/30/2015 (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
11/01/1986
(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: **00** (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03001
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
09/02/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245365
September 30, 2015

Ms. Denise Juday Barnett, Administrator
Cerenity Care Center - Marian
200 Earl Street
Saint Paul, Minnesota 55106

Dear Ms. Juday Barnett:

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 August 25, 2015 the above facility is certified for or recommended for:

90 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 90 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,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
September 29, 2015

Ms. Denise Juday Barnett, Administrator
Cerenity Care Center - Marian
200 Earl Street
Saint Paul, Minnesota 55106

RE: Project Number S5365024

Dear Ms. Juday Barnett:

On July 29, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on July 16, 2015. 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 August 31, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on September 18, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on July 16, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on July 16, 2015, effective August 25, 2015 and therefore remedies outlined in our letter to you dated July 29, 2015, 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.

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245365	A. Building B. Wing	8/31/2015

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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 **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **08/25/2015**	ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **08/25/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **08/25/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **08/25/2015**	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	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 _____ **State Agency**	**Reviewed By** SR/KJ	**Date:** 09/29/2015	**Signature of Surveyor:** 16022	**Date:** 08/31/2015
Reviewed By _____ **CMS RO**	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 7/16/2015

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

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

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
245365	A. Building B. Wing 01 - MAIN BUILDING 01	9/18/2015

Name of Facility	Street Address, City, State, Zip Code
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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 Reg. # NFPA 101 LSC K0029	Correction Completed 08/07/2015	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 08/03/2015	ID Prefix Reg. # NFPA 101 LSC K0056	Correction Completed 08/07/2015
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	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 State Agency	Reviewed By GS/KJ	Date: 09/29/2015	Signature of Surveyor: 12424	Date: 09/18/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 7/14/2015		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 6QUQ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00354

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(L1) **245365**

2.STATE VENDOR OR MEDICAID NO.
(L2) **723816900**

3. NAME AND ADDRESS OF FACILITY
(L3) **CERENITY CARE CENTER - MARIAN**
(L4) **200 EARL STREET**
(L5) **SAINT PAUL, MN** (L6) **55106**

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 **07/16/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **90** (L18)

13.Total Certified Beds **90** (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	IID
	90			
(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):

17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NE II 08/10/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 08/20/2015 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
11/01/1986
(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 09/02/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
July 29, 2015

Ms. Denise Juday Barnett, Administrator
Cerenity Care Center - Marian
200 Earl Street
Saint Paul, Minnesota 55106

RE: Project Number S5365024

Dear Ms. Juday Barnett:

On July 16, 2015, 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 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.

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
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

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 August 25, 2015, 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 October 16, 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 January 16, 2016 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-3992 Fax: (651) 215-9697
Enclosure (s)
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245365	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure that 1 of 3 residents (R44) who was assessed for activity choices, was offered an important priority activity, as often as possible, to meet the needs of the resident. Findings include: R44's electronic health record (eHR) Activity	F 248	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, 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 thie Credible	8/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		08/07/2015

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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	245365	A. BUILDING _____ B. WING _____	07/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CERENITY CARE CENTER - MARIAN	200 EARL STREET SAINT PAUL, MN 55106

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F 248	Continued From page 1 Assessment dated 12/3/14, identified that daily mass was important to the resident and the family had requested that R44 attend daily mass as often as possible, and indicated that R44 is more peaceful if hand is held during mass. The assessment identified that activities will continue to be involved and take R44 to mass. A review of a handwritten Activity Assessment, dated 12/3/14, revealed "Daily Mass" as an interest for the resident. Review of the activity calendars revealed mass was offered every day, except for Saturdays, however, R44 was not being offered mass on a daily basis. On 7/15/15, at 8:26 a.m., family was observed visiting R44. Family member (FM)-A was interviewed regarding activities and reported visiting R44 three times a week, spending one to four hours visiting, and seldom saw R44 at an activity and "never" going on outings. FM-A explained that R44 wasn't always invited to attend activities and added that R44's TV had not been working since Monday. Review of the June and July, 2015 activity logs for R44, revealed mass was not being offered to R44 on a daily basis. The June 2015 activity log revealed mass and a spiritual activity had been offered 8 of 30 days for the month. Of the eight days offered the resident had attended the mass/spiritual activity six days. For the month of July 2015, a mass/spiritual activity had been offered 4 of 15 days, and R44 attended three times. On 7/16/15 at 9:43 a.m. the wellness director stated she wasn't sure if R44 was attending mass every day, but would check.	F 248	Allegation of Compliance. In addtion, preparation and submission of this Credicble Allegation of Compliance does not contsitute 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. Accordingy, 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) calendar days of receipt of the Statement of Deficincies as a condition to particopate 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 admission by the Facility. R44 has had her activity interests met by the following manner: attending church one-two times per week and by attending small prayer groups weekly in her neighborhood. Resident interview confirms that she is satisfied with this level of activity. Associates will continue to invite her to church and prayer groups. The facility has corrected the identified deficiency in the following manner: Resident interests are identified upon admission and are reviewed quarterly and upon significant change. A wide variety of activities are provided seven days per week throughout the day and evening hours. For residents who are desiring a	

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F 248	Continued From page 2 On 7/16/15, at 9:46 a.m., the unit manager for R44's unit, licensed practical nurse (LPN)-B reported not knowing if R44 was attending daily mass and would have to check with activities. On 7/16/15, at 9:56 a.m., the wellness coordinator (WC)-D, who was the regular coordinator for the unit, was interviewed regarding the frequency of mass invitations for R44 and stated, "I don't know if we ask her every day." On 7/16/15, at 10:19 a.m., the wellness director explained that R44 had been becoming disruptive, by calling out during mass, and would look for documentation to support the statement. The wellness director provided documentation of a Quarterly Recreation Review dated 1/23/15, which indicated R44 still attended mass, but watched it on the unit. The review identified that R44's attention span, with mass, was short, that R44 had actually attended mass, but moved about and called out, "hello." An additional Quarterly Recreation Note dated 7/8/15, was provided by the wellness director. The documentation addressed R44's short attention span, but did not reference mass. The documentation identified R44 had attended wellness, music program, active games, decorating calendars, sensory group, going outside and family visits. The care plan, dated 12/3/14, addressed R44 being peaceful when R44's hand was held during events and identified that activities would take R44 to events, sit by R44 and hold R44's hand, however, there was no reference of R44's interest	F 248	religious activity we have initiated a prayer group that is offered in the neighborhood one time per week. Additionally, residents are invited to Mass which occurs six days per week and interfaith services twice per week. Residents who have identified interests outide of scheduled activities are offered one to ones with volunteers or associates. Residents satisfaction with activity levels is evaluated by a weekly audit of the activity log until we identify consistent positive results. The same audits will be completed quarterly times one year. Results will be reports to quaity council and the Director of Wellness is responsible for this plan.	

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F 248	Continued From page 3 in attending mass as much as possible or how important this event was to the resident. During all days of the survey, R44 was not observed to watch mass on the TV.	F 248		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility did not ensure visits by hospice providers were coordinated with the facility for 1 of 1 resident (R91) reviewed for hospice services. Findings include: Hospice (H)-A did not coordinate the time of services with facility staff for R91. During an interview on 7/14/15, at 3:00 p.m. the health unit coordinator (HUC) and registered nurse (RN)-B, were unable to find hospice information for R91. Both verified the information was not available and did not know which day of the week hospice staff came to provide services to R91. The nurse report sheet listed H-A as the hospice agency, but did not specify the date and time of visits.	F 309	R91 has a current signed hospice agreement and a coordinated plan of care. The hospice agency has provided a hospice visit schedule for their staff. A hospice checklist for facility documentation has been developed. The checklist will ensure a coordination of care between hospice and the faciity. The checklist contains the following information: hospice contact team information such as case manager, social worker, hospice aide, volunteer , hospice medication instruction sheet, hospice visit schedule, hospice documentation record (if not utilizing Matrix EMR), hospice aide report, hospice and facility coordinate plan of care, hospice signed agreement and copies of physician orders. The checklist will serve as our auditing tool. We will audit to assure that patients enrolled in a	8/25/15

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F 309	Continued From page 4 A review of the care plan dated 6/19/15, designated H-E Hospice as the hospice provider, with a goal to provide the facility with patient specific information from hospice. The approach was to coordinate care between hospice and the facility. There was no copy of the hospice plan of care found in the facility's care plan, and the physician certification ended 6/12/15, with no current certification available. R91 was not currently receiving H-E hospice services, but was instead receiving H-A hospice services since 12/15/14. There was no calendar from H-A hospice for June or July of 2015, to indicate what discipline had completed or scheduled a visit and the calendar present from May of 2015, did not indicate a time the hospice health aide (HHA) or registered nurse (RN) would be present. The May of 2015, hospice calendar form directions read; "Staff will contact you to schedule a visit by 7 p.m. the evening before or by 9 a.m. the day of the visit. A 30 minute window will be provided for you, if arrival is outside of the 30 minute window, you will be contacted." During an interview on 7/15/15, at 9:50 a.m. nursing assistants who typically worked full time, (NA)-A, NA-B, NA-C and NA-D were not aware of the specific hospice routine for R91. The NA's did not know what services the hospice aide provided for R91, and did not know the time scheduled for hospice services. During an interview on 7/15/15, at 10:00 a.m. licensed practical nurse (LPN)-A who worked full time, verified the time of the hospice nurse and aide visits were not clear.	F 309	hospice program have the above elements met as listed in the checklist. The results of this audit will be reported in the quality council. The Director of Nursing is responsible for this plan of correction.	

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F 309	Continued From page 5 During an interview with family (F)-A regarding hospice services on 7/15/15, at 11:01 a.m., F-A indicated the expectation would be to provide services above and beyond what the facility was able to provide such as- hand massages,extra bathing and nail care, but F-A did not know the time of the visits or the additional services provided. RN-A contacted H-A hospice on 7/15/15, to request the current physician certification, as well as the calendar for June and July of 2015, visits. RN-A verified the H-A hospice did not follow the hospice policy of informing facility nursing staff of the time of visits to further enhance the nursing services from the hospice agency. Furthermore, RN-A validated the plan of care would be updated to reflect H-A Hospice had been the current hospice provider since 12/6/14, and to remove H-E hospice from the current plan of care.	F 309		
F 314 SS=E	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: Based on observation, document review, and interview, the facility did not provide timely	F 314	R103,R13,R165 and R96 have on file weekly comprehensive wound rounds that	8/25/15

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F 314	Continued From page 6 comprehensive assessments and consistent comprehensive monitoring of pressure ulcers for 4 of 4 residents (R103, R13, R165, R96) reviewed for pressure ulcers. Findings include: R103 did not receive timely comprehensive assessment or consistent comprehensive monitoring that included measurement and staging of multiple pressure ulcers to the lower extremities. Record review for R103 revealed a wound care physician's visit note, dated 6/23/15, describing a stage 3 pressure ulcer of the left calcaneous (heel) that had an onset date of 1/31/15. A nursing Progress Note from 1/31/15 read, "Spoke with Dr. [physician (P)-A] and reported blisters/with purple and red discoloration both heels..." The first documentation of measurement of these wounds was a nursing Progress Note, dated 2/2/15, that read, "Resident had tub bath at this time, blister to bilateral heels burst, Left heel skin to blister almost of, surrounding areas measured 8 cm x 7 cm, Right heel measured 1 cm x 0.5 cm, observed serosanguinous drainage, cleansed with Normal Saline, [nurse practitioner (NP)-A]/NP in, was observed, 'wound doctor will evaluate and treat; use Bacitracin Ointment to both heels [sic] ..." The first comprehensive skin assessment after the discovery of the wounds was a Skin Risk Assessment form, dated 2/25/15, that described the wounds as one stage 2 pressure ulcer and one unstageable pressure ulcer. There were no measurements of the wounds on this form. This form included a Braden Scale that scored the resident as a 17, meaning at risk for developing a	F 314	include the healing progression, size, location and adequacy of the treatment program. Wound rounds will occur on a weekly basis. The facility has assigned a primary nurse on each floor to manage weekly wound rounds. This will assure continuity with tracking the status of wounds as well as accountability for follow through with the comprehensive assessment and monitoring of wounds. Each resident's wounds will be assessed and progress noted weekly. Wound rounds will include: evaluation for healing progression, size and location, and adequacy of treatment program. Recommendations for treatment changes or plan of care revisions will be noted and reported to the primary physician during weekly rounds. Pressure ulcer wound statistics reviewed at quality council on a quarterly basis. Audits will occur on a weekly basis until resolved. Director of Nursing is responsible for this plan.	

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F 314	Continued From page 7 pressure ulcer. Nursing documentation of consistent assessment and monitoring of the wounds could not be found in the record. Physician visit notes documenting the evaluation, measurement, staging, and treatment of the wounds were found in the record for every week of February 2015, starting 2/3/15. In the note dated 2/3/15, P-B described the first wound as a stage two pressure ulcer to the right posterior heel that measured 1cm x 1cm x 0cm deep, and the second as an unstageable pressure ulcer to the left posterior heel that measured 6cm x 9cm x 0.2cm deep. The next documentation of wound monitoring was a nursing Progress Note, dated 3/6/15, describing the wound to the left heel as 8.5 cm x 6.5 cm, and the wound to the right heel as increased in size to 3.5 cm x 6 cm. No staging was included in this documentation. Although physician visit notes documented that P-B provided the comprehensive evaluation and treatment of the wounds every week from 3/10/15 to 4/7/15, there was no further documentation of a physician visit until 4/21/15. A nursing Progress Note, dated 4/14/15, described the left heel wound as measuring 4 cm x 6 cm, and the right heel wound as measuring 1 cm x 1.5 cm, but no staging was included in this documentation. A thorough physician visit note for the wounds was dated 4/28/15, however, there was no physician visit documented for the wounds again until 5/19/15. A nursing Progress Note, dated 5/5/15, reported that P-B visited R103 that day for wounds and the left heel wound measured 6 cm x	F 314		

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6cm, however, there was no measurement documented for the right heel wound and no staging for either wound.

Nursing Progress Notes identified that R103 was hospitalized on 5/6/15 for a psychiatric evaluation and returned to the facility on 5/15/15. The first documented wound assessment after R103's return from the hospital was on a Skin Risk Assessment form, dated 5/17/15, that described the wounds as one stage 2 pressure ulcer and one unstageable pressure ulcer, with no measurement included. A physician's visit note, dated 5/19/15, described the wound to the right heel as a stage 3 pressure ulcer measuring 1 cm x 1 cm, and the wound to the left heel as a stage 3 pressure ulcer measuring 4 cm x 6 cm. There were then only physician visit notes regarding the wounds, dated 5/26/15 and 6/9/15, in the record. The 6/9/15 note was the last physician note in the record that had been completed by P-B. A nursing Progress Note, dated 6/15/15, read, "Resident VSS, BS-111, Drsgs changed bilater heals left heal open worst than right. Surrounding tissus pink [sic]..." The remaining wound monitoring documentation in the record that contained any wound measurement was a nursing Progress Note, dated 6/20/15, that read, "Dressing change to both lower extremities. Left foot on lateral side has a 1cm by 1cm sore with slough tissue. Writer noted a change in tissue from previous changes which had epithial tissue. Heal tissue continues to be 80% granulation tissue with continued improvement [sic]." Nursing progress notes, dated 7/2/15, 7/7/15, 7/14/15, report that the right heel wound appeared to be healed, but those notes contained no measurement or staging of the wounds.

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F 314	Continued From page 9 During interview on 7/16/15, at 9:45 a.m. licensed practical nurse (LPN)-B, the nurse manager for this unit, stated that staff nurses in the facility no longer do staging or measurements on pressure ulcers because they were not consistent and accurate in that task and a visiting wound physician has been hired to evaluate, treat, and document pressure ulcers in the facility. She explained that this physician may have missed some visits, but she thought that issue had been addressed. The facility's Skin Integrity Team policy, dated 1/1/15, read, "...a. At least one time weekly, wound rounds are conducted by the facility Wound Nurse/Clinical Managers or the Skin Integrity Team which includes the MD Accelecare, inspect and review each individual case. This is a team approach. Documentation from the team rounding is provided within the Accelecare MD notes. If Accelecare is not present for the weekly wound rounds the nurse is to chart within the medical record a summary of the wound rounds. b. Wound Rounds include: Evaluating healing progression of all wounds. Size and location (ongoing), date healed, stage, cultures, treatment, dietary interventions, drainage, lab data, etc..." R13's right heel pressure ulcer lacked documentation that the ulcer was monitored when the ulcer was open. On 7/16/15, at 7:30 a.m. the back of R13's heel was observed. There was a crescent moon shaped scabbed over an area noted on the upper back of the right heel. There was no drainage	F 314		

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F 314	Continued From page 10 observed and R13 denied pain in the area. R13 was admitted to the facility 8/5/14 with a Stage III pressure ulcer on the back of the right heel. The minimum data set (MDS), dated 8/12/14, identified under stage 3 or 4 pressure ulcer: A). longest length 4.1 B). widest width 3.5 C). deepest area 0.0. Measurements found of the pressure ulcer, dated 9/4/14, found in an electronic health record (eHR) progress note and an eHR document titled Clinical Documentation Skin Integrity Concern, indicated the pressure ulcer on the right heel measured 3.5 cm X 3.7 cm (centimeters.) The next measurement of the right heel pressure ulcer was not documented until 14 days later on 9/18/14, and according to documentation on the 9/18/14, Clinical Documentation Skin Integrity Concern, the pressure ulcer measured 3.5 cm X 2.8 cm. The facility did weekly measurement documentation the weeks of 9/25 and 10/2/14, however after 10/2/14, the next measurement of the pressure ulcer was not until 42 days later on 11/13/14. On 11/13/14, the pressure ulcer had increased in size from 10/2/14, and measured 1.5 cm X 1.9 cm x 0.1 cm. The next wound measurement was 29 days later on 12/12/14, when a progress note in the eHR indicated a callous had come off during application of skin prep and the "bright pink" tissue beneath measured 2.4 cm X 2.7 cm. Twenty days later on 1/2/15, the eHR Skin Risk Assessment w/Braden Scale form revealed the area measured 0.4 cm X 0.6 cm X 0.1 cm. Documentation on the eHR Skin Risk Assessment w/Braden Scale, dated 1/30/15, revealed the right heel pressure ulcer had healed, but an eHR Skin Risk Assessment w/Braden Scale documentation dated 2/18/15, revealed the	F 314		

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area had reopened and measured 0.4 cm X 0.4 cm X 0.1 cm. The next documentation found regarding the right heel pressure ulcer was 52 days later on 4/11/15, when an eHR Skin Risk Assessment w/Braden Scale indicated there were no pressure ulcers.

On 7/16/15, at 11:47 a.m. RN-C stated there was no other documentation regarding wound measurements other than the skin assessments. RN-C stated R13 had elected not to see the facility's wound physician, preferring instead to have the primary physician monitor and prescribe for the right heel pressure ulcer.

The care plan dated 9/5/14, directed nursing staff to assess the pressure ulcer for the location, stage, size (length, width and depth), presence/absence of granulation tissue and epithelization. However, the care plan did not direct staff of the frequency of the assessments.

R165 was admitted to the facility on 5/8/15, with a Stage IV pressure ulcer on the right ischial area which was being treated with a wound vac. A review of the eHR revealed a Skin Risk Assessment w/Braden Scale was completed on 5/11/15. However, the assessment did not include any measurements of the pressure ulcer. A review of the eHR revealed the first documentation regarding measurement of the right ischial pressure ulcer was not conducted until 14 days after R165 had been admitted to the facility. An eHR progress note dated 5/22/15, revealed the right ischial pressure ulcer measured 4.5 cm X 2.5 cm X 5 cm.

The 6/5/15, weekly pressure ulcer measurement

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documentation indicated a new pressure ulcer had developed on the left ankle and measured 2.5 cm X 2.5 cm. There was no documentation indicating the right ischial had been measured again until 14 days later on 6/19/15. There was no indication the left ankle pressure ulcer had been measured until 26 days later on 7/1/15. The eHR revealed on 7/1/15, the right ischial and left ankle had been measured, and that new areas on the left and right heels, and the coccyx area were measured. The last documented measurements of all of R165's pressure ulcers were found in the eHR and dated 7/8/15.

The eHR progress note documentation for 7/1/15, recorded measurements of the open areas as follows: left heel-4.5 cm X 5.5 cm; right heel-8 cm X 6.5 cm; left ankle-2 cm X 0.5 cm; and coccyx-2.7 cm X 1.8 cm. Measurements on 7/8/15, revealed all had gotten smaller except the coccyx which remained the same size: left heel-3.5 cm X 4.5 cm; right heel-4.8 cm X 3 cm; and the left ankle remained the same.

On 7/16/15, at 2:00 p.m. RN-C reviewed the eHR and verified that at a quick glance, wound measurements were documented on 7/8, 7/1, 6/19, 6/5 and 5/22/15. RN-C also stated R165 did not see the facility's wound physician, but went to a vascular physician. A review of the Consult section of the eHR revealed R165 had seen a vascular surgeon on 6/23/15. However, the vascular surgeon did not note the size of R165's pressure ulcers.

Also found in the Consult section of the eHR was a dictated note from R165's regular physician indicating R165 had been seen on 6/25/15. The dictated note indicated the coccyx pressure ulcer

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was healing well, the initial Stage IV area on the right buttocks had stabilized, but didn't appear to making any progress and R165 had developed some new areas on the heels. There was no indication as to the size of the new areas on the heels. A review of the eHR revealed the facility failed to address and measure the new areas until 7/1/15, when wound measurements were documented.

R96 was admitted on 4/30/15, with an unstageable pressure ulcer on the right heel, and the facility did not fully assess and provide regular monitoring of the pressure ulcer.
On 7/13/15, at 6:40 p.m. RN-B indicated R96 had an unstageable ulcer.
R96 was admitted to the facility on 4/30/15, with a diagnoses of hypertension (HTN), diabetes (DMII), malnutrition and gout. The Admission Skin Risk Assessment dated 4/30/15, indicated R96 was admitted with one unstageable deep tissue injury. The Braden Scale (for Predicting risk of pressure sore) indicated the resident was at moderate risk for developing pressure ulcers and interventions were put in place.
The assessment did not identify location or measurements of the unstageable pressure wound.
A review of the eHR nursing progress notes indicated no nursing notes were available which identified the pressure ulcer until 5/6/15. The following eHR progress notes revealed the following:
5/6/15 "noted a wound on right heel. Area measuring 1.5 cm x 1.5 cm. No s/s [signs and symptoms] of infection noted. Resident c/o [complained of] feeling dizzy..."
5/7/15 "Unstageable wound on right heel, 1.5 cm x 1.5 cm, 90% eschar and 10% slough noted,

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surrounding skin is intact, and no drainage present. Wound present on admit from prior nursing home. Resident is alert and oriented, primary diagnosis of DM II, HTN, Gout and lumbago, Res. reports she has little to no feeling in BLE [bilateral lower extremities] secondary to DM..."
5/12/15 "...NP [nurse practitioner] here... New orders for doctor (personal name) in house wound doctor to f/u [follow up] on wound."
5/22/15 "Open area right heel appears clean and dry. TX done as order. Wound measuring 1.5 cm x 1 cm. No inflammation (sic) or drainage noted. Resident denies pain or discomfort."
5/26/15 "Dr. [personal name] here and saw resident. Wound measures 0.5 cm x 0.5 cm. No s/s of infection. Denies any pain in area. Cont. with current treatment cleanse with normal saline and apply hydrogel cover with foam and wrap with kerlix change QD [every day]."
7/14/15 "Wound on right heel is healed now. TX DC. (treatment discontinue)."
According to the eHR the facility's wound physician saw R96 on 5/19, 5/26, 6/2 and 6/9/15. On 6/9/15, the physician's note read: "Wound #1 Right, Posterior heel is an acute Stage 3 Pressure Ulcer and has received a status of Not Healed. Subsequent wound encounter measurements are 0.2 cm length x 0.3 cm width, with an area of 0.06 sq cm. The patient reports a wound pain of level 0. Wound bed is 76-100% epithelialization..." The current treatment was to cleanse the wound with cleanser, protect periwound with skin prep daily and as needed for soiling and or saturation. There was no indication in the eHR the wound physician had seen R96 since 6/9/15, nor were there any further pressure ulcer wound measurements since that day. The medical record indicated the skin prep treatment

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F 314	Continued From page 15 was discontinued on 7/14/15, as wound was healed. Weekly Skin and Body Check audit forms were completed on: 5/6/15, 5/22/15, 6/5/15, 6/19/15, 7/3/15 and 7/10/15. The form directed nursing staff to make a progress note regarding the outcome of the skin check. Body checks were missing for the week of 6/12 and 6/26/15. On 7/16/15 at approximately 11:00 a.m., RN-B verified the lack of a complete assessment of the pressure ulcer on admission and the inconsistent monitoring of the wound.	F 314		
F 465 SS=B	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not maintain cleanliness for 3 of 4 mechanical lift stands, which had the potential to affect eleven of eleven residents (R3, R20, R36, R59, R89, R92, R95, R109, R127, R131) on the second floor and 3 of 8 residents (R48, R103, R186) on the third floor who required a mechanical lift stand for transfers. Findings include: During an initial facility tour on 7/13/15, at 1:00 p.m. three mechanical lift stands were observed to have an accumulation of food particles/crumbs, hair, and particles of dust on the front edge of the	F 465	The Director of Nursing will assure the associates are educated in the proper cleaning of lifts which includes cleaning the lifts after each use. The night shift associates will continue to clean the lifts every night as scheduled. Shift Action Rounds are completed by nurses and include auditing of the cleanliness of lifts. Environmental associates will provide deep cleaning of the lifts on a weekly basis. The status of this deficiency will be monitored and reviewed at the quarterly quality council meeting. The Director of Nursing and Director of Environmental Servces are responsible for this plan of	8/21/15

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F 465	Continued From page 16 foot plates of the machines. The accumulation of debris was across the entire front of the foot plate and one fourth to one half inch thick all across the plate. On 7/15/15, at 9:10 a.m. nursing assistant (NA)-D transferred R103 using the mechanical stand in the third floor shower room. NA-D verified R103 did not have shoes on and the machine foot piece had a heavy accumulation of food particles/crumbs, hair and particles of dust on the front edge of the foot plate. NA-D cleaned the foot plate of the mechanical stand, at this time. When interviewed on 7/15/15, at 9:15 a.m. NA-A, NA-B, NA-C and NA-D verified the two mechanical stands stored in the second floor shower room had a heavy accumulation of what looked like food particles/crumbs, hair, and particles of dust across the entire front of the foot plate and one fourth to one half inch thick on both the stands. The nursing assistants did not know who was responsible for cleaning of the mechanical stands and expressed thinking the housekeeper cleaned the stands. The nursing assistants validated the foot plates needed to be cleaned. During an interview with housekeeper (H)-A on 7/15/15, at 9:30 a.m. H-A stated, "Nursing is responsible for cleaning the stands." The director of housekeeping was on vacation and the human resource director (HRD) provided a form dated 3/10/15, titled, Night Shift Action Rounds, which read; "NAR tasks: Electric lifts and wheelchair scales are wiped down with sani-wipe and this is to include the base for the feet on the stand up lift." The HRD reported there was no	F 465	correction.	

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F 465	Continued From page 17 further policy or procedure for the cleaning of the lifts other than the direction on the Night Shift Action Rounds form.	F 465		

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K 000	INITIAL COMMENTS 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 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 Marian 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: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145 Or by email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us	K 000	EPOC	

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

Electronically Signed | 08/07/2015

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 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 Marian is a 5-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type I(332) construction. In 1969 a 2 story addition was constructed above the 3rd story that was determined to be of type I(332) construction. In 2002 a 1 story addition was constructed to the north that was determined to be type I(332) construction. Because the original building and the addition(s) meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected, The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. Also, all sleeping rooms have single station smoke detection. The facility has a licensed capacity of 90 beds and had a census of 74 at the time of the survey. A deficiency for K-067 and annual waiver has	K 000		

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K 000	Continued From page 2 been written in past surveys, regarding corridors used as a plenum. It has been determined that this facility meets the CMS S&C-06-18 letter from May 26, 2006. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide protection of hazardous areas in accordance with the requirements of NFPA 101 -2000 edition, Section 19.3.2.1 and 8.4.1 Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/14/2015, it was observed that: A) 3rd floor storage room 308A has a 2'x2' hole in fire rated ceiling. B) Soiled Laundry Room G-7 door to corridor	K 029	Cerenity Senior Care - Marian of Saint Paul's Credible Allegation of Compliance has been prepared and timely submitted. Submission of this Credible Allegation of Complainace is not a legal admission that a deficiency exists or that the Statement of the Deficiencies were correctly sited, 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 thie Credible Allegation of Compliance. In addtion,	8/7/15

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K 029	Continued From page 3 does not auto close and latch into the frame. C) Trash Room G-4 has penetrations in the wall to corridor. D) Soiled Utility Room 323B door to corridor did not auto close and latch into the frame. This deficiency was verified by the facility Director of Envirronmental Services (PF) at the time of discovery.	K 029	preparation and submission of this Credicble Allegation of Compliance does not contsitute 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. Accordingy, 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) calendar days of receipt of the Statement of Deficincies as a condition to particopate 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 admission by the Facility. The identified items A-D have been corrected. Director of Environmental Services is responsible for assuring these areas are corrected and future areas identified and repaired.	
K 050 SS=D	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	K 050		8/3/15

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K 050	Continued From page 4 This STANDARD is not met as evidenced by: Based on review of reports, records and interview,, it was determined that the facility failed to conduct fire drills in accordance with NFPA 101 LSC (00) Section 19.7.1.2. This deficient practice could affect how staff react in the event of a fire. Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/14/2015, based on review of available documentation it was reveled that the facility had no documentation for fire drills conducted on the evening shift during the 3rd quarters of 2014. This deficiency was verified by the facility Director of Envirronmental Services (PF) at the time of discovery.	K 050	The schedule was reviewed by the Director of Environmental Services with the maintenance team and we will adhere to the set schedule of varied shifts/times going forward. The fire drills will be reviewed at the Safety Committee Meetings. The Director of Environmental Services is responsible for this plan of correction.	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5	K 056		8/7/15

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K 056	Continued From page 5 This STANDARD is not met as evidenced by: Based on observation, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7: NFPA 13 - 1999 edition, Sections 5-1.1, 5-6.3.4, 5-6.5.2.3 and 5-13.8.1. The deficient practice could affect all residents, staff and visitors within the smoke compartment. Findings include: On facility tour between 09:00 AM and 01:00 PM on 07/14/2015, it was observed that ceiling tiles throughout the 1st floor Surgical corridor and room area are missing. This deficiency was verified by the facility Director of Envirronmental Services (PF) at the time of discovery.	K 056	All identified ceiling tiles have been replaced. A walk through observation will be completed to assure we have identified all other missing tiles. The Director of Environmental Services is responsible for this plan of correction.	