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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 8SV7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00538

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

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

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/29/2016** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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
	117			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Facility's request for a continuing waiver involving F458 is recommended.

17. SURVEYOR SIGNATURE — Date :
Momodou Fatty, HFE NE II — 12/29/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 03/03/2017 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/16/2016
(L33)

Posted 03/03/2017 Co.

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245255
January 13, 2017

Mr. Michael Syltie, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Dear Mr. Syltie:

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 December 16, 2017 the above facility is certified for or recommended for:

117 Skilled Nursing Facility/Nursing Facility Beds

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

Your request for waiver of F458 has been recommended based on the submitted documentation. You will receive notification from CMS only if they do not concur with our recommendation.

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

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 13, 2017

Mr. Michael Syltie, Administrator
Cerenity Care Center on Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

RE: Project Number S5255026 & H5255039

Dear Mr. Syltie:

On November 18, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 23, 2016. (42 CFR 488.422)

In addition on November 18, 2016, as authorized by the CMS Region V Office, we notified you of the imposition of the following enforcement remedy:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 5, 2017. (42 CFR 488.417 (b))

Furthermore, in our letter of November 18, 2016, we informed you that in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 5, 2017.

This was based on the deficiencies cited by the Department's Office of Health Facility Complaints for an abbreviated standard survey completed October 5, 2016, and a standard survey completed by the Departments of Health and Public Safety on November 3, 2016. The most serious deficiencies at the time of the standard survey were found 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), and the most serious deficiencies at the time of the complaint investigation were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On December 29, 2016, the Minnesota Departments of Health and Public Safety, and the Office of Health Facility Complaints 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 November 3, 2016, and a complaint investigation completed October 5, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 16, 2016. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 29, 2016, as of December 16, 2016. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 16, 2016.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of November 18, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective January 5, 2017, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective January 5, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective January 5, 2017, is to be rescinded.

In our letter of November 18, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 5, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on December 16, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Your request for a continuing waiver involving the deficiency cited under K067 at the time of the November 3, 2016 standard survey has been forwarded to CMS for their review and determination. Your facility's compliance is based on pending CMS approval of your request for waiver.

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
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 Y1	A. Building B. Wing Y2	12/29/2016 Y3

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).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	F0280	Correction	ID Prefix	F0282	Correction	ID Prefix	F0312	Correction
Reg. #	483.20(d)(3), 483.10(k)(2)	Completed	Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	483.25(a)(3)	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	F0314	Correction	ID Prefix	F0315	Correction	ID Prefix	F0325	Correction
Reg. #	483.25(c)	Completed	Reg. #	483.25(d)	Completed	Reg. #	483.25(i)	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	F0332	Correction	ID Prefix	F0412	Correction	ID Prefix	F0431	Correction
Reg. #	483.25(m)(1)	Completed	Reg. #	483.55(b)	Completed	Reg. #	483.60(b), (d), (e)	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	F0441	Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	483.65	Completed	Reg. #		Completed	Reg. #		Completed
LSC		12/16/2016	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 01/13/2017	SIGNATURE OF SURVEYOR 32984	DATE 12/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON
11/3/2016

☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245255 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	12/8/2016 (Y3)

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0211	Correction Completed 11/04/2016	ID Prefix Reg. # NFPA 101 LSC K0351	Correction Completed 11/04/2016	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 11/07/2016
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 (INITIALS) SR/KJ	DATE 01/13/2017	SIGNATURE OF SURVEYOR 32984	DATE 12/8/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
11/3/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00538 Y1	A. Building B. Wing Y2	12/29/2016 Y3

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix	20565	Correction	ID Prefix	20570	Correction	ID Prefix	20840	Correction
Reg. #	MN Rule 4658.0405 Subp. 3	Completed	Reg. #	MN Rule 4658.0405 Subp. 4	Completed	Reg. #	MN Rule 4658.0520 Subp. 2 B	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	20855	Correction	ID Prefix	20905	Correction	ID Prefix	20965	Correction
Reg. #	MN Rule 4658.0520 Subp. 2 E.	Completed	Reg. #	MN Rule 4658.0525 Subp. 4	Completed	Reg. #	MN Rule 4658.0600 Subp. 2	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	21325	Correction	ID Prefix	21375	Correction	ID Prefix	21426	Correction
Reg. #	MN Rule 4658.0725 Subp. 1	Completed	Reg. #	MN Rule 4658.0800 Subp. 1	Completed	Reg. #	MN St. Statute 144A.04 Subd. 3	Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		12/16/2016
ID Prefix	21545	Correction	ID Prefix	21620	Correction	ID Prefix		Correction
Reg. #	MN Rule 4658.1320 A.B.C	Completed	Reg. #	MN Rule 4658.1345	Completed	Reg. #		Completed
LSC		12/16/2016	LSC		12/16/2016	LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	SR/KJ	01/13/2017	32984	12/29/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION A. Building B. Wing (Y2)	DATE OF REVISIT (Y3)
00538		12/28/2016

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 State surveyor to show those deficiencies previously reported 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 State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20565 Reg. # MN Rule 4658.0405 Subp. 3 LSC	Correction Completed 12/16/2016	ID Prefix 21850 Reg. # MN St. Statute 144.651 Subd. 14 LSC	Correction Completed 12/16/2016	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 01/13/2017	SIGNATURE OF SURVEYOR 10567	DATE 12/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 10/5/2016	☐ 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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245255	A. Building B. Wing	12/28/2016

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0282 Reg. # 483.20(k)(3)(ii) LSC	Correction Completed 12/16/2016	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	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	**REVIEWED BY (INITIALS)** SR/KJ	**DATE** 01/13/2017	**SIGNATURE OF SURVEYOR** 10567	**DATE** 12/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 10/5/2016	☐ 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: 8SV7

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 **11/03/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
06/30

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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: (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Susan Miller, HFE NE II 11/28/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Program Specialist 12/12/2016 (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)

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
Health Waiver Request F458 - Emailed CMS 12/15/2016. Co.

Posted 12/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
November 18, 2016

Mr Michael Syltie, Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, Minnesota 55107

RE: Project Number H5255038, H5255039 and S5255026

Dear Mr. Syltie:

On October 28, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department's Office of Health Facility Complaints for an abbreviated standard survey survey, completed on October 5, 2016 tThis survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections were required.

On November 3, 2016, the Minnesota Departments of Health and Public Safety completed a standard survey 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 evidence by the attached CMS-2567, whereby corrrections are required.

As a result of our finding that your facility continues to not be in substantial compliance, we are imposing the following Category 1 remedy:

- State Monitoring, effective , November 23, 2016 (42 CFR 488.422)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective January 5, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective January 5, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 5, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Cerenity Care Center On Humboldt is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective NO DATA. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions

regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by January 5, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 5, 2017 (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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING _____ B. WING _____	11/03/2016

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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable 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 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280		12/16/16

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

Electronically Signed | 11/27/2016

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F 280	Continued From page 1 by: Based on observation, interview, and document review, the facility failed to update the comprehensive care plan to include interventions for reducing risk of falls for 1 of 4 residents (R102) reviewed for falls with injury. Findings include: R102 had diagnoses that included shortness of breath, generalized muscle weakness, congestive heart failure, acute respiratory failure, low blood pressure, anemia (lowered ability of the red blood cells to carry oxygen), and type II diabetes. The care area assessment dated 2/24/16 revealed R102 required limited assist with ambulating, supervision with toileting, and was unsteady when ambulating, moving from seated to standing, turning around, moving on and off the toilet, and transferring from surface to surface. The assessment identified R102 at risk for falls. Event reports indicated R102 had five falls during the month of October on 10/8/16, 10/13/16, 10/17/16, 10/25/16, and 10/27/16. Three of these falls happened when R102 attempted to use the bathroom alone in room, and one fall resulted in a broken finger. Progress notes highlighted interventions reviewed by the interdisciplinary team. R102 broke the right fourth finger on 10/8/16 at 4:45 a.m., when R102 got out of bed to go to the bathroom and fell. Progress notes dated 10/13/16 instructed R102 to wear a splint on the injured right hand most of the time (splint could be removed for bathing, washing, and gentle range of motion).	F 280	The facility has policies and procedures in place to assure the resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. The comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with a responsibility for the resident, and other appropriate staff in disciplines as determined but the resident□s needs, and, to the extent practicable, the participation of the resident, the resident□s family or the resident□s legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. The policy and procedure titled Care Plan Revision was reviewed and deemed appropriate. The policy and procedure titled Fall Event and Post Fall Assessment was reviewed and deemed appropriate. R102□s care plan has been updated with the individualized interventions used to prevent falls. All residents who have had falls in the past 90 days or have been assessed to be at risk for falls have had their care plans reviewed and updated if necessary to include individualized interventions to prevent falls.	

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F 280	Continued From page 2 On 10/13/16 at 11:30 p.m., R102 was using the bathroom in room just before falling. Progress notes dated 10/14/16 indicated R102 was provided a spill proof urinal to use at night instead of getting up to go to the bathroom. Staff also discussed proper footwear when walking to the bathroom, and supplied R102 with a new pair of non-skid socks. On 10/17/16 at approximately 5:00 a.m., R102 slipped off wheelchair. Progress notes dated 10/18/16 indicated a physical therapy evaluation had been completed, and the rehabilitation nursing program for transfers included stand pivot, limited assist of one, and use of a gait belt. On 10/25/16 at approximately 6:45 a.m., staff found R102 lying on right side, on the scale in the lounge. R102 explained that before falling, was trying to weigh self. In progress notes dated 10/25/16, staff noted the scale was in the lounge next to R102's room, out of sight of the nurses' station. According to the notes, R102 had previous falls related to weighing self without staff present. Staff reminded R102 not to use the scale alone, and decided to move the scale to the opposite lounge so the resident would have to walk past the nurses' station to get to the scale. Staff also discontinued an order for daily weights, and started weekly weights. On 10/27/16 at approximately 3:30 a.m., R102 was turning to use the toilet and lost balance. Progress notes from 10/27/16 explained the resident was able to reach both the call light and urinal from bed, but neither had been used. Staff documented re-education to use call lights and urinal at night to avoid having to get out of bed.	F 280	Mandatory education for all licensed nursing staff will be provided on December 6th and December 7th, 2016. Education will include review of policies titled Care Plan Revision and Fall Event and Post Fall Assessment as well as the expectations for updating care plans with fall interventions. Care plan audits will be completed after each fall to ensure the care plan was updated with new interventions through January 24, 2017. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	

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F 280	Continued From page 3 Nursing assistants used Care Cards to quickly access up to date information about how to take care of each resident. Care cards included information about special needs, wake-up time and bed time, dietary information, toileting and repositioning, activities of daily living, ambulation, transfers, rehabilitation programs, scheduled items (bath, weights, etc.), and special interventions. R102's care card, dated 11/03/16, directed staff to keep the resident's right hand in a splint at all times (remove for hygiene), supervise toileting, keep a spill proof urinal at the bedside and encourage the resident to use it, remind resident to use call light, limited assist of one for transfer, use of pivot transfers and gait belt, and to use non-skid socks when possible. The falls care plan was last edited 8/21/16, and mentioned R102 was at risk for falls due to unsteadiness when moving from sitting to standing, moving on and off the toilet, and transferring from surface to surface. The care plan did not mention that R102 fell five times in October and broke a finger. The long term goal, dated 8/21/16, was to keep R102 free from fall related injuries through 11/30/16. The facility last updated the approaches used to meet this goal on 12/15/14. Approaches listed: analyze R102's falls to determine patterns, avoid restraint use, keep the call light in reach, obtain a physical therapy consult, orient R102 when there are changes in furniture placement or environment, keep the environment clutter free, and use a wanderguard at all times. The activities of daily living/rehabilitation care plan was last edited 11/02/16, and highlighted deficits in R102's mobility. This care plan included	F 280		

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F 280	Continued From page 4 the current rehabilitation program for transfers (stand pivot, limited assist of one, use gait belt), but did not include the assessment that R102 required supervision with toileting. Although nursing assistant care cards provided current interventions used to reduce risk of falls, the facility did not update R102's comprehensive care plan after recent falls to include the following treatment and interventions determined by clinical staff and reviewed by the interdisciplinary team: Wear a splint on injured right hand most of the time, use a spill proof urinal at night to avoid getting up to go to the bathroom, wear non-skid socks when appropriate, and supervise toileting. The facility policy titled, Fall Event and Post Fall Assessment, last updated 12/15, instructed the charge of building, clinical manager, or designee to ensure the newly implemented intervention(s) is documented in all necessary places (Care Card, Care Plan, etc.). In an interview on 11/03/16 at 2:37 p.m., when asked about whether R102's fracture and interventions for recent falls should be in the care plan, Registered Nurse (RN-B) said, "The fracture and history of fracture should be put in the fall care plan. I will need to update that. I should have put all that in the care plan. I put it in the care card so that the staff knows, but I need to put it into the care plan."	F 280		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282		12/16/16

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F 282	Continued From page 5 care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for 1 of 3 residents (R75) with identified dental needs; for 1 of 3 residents (R63) who required staff assistance with oral care, and for 2 of 5 residents (R31, R24) who required assistance with incontinent care. Findings include: R75 on 11/01/6, at 12:09 p.m., was observed to have missing teeth. The care plan revised 8/29/16, identified R75 as having broken and missing teeth and indicated R75 was to see the dentist as needed. On 11/02/16, at 1:39 p.m. health unit coordinator (HUC)-G reviewed R75's record and found R75 had been to the dentist on 3/31/15, and the dentist had recommended a return visit six months later. No return visit to the dentist was found in the record and this was confirmed at this time by HUC-G. R63, document review of the form titled, Care Plan, dated, 3/20/15, read, total assistance with oral cares. The document titled, Care Area Assessment (CAA) dated 3/10/16, read, "Resident is NPO (nothing per oral) and receives TF (tube feeding) Staff assist with oral cares-mouth swabs Q2H (every 2 hours). Thick white/yellow coating over tongue, had been	F 282	The facility has policies and procedures in place to assure that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident□s written plan of care. The policy titled Mouth Care was reviewed and deemed appropriate. The policy titled Urinary Incontinence was reviewed and deemed appropriate. The policy titled Following the Plan of Care was reviewed and deemed appropriate. R75 was discharged from the facility on 11/20/16. Multiple attempts to reach the Responsible Party by phone were made by facility staff. A copy of the consent form was at the Nursing Station for the Responsible Party to sign, if he visited. A certified letter, including a copy of the Consent Form, was mailed to the Responsible Party and was not returned prior to the discharge. R63 has been re-assessed for oral care needs. He is offered/provided oral care with repositioning. The care plan has been reviewed and updated as needed. Pre-moistened swabs are kept at the bedside at all times. Staff to verify moistened swabs to be kept at the bedside, has been added to the NA/R Care Card.	

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

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F 282	Continued From page 6 treated with nystatin but no effect-does not appear to be thrush. Resident denies any discomfort, no bleeding, or open areas present, and coating is only on tongue-not sides of cheeks. Per wife has been present since he started TF. Staff to continue to assist with oral cares and will refer to dental prn." Document review of the form titled, Care Sheet, directed nursing staff for mouth swabs every two hours. During observation on 11/1/16, at 3:00 p.m. R63 was observed to have a white moist substance on the lips and tongue. R63 was observed with a heavy coating on the tongue and did complain that it was bothersome. Family member (F)-B is present and stated the facility is suppose to provide oral care every two hours using the pre-moistened swabs but there are none in the drawers currently and F-B verified frequently having to ask for more swabs because F-B did not think the oral cares were being provided every two hours. During continuous observations of R63's care on 11/2/16, from 7:30 a.m. through 12:15 p.m.: R63 was observed to be lying in bed and there were no offers to provide oral care. On 11/2/16, at 1:21 p.m. registered nurse (RN)-A, nursing assistants (NA)-A and NA-B were in the room with R63 providing care, and when interviewed, verified no oral care had been provided to R63 yet today but they would provide the oral care now. Document review of the policy titled, Mouth Care, dated revised October 2010, directed, to review the resident's care plan to assess for any special	F 282	All residents with tube feedings were reviewed, swabs are at the bedside, care cards and care plans were updated where appropriate. All care plans for residents who require assistance with oral care cares have been reviewed and updated as needed. R31 and R24 have had a new Bowel and Bladder Assessment completed. New Tissue Tolerance Test and Braden Scales have also been completed. The care plans have been reviewed and updated as needed. NA/R□s will be trained to round with the oncoming NA/R to provide pertinent information about the residents they will be caring for on the next shift. All care plans for residents who require assistance with incontinent care have been reviewed and updated as needed. Mandatory education for all nursing staff will be provided on December 6th and December 7th, 2016. Education will include review of policies titled Mouth Care, Urinary Incontinence, and Following the Plan of Care, as well as the expectations for following the plan of care, providing oral care, incontinence care, and ensuring dental appoints are made and attended as recommended. Audits for oral care and incontinent care assistance will be completed daily alternating on all three shifts x 2 weeks	

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	245255	A. BUILDING _____ B. WING _____	11/03/2016

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F 282	Continued From page 7 needs of the resident. During an interview with RN-A on 11/2/16, at 1:30 p.m. verified the facility expectation was to provide oral care every two hours. R31's urinary incontinence care plan, last updated 10/10/16, indicated R31 was continent of bladder and bowel. The long term goal listed in the care plan was for R31 to maintain current level of bladder and bowel continence. To meet this goal, the care plan directed staff to provide toileting every two hours with extensive assist of one. R31's nursing assistant care card, dated 11/03/16, directed care staff to provide toileting every two hours with extensive assist of one. During continuous observation on 11/03/16 from 8:22 a.m. until 11:24 a.m., R31 was first seen leaving bedroom using rolling walker to reach a reclining chair in front of the nurses' station. R31 was observed moving back and forth between sitting in the reclining chair, and sitting at a table in the dining room. R31 remained sitting either in the reclining chair or the dining room for three hours. At 11:24 a.m. R31 got up from the table and walked down the hall toward bedroom using the rolling walker. The back of R31's dress had a dark marking on it. R31 got to bedroom, took off brief and dress and seemed distraught saying, "I wet my pants, I wet my pants. Can you put this in the laundry?" At this time the nurse had come down to R31's bedroom to give medications. The nurse helped R31 put on a clean brief and dress, and gave the medications. When asked whether staff helped with toileting, R31 replied	F 282	and then 3 x/week alternating between AM and PM shifts through January 24, 2017. Audits of dental appointments will be completed after each dental appointment to ensure appointments are made as recommended and written on the calendar. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	

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F 282	Continued From page 8 "Sometimes." In interview on 11/03/16 at 11:02 a.m. registered nurse (RN-E) said R31 was independent but staff encouraged toileting, and that R31 was assist of one with activities of daily living. On 11/03/16 at 12:14 p.m., trained medication administrator (TMA-A) said that R31 goes to the bathroom independently, but wets brief once in a while. TMA-A said that staff were supposed to ask R31 every two hours to go to the bathroom, but the resident might not want to go. In an interview on 11/03/16 at 11:40 a.m., registered nurse (RN-B) said R31 was continent so she does toilet herself at times too, but staff should be prompting R31 to go to the bathroom. RN-B confirmed R31 needed extensive assist with the briefs, and said the nursing aid care card probably needed to be reworded in regards to toileting, as the toileting program was not clear as written. R24's self-care care plan dated as edited on 8/8/16, directed staff that R24 does not use the toilet due to inability to sit on the toilet safely and that R24 required, "Check and change q [every] 2 hours. Total dependence of 1-2 staff to check, change, and provide good peri care after each incontinent episodes." R24's skin integrity care plan dated as edited on 8/8/16, identified R24 had "PROBLEM: Resident is at risk for skin impairments and pressure ulcers AEB incontinence, immobility, totally dependent for ADL's [assist of daily livings], and mobility, APPROACH: Check and change Q 2 hours and PRN, provide Peri care after incontinence. Report	F 282		

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F 282	Continued From page 9 redness and breakdown to nurse. Per turning and repositioning observation resident tolerates 2 hours of positioning without redness noted. Reposition Q 2 hours as resident allows." Undated nursing assistant assignment sheet reads, "... 2 staff present for cares Toileting: TA2 [total assist of two] Change every 2 hours and per request. Repositioning: TA2 every 2 hours Heels up on pillows when in bed". On 11/1/16 at 3:44 p.m., during observations of care, R24 was incontinent of bowel and bladder when the incontinence pad was checked and changed. NA-Z verified R24 was incontinent with bowel and bladder. On 11/2/16, from 7:57 a.m., until 10:44 a.m., R24 was observed to be in the bed, lying on back with bed in a low position and eyes closed. At 10:44 a.m. NA-A started to perform morning cares including turn, check and change of R24's incontinence brief. Upon removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and the skin was intact. At 10:59 a.m. a NA-A confirmed R24 was last repositioned and checked and changed around 7:30 a.m. NA-A added, R24 was wet because R24 is a heavy wetter. On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A replied that the expectation was for all nursing staff to follow the care plan. RN-A verified R24 should have been repositioned, and checked and changed.	F 282		
F 312	483.25(a)(3) ADL CARE PROVIDED FOR	F 312		12/16/16

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F 312 SS=D	Continued From page 10 DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral care for 1 of 1 resident's (R63) dependent upon staff for personal cares; and failed to check and change 1 of 1 resident (R24) dependent on staff for incontinent care. Findings include: R63 was observed 11/1/16, at 3:00 p.m. to have a white moist substance on the lips and tongue. R63 was observed with a heavy coating on the tongue and did complain that it was bothersome. Family member (F)-B was present and stated the facility is supposed to provide oral care every two hours using the pre-moistened swabs but there are none in the drawers currently and F-B verified frequently having to ask for more swabs. F-B questioned if oral cares were being provided every two hours. During continuous observations of R63's care on 11/2/16, from 7:30 a.m. through 12:15 p.m., R63 was observed to be lying in bed and there were no offers to provide oral care. On 11/2/16, at 1:21 p.m. registered nurse (RN)-A, nursing assistants (NA)-A and NA-B were in the	F 312	The facility has policies and procedures in place to ensure residents who are unable to carry out activities of daily living received the necessary services to maintain good nutrition, grooming and personal and oral hygiene. The policy titled Mouth Care was reviewed and deemed appropriate. The policy titled Following the Plan of Care has been reviewed and deemed appropriate. The policy titled Urinary Continence and Incontinence Assessment and Management was reviewed and deemed appropriate. R63 has been re-assessed for oral care needs. He is offered/provided oral care with repositioning. The care plan has been reviewed and updated as needed. Pre-moistened swabs are kept the bedside all times. Staff to verify moistened swabs to be kept at the bedside, has been added to the NA/R Care Card. All residents with tube feedings were reviewed, swabs are at the bedside, care	

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F 312	Continued From page 11 room with R63 providing care, and when interviewed, verified no oral care had been provided to R63 yet today but they would provide the oral care now. R63's quarterly Minimum Data Set (MDS) dated 3/9/16, indicated R63 had intact cognition and was dependent with activities of daily living (ADL's). Document review of the form titled, Care Plan, dated, 3/20/15, read, total assistance with oral cares. The document titled, Care Area Assessment (CAA) dated. 3/10/16, read, "Resident is NPO (nothing per oral) and receives TF (tube feeding) Staff assist with oral cares-mouth swabs Q2H (every 2 hours). Thick white/yellow coating over tongue, had been treated with nystatin but no effect-does not appear to be thrush. Resident denies any discomfort, no bleeding, or open areas present, and coating is only on tongue-not sides of cheeks. Per wife has been present since he started TF. Staff to continue to assist with oral cares and will refer to dental prn." Document review of the form titled, Care Sheet, directed nursing staff for mouth swabs every two hours. Document review of the policy titled, Mouth Care, dated revised October 2010, directed, to review the resident's care plan to assess for any special needs of the resident. During an interview with RN-A on 11/2/16, at 1:30 p.m. verified the facility expectation was to provide oral care every two hours.	F 312	cards and care plans were updated where appropriate. All care plans for residents who require assistance with oral care cares have been reviewed and updated as needed. A new Bowel and Bladder Assessment has been completed. R24 has had a new Bowel and Bladder Assessment completed. A new Tissue Tolerance Test and Braden Scale have also been completed. The care plans have been reviewed and updated as needed. NA/R□s will be trained to round with the oncoming NA/R to provide pertinent information about the residents they will be caring for on the next shift. All care plans for residents who require assistance with incontinent care have been reviewed and updated as needed. Mandatory education for all nursing staff will be provided on December 6th and December 7th, 2016. Education will include review of policies titled Mouth Care, Following the Plan of Care, and Urinary Continence and Incontinence Assessment and Management as well as the expectations for following the plan of care, providing oral care, incontinence care and ensuring dental appoints are made and attended as recommended. Audits for oral care and incontinent care assistance will be completed daily	

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F 312	Continued From page 12 Resident (R24) was incontinent of bowel and bladder, and did not receive assistance with incontinence care every two hours on 11/1/16 and on 11/2/16 from 7:57 a.m., until 10:44 a.m., (two hours and 47 minutes).. On 11/1/16 at 3:44 p.m., R24's was observed to be incontinent with bowel and bladder during check and change of the incontinent pad. NA-Z verified R24 was incontinent with bowel and bladder. On 11/2/16, during continous observations. from 7:57 a.m., until 10:44 a.m., R24 was not checked for incontinence. The following was observed: - Between 7:57 a.m. and 8:31 a.m. R24 was observed to be in the bed, lying on back with eyes closed. The bed was in low position and R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 8:31 a.m. nursing assistant (NA)-A entered R24's room, looked at R24 and stepped out of the room without providing cares and/or speaking to R24. - From 8:32 a.m. until 9:08 a.m. R24 was lying on back in bed with eyes closed. The bed was in low position. R24 covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:08 a.m. NA-A entered R24's room, looked at R24, opened R24's closet, closed it, and stepped out of the room without providing cares and/or speaking to R24. - Between 9:12 a.m. and 9:42 a.m. R24 was observed lying on back in bed with eyes closed. The bed was in low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - From 9:12 a.m. until 9:42 a.m. no staff provided positioning or checked R24 for incontinence.	F 312	alternating on all three shifts x 2 weeks and then 3 x/week alternating between AM and PM shifts through January 24, 2017. Audits of dental appointments will be completed after each dental appointment to ensure appointments are made as recommended and written on the calendar. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	

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F 312	Continued From page 13 - At 9:43 a.m. NA-A. walked past R24's room, looked at the room but never entered. - Between 9:43 a.m. and 9:49 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in low position. R24 was covered with a bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:49 a.m. NA-A entered R24's room, looked at R24 and stepped out of the room without providing cares, such as check, change, repositioning and/or speaking to R24. - From 9:49 a.m. to 10:41 a.m. R24 was observed in bed, lying on back with eyes closed and bed in low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 10:41 a.m. NA-A entered R24's room with mechanical Hoyer lift. NA-A started to perform morning cares which included, turn, check and change of R24's incontinence brief. Upon removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and skin was intact. NA-A confirmed R24 was last repositioned and checked and changed around 7:30 a.m. and added, is a heavy wetter. The quarterly Minimum Data Set (MDS) dated 8/8/16, indicated R24 was always incontinent of bladder and bowel, required total assistance of two staff for bed mobility, transfers and toileting. Care Area Assessment for Urinary incontinence dated 5/12/16, reads, "[R24] triggers Urinary Incontinence D/T [due to] her requiring total assistance with toileting. [R24] is always incontinent of bladder and bowel... Staff will continue to check and change every 2 hours and	F 312		

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F 312	Continued From page 14 PRN [as needed]". R24's self-care care plan dated as edited on 8/8/16, identified R24 had a self care deficit in toileting, does not use toilet due to inability to sit on toilet safely and requires check and change every 2 hours. The plan directed staff that R24 required total dependence of 1-2 staff to check, change, and provide good peri care after each incontinent episode. R24's skin integrity care plan dated as edited on 8/8/16, identified, "GOAL: Resident's skin will remain intact through the next review date. APPROACH: Check and change Q 2 hours and PRN, provide. Peri care after incontinence. Report redness and breakdown to nurse." Undated nursing assistant assignment sheet reads, "... 2 staff present for cares Toileting: TA2 [total assist of two] Change every 2 hours and per request." On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A indicated the expectation was for all staff to follow the care plan and verified R24 should have been checked every two hours for incontinence. Policy and procedure title URINARY CONTINENCE AND INCONTINENCE - ASSESSMENT AND MANAGEMENT, revised September 2010, directed staff, "19. The staff will document the results of the toileting trial in the resident's medical record. C. A 'check and change' strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to	F 312		

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F 312	Continued From page 15 protect the skin."	F 312		
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: Based on document review,observation and interview, the facility failed to ensure 2 of 3 residents (R63, R24) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R63 who was at risk of developing pressure ulcers did not receive a position change for 4 hours. Document review of the Care Area Assessment (CAA) dated 3/9/16, indicated R63 was cognitively intact and able to make needs known. R63 was assessed as being moderately at risk for pressure ulcers, and directed, unable to off load independently, assist with turning and repositioning every two hours, staff monitor skin daily with cares and licensed staff assess every week with bath body audit. The plan of care dated	F 314	The facility has policies and procedures in place to assure 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. The policy titled Following the Plan of Care was reviewed and deemed appropriate. The policy titled Repositioning was reviewed and deemed appropriate.	12/16/16

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F 314	Continued From page 16 9/6/16, directed at risk for pressure ulcer development and to reposition every 2 hours lying and sitting. During continuous observation of R63's care on 11/2/16, from 7:30 a.m. through 10:00 a.m. R63 remained positioned to the right side while lying in bed without an offer to change position. When interviewed on 11/2/16 at 10:00 a.m. nursing assistant (NA)-B was not aware of what time the night shift would have completed a position change for R63. NA-B was not aware of how long R63 was positioned to the right side. NA-B verified R63 did not have a position change until 10:00 a.m.. NA-A came to the room to assist with cares. R63 was turned to the left side at 10:05 a.m. and an open area to the right hip was observed. There was a white substance on the right hip open area that NA-A and NA-B said was the protective barrier the facility used. NA-A expressed taking care of R63 the day prior and the open area was not present to the right hip. R63 expressed pain to the right hip but also was experiencing pain to the left hip and did not want to remain on the right hip. NA-A and NA-B positioned R63 to the right hip after applying barrier cream to the open area right hip. NA-A and NA-B placed a chux, folded draw sheet and a thick soaker pad under R63 and on top of the pressure relieving mattress. When interviewed on 11/2/16, at 10:31 a.m. registered nurse (RN)-A was not aware of the open area to the right hip region. Furthermore, RN-A was not aware of when the night shift would have last changed the position for R63 but would find out. Currently the facility did not have a	F 314	R63 and R24 have been re-assessed for continent/incontinent care needs, risk for pressure and when repositioning should occur. A new Skin Assessment/Braden and Tissue Tolerance Test were completed. Residents will be assisted with repositioning based on the findings and plan of care. The care plan and care cards have been reviewed and updated as needed. NA/R□s will be trained to round with the oncoming NA/R to provide pertinent information about the residents they will be caring for on the next shift. All residents at risk for pressure ulcers have been reviewed and reassessed as needed for repositioning. Assistance with repositioning is provided as assessed and care planned. All care plans for residents who require assistance with incontinent care have been reviewed and updated as needed. Weekly bath body audit tools are reviewed for completion by the Clinical Managers/designee. NA/R□s will document on their NA/R Group Care Card, the last time each resident was repositioned before the end of their shift, and pass the documentation to the oncoming shift. Mandatory education for all nursing staff will be provided on December 6th and December 7th, 2016. Education will include review of policies titled Following the Plan of Care, and Repositioning, as	

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F 314	Continued From page 17 system to communicate change of shift position time changes for residents who have been assessed at risk for skin breakdown. R63 was administered pain medication on 11/2/16, at 11:04 a.m. and at 11:50 a.m. RN-A assessed the right hip as a stage 2 pressure ulcer, and measurements length 1.5 cm (centimeter) width 0.5 cm and depth 0.2 cm. Document review of the facility form titled, Weekly Bath Day Body Audit Form, dated, 10/9/16, indicated no open areas or skin conditions for R63. There were no other completed weekly body audits for October or November to review. When interviewed on 11/3/16, at 9:30 a.m. verified speaking with the night shift who affirmed changing R63's position at 6 a.m. and NA-A verified a position change did not occur until after 10:00 am resulting in a 4 hour time span without a position change. Furthermore, RN-A verified the weekly bath audit was not documented since 10/9/16, but would investigate further. RN-A verified R63 did not have a position change for 4 hours and the facility had assessed R63 to require an every two hour position change. RN-A verified the pressure relieving mattress was not effective due to the soaker pad, chux and draw sheet being used over the pressure relieving mattress. R24 was at risk for skin breakdown and was not repositioned every two hours on 11/2/16, from 7:57 a.m., until 10:44 a.m., (two hours and 47 minutes). During continuous observations 11/2/16, from	F 314	well as the expectations for following the plan of care, and proper use of pressure reducing equipment. Audits for repositioning will be completed 5 x per week on all shifts for 2 weeks and then 3 x per week on varied shifts through January 24, 2017. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	

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F 314	Continued From page 18 7:57 a.m., until 10:44 a.m., the following was observed: - Between 7:57 a.m. and 8:31 a.m. R24 was observed to be in the bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with a bed spread sheet and blue blanket and had a pillow on abdomen area. - At 8:31 a.m. nursing assistant (NA)-A entered R24's room, looked at R24 and stepped out without providing care and/or speaking to R24. - From 8:32 a.m. until 9:08 a.m. R24 was in bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:08 a.m. NA-A entered R24's room, looked at the R24, opened and shut R24's closet and left the room without providing cares and/ or speaking to R24. - Between 9:12 a.m. and 9:42 a.m. R24 was observed in the bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - From 9:12 a.m. until 9:42 a.m. no staff entered R24's to reposistion R24. - At 9:43 a.m. NA-A. walked past R24's room, looked at the room but never entered. - Between 9:43 a.m. and 9:49 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:49 a.m. NA-A entered R24's room, looked at R24 and stepped out of the room without providing cares such as repositioning R24. - From 9:49 a.m. to 10:41 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in a low position. R24 was	F 314		

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F 314	Continued From page 19 covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 10:41 a.m. NA-A entered R24's room with mechanical Hoyer lift. NA-A started to perform morning cares including turn, check and change of R24's incontinence brief. Upon removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and the skin was intact. - At 10:59 a.m. a NA-A confirmed R24 was last repositioned around 7:30 a.m. and stated, R24 gets dressed and is left in bed until now. Skin assessment summary dated 8/8/16, reads, "Resident has a Braden scale score of 12 and is at risk for pressure ulcers. Risk factors include: diplegic CP [cerebral palsy], decreased ROM [range of motion] to all extremities, contractures, incontinence of B/B [bowel/bladder], PVD [Peripheral vascular disease], obesity, HX [history] of pressure ulcers and need for assistance with all mobility... Staff reposition Q2H [every two hours] and observe skin daily with cares, skin assessed by licensed staff with bath body audit..." The quarterly Minimum Data Set (MDS) dated 8/8/16, indicated R24 required total assistance of two staff for bed mobility, transfers and toileting, and R24 was at risk for developing pressure ulcers. R24's skin integrity care plan dated as edited on 8/8/16, identified R24 at risk for skin impairments and pressure ulcers and indicated R24 was totally dependent on staff for cares and mobility. The goal was for R24's skin to remain intact through the next review date. "APPROACH: Check and	F 314		

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F 314	Continued From page 20 change Q 2 hours and PRN, provide. Peri care after incontinence. Report redness and breakdown to nurse. Per turning and repositioning observation resident tolerates 2 hours of positioning without redness noted. Reposition Q 2 hours as resident allows." Undated nursing assistant assignment sheet reads, "Repositioning: TA2 every 2 hours Heels up on pillows when in bed". On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A explained that the expectation is for all nursing staff to follow the care plan and verified R24 should have been repositioned every two hours. Policy and procedure title REPOSITIONING, revised May 2013, directed staff, "3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Interventions 3. Residents who are in bed should be on at least an every two hour (q2h) repositioning schedule."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		12/16/16

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F 315	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 2 of 5 residents (R63, R31) in the sample, identified as incontinent of urine, received the necessary care and services to manage incontinence. Findings include: R63 was not checked and changed for incontinence for 4 hours. Document review of the Care Area Assessment (CAA) dated 3/9/16, indicated R63 was cognitively intact and able to make needs known. R63 was assessed as being total assist of 1-2 staff due to cerebral vascular accident and right hemiplegia. R63 was incontinent of bladder and bowel and R63 was assessed as moisture associated skin damage (MASD) to peri area, excoriation to sacrum/coccyx with scabbing present from previous experiences with incontinence. Barrier cream with each incontinence episode was to be applied and staff were to check and change for incontinence every two hours. The plan of care dated 9/6/16, directed, self care deficit in toileting due to total assistance with toileting, unable to use toilet or commode due to discomfort, and incontinent of bowel and bladder requiring total assistance of two staff for incontinence care every two hours. During continuous observation of R63's care on 11/2/16, from 7:30 a.m. through 10:00 a.m. R63 remained positioned to the right side while lying in	F 315	The facility has policies and procedures in place based on the resident□s comprehensive assessment, the facility ensures that a resident who enters the facility without and indwelling catheter is not catheterized unless the residents clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. The policy titled Management of Incontinence was reviewed and deemed appropriate. Resident R63 and R31 have been reassessed for incontinence needs. New Bowel and Bladder Assessments have been completed. The care plans have been reviewed and updated as needed. Residents who required assistance to manage their incontinence have been reviewed and reassessed as needed. Assistance with incontinence is provided as assessed and care planned. Mandatory education for all nursing staff will be provided on December 6th and December 7th, 2016. Education will include review of policies titled Management of Incontinence, as well as the expectations for providing incontinent	

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F 315	Continued From page 22 bed without an offer to check and change for incontinence of urine. When interviewed on 11/2/16, at 10:00 a.m. nursing assistant (NA)-B was not aware of what time the night shift would have completed a check and change for R63's incontinence and NA-B verified R63 had not been checked for incontinence earlier in the shift. On 11/2/16, at 10:00 a.m. NA-A came to the room to assist NA-B with cares. R63 was incontinent of urine and loose bowel movement. R63's buttocks and hips had deep red creases and crevices and there was redness/irritation to the groin and perineal areas from incontinence of urine and bowel. When interviewed on 11/2/16, at 10:31 a.m. registered nurse (RN)-A was not aware of when the night shift would have last checked and changed R63 for incontinence but would find out. Currently the facility did not have a system to communicate change of shift check and change times for incontinence. When interviewed on 11/3/16, at 9:30 a.m. RN-A verified speaking with the night shift who affirmed R63 had a check and change for incontinence at 6 a.m. and NA-A verified a check and change did not occur until after 10:00 am resulting in a 4 hour time span without a check and change for incontinence. RN-A verified the facility expectation would be to check and change R63 every two hours for incontinence. R31 admitted to the facility on 7/07/16. The admission minimum data set revealed R31 was	F 315	care to residents as directed by the care plan. Audits for repositioning will be completed 5 x per week on all shifts for 2 weeks and then 3 x per week on varied shifts through January 24, 2017. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	

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F 315	Continued From page 23	F 315		

always continent of bladder.

The urinary care area assessment, dated 7/14/16, revealed R31 required limited assist with toileting, and was continent of bladder and bowel. The care area assessment worksheet, dated 7/14/16, revealed R31 had urinary urgency and needed assistance toileting.

Quarterly minimum data set, dated 10/10/16, revealed R31 was occasionally incontinent of bladder (less than seven episodes of incontinence during a seven day period).

In a progress note dated 10/10/16, staff wrote that R31 had been continent of bladder and bowel during the look back period, but explained the resident needed a strict schedule of toileting every two hours due to resident mental illness and fixation on toileting. According to the note, R31 needed extensive staff assistance with toileting and perineal care, and used pull up briefs.

The urinary incontinence care plan, last updated 10/10/16, indicated R31 was continent of bladder and bowel. The long term goal listed in the care plan was for R31 to maintain current level of bladder and bowel continence. To meet this goal, the care plan directed staff to provide toileting every two hours with extensive assist of one.

R31's nursing assistant care card, dated 11/03/16, directed care staff to provide toileting every two hours with extensive assist of one.

During continuous observation on 11/03/16 from 8:22 a.m. until 11:24 a.m., R31 was first seen leaving bedroom using rolling walker to reach a

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F 315	Continued From page 24	F 315		

reclining chair in front of the nurses' station. R31 was observed moving back and forth between sitting in the reclining chair, and sitting at a table in the dining room. R31 remained sitting either in the reclining chair or the dining room for three hours. At 11:24 a.m. R31 got up from the table and walked down the hall toward bedroom using the rolling walker. The back of R31's dress had a dark marking on it. R31 got to bedroom, took off brief and dress and seemed distraught saying, "I wet my pants, I wet my pants. Can you put this in the laundry?" At this time the nurse had come down to R31's bedroom to give medications. The nurse helped R31 put on a clean brief and dress, and gave the medications. When asked whether staff helped with toileting, R31 replied "Sometimes."

On 11/03/16 at 12:14 p.m., trained medication administrator (TMA-A) said that R31 goes to the bathroom independently, but wets brief once in a while. TMA-A said that staff were supposed to ask R31 every two hours to go to the bathroom, but the resident might not want to go.

In an interview on 11/03/16 at 11:40 a.m., registered nurse (RN-B) said R31 was continent so she does toilet herself at times too, but staff should be prompting R31 to go to the bathroom. RN-B confirmed R31 needed extensive assist with the briefs, and said the nursing aid care card probably needed to be reworded in regards to toileting, as the toileting program was not clear as written.

In an interview on 11/03/16 at 2:27 p.m., the minimum data set coordinator (MDS-F) confirmed that R31 was continent on the admission minimum data set. During the quarterly

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F 315	Continued From page 25 assessment, R31 had one incontinent episode in the look back period, so staff coded R31 as occasionally incontinent. When asked whether staff might expect the care plan to change because of the occasional incontinence, MDS-F said it was hard to say, but generally didn't think that anyone would have re-written the care plan just because of one episode of incontinence. When asked for a documented history of R31's bladder continence, MDS-F printed a seven day look back for the period of 10/28/16-11/03/16. The look back included 17 total entries where staff documented whether R31 had been continent or incontinent of bladder. MDS-F was surprised to see R31 had 12 documented episodes of incontinence out of 17 total entries.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to minimize the potential for weight loss for 1 of 3 residents (R130) identified with a weight loss of greater than 10%	F 325	The facility has policies and procedures in place to ensure based on a residents comprehensive assessment, that the resident □ (1) Maintains acceptable	12/16/16

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F 325	Continued From page 26 in a sixty day period. Findings include: On 11/2/16, at 11:29 a.m. R130 was observed being served three glasses of milk, a bowl of cereal and two slices of toast. At 11:30 a.m. the wellness director stated the meal served R130 was all the resident wanted to eat. At 11:42 a.m. R130 was observed to have consumed 1/2 a bowl of cereal, two glasses of milk and a few bites of toast before leaving the dining room. R130 was not offered any nutritional supplement and was observed to decline further food. At 10:44 a.m. R130 stated not being hungry. R130 was asked about the morning snack and replied, did not want any. A review of recorded weights during the time period dated 8/26-10/26/16, revealed R130 had gone from 158 pounds to 142 pounds, which was a 10% weight loss in 60 days. Although there were physician orders for R130 to receive a nutritional supplement three times a day, when necessary, the facility had not provided this to R130. A nutrition assessment dated 8/22/16, noted R130 as having a significant weight loss in the last 60 days prior to admission, which was 8/19/16. The assessment indicated R130 was at high nutrition risk for weight loss and was to receive a Mighty Shake nutritional supplement. A registered dietician (RD) note dated 9/7/16, indicated the RD was alerted to 10.4 pound weight loss over the past 20 days; the resident verbalized a dislike for meals served as they	F 325	parameters of nutritional status, such as body weight and protein levels, unless the resident□s clinical condition demonstrates that this is not possible and (2) Receives a therapeutic diet when there is a nutritional problem. Resident R130 discharged on November 15, 2016. The nutritional supplement order was clarified and parameters defined prior to discharge. All residents with orders for nutritional supplements have been reviewed for clearly defined directions and clarifications have been obtained for those that had unclear parameters. The Dietician reviews resident weights on a regular basis and alerts staff to residents with weight loss and recommends appropriate interventions. Mandatory education will be provided for all licensed nursing staff on December 1st, 6th, and 7th, 2016, regarding nutritional supplements, obtaining clarifications if the instructions did not include clear directions and parameters. Audits of all new nutritional supplement orders will occur weekly, and audits of documentation of being offered nutritional supplements will occur daily on varied shifts through January 24, 2017. All audits will be reported to the Quality Council in January and the Quality Council shall determine if an ongoing audit schedule is required. The Director of Nursing/designee shall be responsible for	

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F 325	Continued From page 27 made her sick; and the resident requested a change in nutritional supplement to Ensure versus Mighty Shake. A RD note dated 9/13/16, revealed the following: a 10 pound weight loss in less than a month; Ensure was being offered three times a day, with 3 of 17 refusals; and the resident was complaining of nausea and not feeling well. A RD note 9/16/16, revealed R130 was taking a daily probiotic yogurt daily, had frequent loose stools and weight loss noted at 11.4 pounds. A RD note dated 9/29/16, indicated R130 recently returned from the hospital after a bout with pneumonia and that R130 had told the RD eating was much better and loose stools had improved. On 10/7/16, the physician ordered a nutritional supplement called Boost Glucose Control. The physician ordered the supplement to be administered three times a day, when necessary. However, the physician did not identify any parameters on when the supplement was to be administered and the facility did not get clarification on parameters of use. A RD note dated 10/25/16, noted the resident's weight loss and the the order for three times a day, when necessary, nutritional supplement. The RD note also identified that R130 had not received the nutritional supplement since the date the physician had ordered it. On 11/2/16, at 12:01 p.m. trained medication aide (TMA)-D was asked how it was determined when to give R130 the nutritional supplement. TMA-D explained that the nurse would tell the TMA-D	F 325	monitoring compliance. Date of completion: December 16, 2016	

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	245255	A. BUILDING _____ B. WING _____	11/03/2016

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F 325	Continued From page 28 when to give the supplement. TMA-D stated she had not offered the supplement to R130. On 11/2/16, at 12:07 HUC--G stated being responsible for ordering nutritional supplements for the facility and had never ordered Boost Glucose Control supplement for R130. On 11/2/16, at 12:10 p.m. RD-A, who had completed the 10/25/16, RD note was interviewed explained being at the facility for a week and verified there were no parameters for staff to know when to administer the "when necessary" nutritional supplement to R130. RD-A also verified R130 had not received the supplement that was ordered by the physician on 10/7/16.	F 325		
F 332 SS=E	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered to 3 of 7 (R96, R82, R111) residents observed during medication administraiton times. This resulted in an 11.11% med error rate. Findings include: During observation and interview during a medication administration on 11/2/16, from 3:50 to 5:10 p.m., registered nurse (RN)-D was	F 332	The facility has policies and procedures in place to ensure that it is free of medication error rates of five percent or greater. Policy and procedure for Administering Medications has been reviewed and deemed appropriate. The Policy and Procedure titled Medication Errors has been reviewed and deemed appropriate. Medication orders have been reviewed for R96, R82 and R111. All residents have	12/16/16

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F 332	Continued From page 29 observed to administer medications to four residents and the following medication errors were observed: On 11/2/16, at 3:55 p.m. RN-D was observed to administer R96 one tablet of 500 mg (milligram) calcium carbonate. A review of the physician orders dated 11/1-11/30/16, revealed the resident was to receive 1250 mg of calcium carbonate. At 4:05 p.m. RN-D was observed to administer R82 one tablet of the laxative senna plus. A review of physician orders dated 11/1-11/30/16, revealed the resident was to receive two tablets of senna plus. At 5:07 p.m. RN-D removed from the medication cart a bottle of Tylenol Extra Strength 500 mg tables. RN-D stated R111 did not receive that dosage, replaced the bottle in the cart and removed a bottle of Tylenol 325 mg tablets. When asked what dose of Tylenol R111 was to receive, RN-D stated R111 received the 325 mg dose. RN-D then placed two tablets of Tylenol 325 mg into the medication cup and administered the medication to R111. A review of the physician orders dated 11/1-11/30/16, revealed the resident was to receive Tylenol 500 mg, two tablets for a total of 1000 mg. The facility's 12/12 revised policy titled Administering Medications, indicated medications were to "be administered in accordance with orders."	F 332	the potential to be affected. Additional education regarding accurate medication administration will be provided to RN-D. Mandatory education will be provided for staff responsible for passing medications on December 1st, 6th, and 7th, 2016, this will include the include the Policy for Administering Medications. Audits of medication administration will occur 3x/week on each floor, on alternating shifts, through January 24, 2017. All audit results will be reported to the Quality Council in January and the Quality Council shall determine if an ongoing audit schedule is required. The Director of Nursing /designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from	F 412		12/16/16

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F 412	Continued From page 30 an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dentist recommendations were implemented for 1 of 3 residents (R75) with identified dental needs. Findings include: On 11/01/6, at 12:09 p.m. R75 was observed to have missing teeth. A review of R75's record failed to reveal the resident had been seen by a dentist since admission on 1/22/15. On 11/02/16, at 1:39 p.m. health unit coordinator (HUC)-G reviewed R75's record and found R75 had been to the dentist on 3/31/15, and the dentist had recommended a return visit six months later. HUC-G stated at this time they were not able to find any other dentist visit in R75's record. HUC-G showed the surveyor a dental consent signed by R75 on 1/23/15. HUC-G stated the dental visit and consent form were from a dental service the facility stopped using in 5/15. HUC-G stated they were not able to find a dental consent for the facility's current dental provider. On 11/03/16, 10:23 a.m., the director of health	F 412	The facility has polices and procedures in place to provide or obtain from an outside resource, in accordance with 483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist□s office; and must promptly refer residents with lost or damaged dentures to a dentist. The policy titled Dental Services was reviewed and deemed appropriate. R75 discharged from the facility 11/20/16. Multiple attempts to reach the Responsible Party by phone were made by facility staff. A copy of the Consent Form was at the Nursing Station for the Responsible Party to sign, if he visited. A certified letter, including a copy of the Consent Form, was mailed to the Responsible Party and was not returned prior to the discharge.	

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F 412	Continued From page 31 information services (HIS) stated R75 had not had a new dental visit scheduled to follow up on the dentist's 3/31/15 recommendations. The director of HIS stated R75 had "slipped through" and a new dental consent had not been obtained. The facility's 11/30/10, revised policy titled Dental Services revealed residents were to receive quality dental services upon admission, yearly and as needed.	F 412	All current residents have had an audit completed to verify consents for Dental Services and date of last Dental visit. Based on the audit results, any resident who did not have a dental visit within the past year will be offered to have a dental visit scheduled. Any resident who does not have a signed consent, will be contacted by Health Information Services/designee to obtain consent. Verification of dental consents/ last dental visit will be added the Care Conference checklist to be reviewed at least quarterly. Care Conference checklists will be audited weekly through January 24th, 2017. All audit results will be reported to the Quality Council in January 2017 and the Quality Council shall determine if an ongoing audit schedule is required. The Director of Health Information Services/designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		12/16/16

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F 431	Continued From page 32 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were properly labeled for 2 of 8 residents (R69 and R102) using inhalers on the third floor, and 1 of 9 residents (R7) using insulin on the second floor west wing. Findings include: R69 had a discontinued physician order for a Ventolin inhaler to be used as needed, in place of a nebulizer, when on leave of absence from the	F 431	The facility has policies and procedures in place to employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with	

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F 431	Continued From page 33 facility. Although the order was discontinued, observation on 11/02/16 revealed the facility kept R69's inhaler in the third floor east medication cart. It was stored inside a plastic bag, and labeled in marker with the resident's name. The inhaler and bag lacked a pharmacy label to indicate medication name, strength, expiration date, resident's name, route of administration, and any applicable instructions and precautions. In an interview on 11/02/16 at 10:40 a.m., registered nurse (RN-B) said that R69's inhaler should have had a pharmacy label attached. In an interview on 11/03/16 at 2:19 p.m., the director of nursing (DON) confirmed that all inhalers should have a pharmacy label. R102 had a current physician order for the Advair Diskus inhaler. Observation on 11/02/16 revealed that the facility stored R102's Advair Diskus in the third floor west medication cart. The inhaler was stored inside a plastic bag, and labeled in marker with the resident's name. The dose indicator on top of the diskus indicated that the medication had been used, but the inhaler lacked a date indicating when the medication was removed from the foil storage pouch. The inhaler also lacked a pharmacy label. When asked about R102's unlabeled inhaler on 11/02/16 at 10:59 a.m., trained medication assistant (TMA-C) said they should throw the unlabeled Advair away and order a new one. In an interview on 11/02/16 at 11:11 a.m., licensed practical nurse (LPN-B) confirmed that R102's Advair needed to have a pharmacy label. On 11/03/16 at 2:19 p.m., the DON said that the Advair Diskus needed to be dated for disposal 30 days after opening.	F 431	currently accepted processional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws. The facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses since unit package drug distribution systems in which the quantity stored is minimal and a missing does can be readily detected. The policy titled Labeling Medications has been reviewed and deemed appropriate. The policy titled Dating Medications was reviewed and deemed appropriate. R69□s discontinued inhaler was removed from the medication cart. R102□s Advair Discus Inhaler is labeled and was dated when opened. R7 has a new vial of Novolog insulin and it is labeled with the date opened.	

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F 431	Continued From page 34 The document titled Guidelines For Use Of Advair Diskus directed users to discard Advair Diskus 1 month after you remove it from the foil pouch. R7 had a current physician order for Novolog insulin on a sliding scale. Observation on 11/02/16 revealed the facility stored R7's insulin in the second floor west medication cart. The insulin lacked a date that indicated when it was opened. There was not much insulin left in the vial, indicating that the medication had been used. When asked about the missing open date in an interview on 11/02/16 at 12:28 p.m., RN-A said that normally the date opened was written on a sticker on the insulin vial. On 11/03/16 at 2:19 p.m., the DON confirmed that the facility policy required staff to date insulin after it was opened.	F 431	All inhalers have been checked to verify they are labeled appropriately. Advair Discus Inhalers have been checked to verify they are labeled appropriately and are dated when opened. All insulin□s have been checked to ensure labels are present and dates opened are present. Mandatory education on labeling of medications and dating open vials and inhalers will be provided on December 1, 2016 to all licensed nursing staff and Trained Medication Assistants that administer medications. Education will include review of the policies titled Labeling Medications and Dating Medications as well as the expectation to follow these policies and removal of medications from the medication cart when they are discontinued or changed. Audits for labeling of medications and dating open vials will occur 3x/weekly on each medication cart through January 24, 2017. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit scheduling is required. The Director of Nursing or designee shall be responsible for monitoring compliance. Date of completion: December 16, 2016	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		12/16/16

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F 441	Continued From page 35 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 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.	F 441		

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F 441	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 4 of 4 residents (R10, R56, R63, R54) observed for blood glucose monitoring; for handwashing during cares for 3 of 3 residents (R57, R63 R54) reviewed for activities of daily living; and for 2 of 7 residents (R96, R62) observed during medication administration. Findings include: On 11/3/16, at 9:56 a.m. during a blood glucose monitoring observation, registered nurse (RN)-G was observed to wash hands with hand sanitizer, remove a basket of blood glucose monitoring supplies from the medication cart and walk down the hall to R10's room. RN-G knocked on the door, walked into R10's room, obtained and applied gloves. RN-G placed the glucometer supply basket on table next to R10. RN-G placed test strip into glucometer, alcohol wiped R10's finger and obtained blood sample. RN-G tossed gloves into garbage, left room, placed glucometer basket on top of medication cart, tossed lancet (a sharp pointed medical instrument) into sharps container, tossed remaining garbage, and placed glucometer basket in bottom drawer of medication cart. RN-G washed her hands with hand sanitizer. RN-G was observed to not sanitize glucometer. On 11/3/16, at 10:01 a.m. when asked RN-G indicated the same glucometer was used on residents who required blood glucose readings and confirmed it had not been sanitized after use. RN-G stated the glucometer was supposed to be	F 441	The facility has policies and procedures in place to 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 infections. (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 the spread of Infection - (1) When the Infection Control Program determines that a resident needs isolation to isolate the resident (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated y accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. A policy titled Glucometer Cleaning has	

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F 441	Continued From page 37 sanitized between each resident. RN-G then walked into nurse's station to obtain green top Clorox hydrogen peroxide container of sanitizing wipes. Container was observed to have non-bleach statement printed on the front. RN-G then indicated to sanitize glucometer she would obtain one cloth, cover the glucometer and wipe it clean for 10 to 30 seconds. On 11/3/16, at 10:20 a.m. after doing a glucometer check for R56, RN-E wiped the glucometer with a product titled Clorox Hydrogen Peroxide. After quickly wiping the glucometer RN-E placed the glucometer in a container and placed the container in the medication cart. When asked about the facility's glucometer cleansing procedure, RN-E stated not knowing and looked at the Clorox bottle container. RN-E read the product information and stated it was to remain wet for 30 seconds. On 11/3/16, at 10:50 a.m. the administrator verified the Clorox Hydrogen Peroxide was a non-bleach product. Facility Assure Platinum Blood Glucose Monitoring System Policy/Procedure dated September 22, 2014 revealed: "B. Cleaning and Disinfecting of the Assure Platinum Blood Glucose Monitoring System... Steps in the Procedure 1. Apply hand sanitizer or wash hands. 2. Apply gloves to hands. 3. Remove wipe from container and wipe entire meter, avoid getting liquid into the test strip port of the meter. 4. If meter is visibly soiled with blood, two wipes should be should be used. 5. Allow to sit for 1 minute. 6. Discard wipe(s) into designated container. 7. Place meter on barrier after disinfection. 8. Remove gloves. 9. Apply hand	F 441	been written and to include the specific product to be used for cleaning/disinfecting a glucometer. A policy titled Glucometer Use has been written to include each resident having their own glucometer for individual use. The policy titled Hand washing/Hand Hygiene has been reviewed and deemed appropriate. The policy titled Facility Standard Precautions has been reviewed and deemed appropriate. Each resident who requires Blood Glucose testing will be provided with their own glucometer. Cleaning/disinfecting of the glucometer will be completed based on the manufacturer□s recommendations and per the policy titled Glucometer Cleaning. Mandatory education for all licensed nursing staff and Trained Medication Aides for cleaning/disinfecting the glucometers and proper procedure for passing/dispensing medications will be provided on December 1st, 6th and 7th, 2016. Education will include review of policies titled Glucometer Cleaning and Glucometer Use as well as the expectations to follow these policies and procedures. Audits will be conducted 3x/weekly through January 24, 2017 by Clinical Managers/designee to verify staff is cleaning glucometers based on manufacturer□s recommendations and facility policy. Mandatory education for nursing staff regarding proper Hand washing and	

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F 441	Continued From page 38 sanitizer or wash hands." Assure Brilliance Comprehensive Service & Support Program Cleaning and Disinfecting your Assure Platinum Blood Glucose Meter dated May 2014 revealed: "Option 1 Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. Many wipes act as both a cleaner and disinfectant. If blood is visibly present on the meter, two wipes must be used, one wipe to clean and a second wipe to disinfect... Step 2 Remove wipe from package or container. Follow instructions on package. If wipe is very wet, gently wring wipe to remove excess liquid. Step 3 Wipe down meter on front, back, and sides. DO NOT WRAP THE METER IN A WIPE. Take extreme care not to get liquid in the test strip and key code ports of the meter. Step 4 Let meter dry per wipe manufacturer's instructions. Dispose of wipe... CMS guidelines read that blood glucose meters need to be cleaned and disinfected after each use. It is our interpretation that individually assigned meters need to be cleaned and disinfected... Disinfecting can be accomplished with an EPA registered disinfectant detergent or germicide that is approved for healthcare settings... It is important than an LTC facility establish a program for infection control... The program should include addressing the cleaning and disinfection of blood glucose meters." During observation of R57's morning cares on 11/3/16, at 8:31 a.m. nursing assistant (NA)-F walked into bathroom, turned on water, washed hands for 10 seconds, wiped hands, turned off water and applied gloves. NA-F asked R57 what she wanted to wear today and removed clothes	F 441	Standard Precautions will be provided on December 1st, 6th, and 7th, 2016. Education will include the review of policy titled Hand washing/Hand Hygiene, the expectation of when to wash hands and the length of time required for proper hand washing, and when to wear and remove gloves. Hand washing audits reflecting observation during medication administration with review of medication dispensing will be completed 3x/weekly on all units/all shifts through January 24, 2017. Hand washing audits and observation when providing resident care will be completed daily on all units/all shifts for 2 weeks and then 3x/weekly on all units/all shifts through January 24, 2017. All audits results will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedules are required. The Director of Nursing/designee is responsible for monitoring compliance. Date of completion: December 16, 2016	

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 _____	11/03/2016

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

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F 441	Continued From page 39 from closet. NA-F looked for cleansing wipes, was unable to find any, removed gloves, tossed in garbage and left room. On 11/3/16, at 8:39 a.m. NA-F walked into room, applied clean gloves, checked R57's pad and indicated it was not wet. NA-F applied R57's leg protectors, informed R57 she would get her dressed, then washed R57's face with wash cloth. NA-F applied R57's socks, pants, removed pad, rolled R57 toward window, wiped away small amount bowel movement, tossed pad into garbage and applied clean pad. NA-F pulled R57's pant legs up and pulled wheelchair over toward resident. NA-F assisted R57 to sit up, elevated head of bed, removed R57's shoes from walker seat and put them on R57. NA-F sat up R57, put transfer belt on, transferred R57 back into bed, strapped belt, laid R57 back down, lowered bed and sat R57 up again. NA-F transferred R57 to sitting position in wheelchair and removed transfer belt. NA-F walked into bathroom, flushed toilet, removed gloves, washed hands for 10 seconds, wiped hands, applied clean gloves, walked back into room, removed R57's nightgown, applied shirt, sweater and eyeglasses. NA-F twisted shut garbage bag with dirty linens. NA-F walked into bathroom to clean R57's dentures. R57 asked for a drink of water. NA-F removed gloves and left room. NA-F knocked on door, entered room and gave R57 a drink of water. NA-F applied clean gloves and put dentures in R57's mouth. NA-F picked up bagged linens and held bag as NA-F wheeled R57 from room. About five feet down the hall NA-F removed her gloves and held them while wheeling R57 down the hall. NA-F tossed linen bag and gloves in utility room and washed hands with sanitizing gel for 10 seconds.	F 441		

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F 441	Continued From page 40 On 11/3/16, at 9:14 a.m. NA-F stated she washed her hands after peri-care. When asked how long she washed her hands after removing gloves in the bathroom, NA-F stated she "could not remember" and indicated did not know proper handwashing time was 20 seconds. On 11/03/16, at 2:12 p.m. assistant director of nursing (ADON) stated her expectation was nursing assistant should remove gloves and wash hands after peri-care before continuing with cares and dressing the resident. ADON stated expectation was to wash hands for 20 seconds. Facility Standard Precautions policy dated December 2007 revealed: "Standard precautions include the following practices:... d. Wash hands after removing gloves (see below). e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one)." Facility Handwashing/Hand Hygiene policy dated August 2014 revealed: "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... h. Before moving from a contaminated body site to a clean body site during resident care;... j. After contact with blood or bodily fluids;... Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 15 seconds (or longer) under a moderate stream of running water, at a comfortable temperature."	F 441		

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F 441	Continued From page 41 During observation of R63's morning cares on 11/2/16, at 9:55 a.m. nursing assistant (NA)-A came to the room, went into the bathroom to wash hands, turned on the water with bare hands, put hands under the water stream, after 2 seconds, NA-A turned off the water with bare hands, dried hands with a paper towel and donned a pair of gloves. NA-B came into the room at the same time and did not wash hands or use hand sanitizer before donning a pair of gloves. R63 was incontinent of a large loose bowel movement which NA-A and NA-B used wipes to cleanse away the bowel movement and to provide perineal cleansing. NA-A and NA-B were handing back and forth a tube of protective barrier cream wearing contaminated gloves, further contaminating the tube of protective barrier cream which then was put back into R63's bedside drawer without being sanitized. NA-A and NA-B removed the contaminated gloves but did not wash or sanitize hands before donning another pair of gloves. After completing cares, NA-A was observed to wash hands for 5 seconds. NA-B used the hand sanitizer in the room and then left. When interviewed on 11/2/16, at 10:13 a.m. NA-A thought the handwashing policy was to wash hands for 30 seconds or while singing the ABC's. On 11/2/16, at 10:14 a.m. trained medication assistant (TMA-A) came into the room to do a blood glucose monitor for R63. TMA-A did not wash or sanitize hands and donned a pair of gloves. TMA-A obtained the sample of blood, removed the gloves and left the room without washing or sanitizing hands. TMA-A did not	F 441		

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F 441	Continued From page 42 sanitize the glucometer and took the glucometer to TMA-B on another wing. TMA-B sanitized the glucometer using a wipe from a purple topped bin. TMA-B wiped the glucometer for 15 seconds with the sanitizing wipes. On 11/2/16, at 10:23 a.m. TMA-B took the glucometer and supplies to R54's room and donned a pair of gloves without hand sanitizing. After the blood was drawn, TMA-B removed the gloves and proceeded to wash hands with soap and running water for 12 seconds. When interviewed at 10:26 a.m. TMA-B thought the facility handwashing policy was for 30 seconds or while singing happy birthday. Back at the med cart, TMA-B proceeded to sanitize the glucometer and wiped off the glucometer for 10 seconds and left the glucometer to air dry on the top of the medication cart. On 11/2/16, at 3:55 p.m. during observation of a medication administration, RN-D placed the antipsychotic medication Haldol 0.25 mg (milligrams) into their hand from the blister pack and then into the medication cup for R96. The meds were then administered to R96. Without washing hands RN-D returned to the medication cart and began setting up medications for R62. RN-D punched out 25 mg of the antihypertensive medication metoprolol from the blister pack into their hand and placed the medication into the med cup. The medication was administered to R62 and afterwards RN-D washed hands. Interview at 4:00 p.m. with RN-D explained that hands were washed before starting the medication pass and no residents had been touched.	F 441		

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F 441	Continued From page 43 Facility Handwashing/Hand Hygiene policy dated August 2014 revealed: Use an alcohol-based hand rub cdntaining at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... c. Before preparing or handling medications;."	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 observation, and interview, the facility failed to provide at least 80 square feet per resident in multiple resident bedrooms for three double resident rooms affecting five residents. Findings include: Resident double occupancy square footage was observed to be approximately 155 square feet instead of the required 160 square feet for double occupancy in rooms 222, 223, and 326. On 11/3/16, at 1:00 p.m. the administrator provided documentation indicating rooms 222, 223 and 326 were double occupancy rooms and acknowledged a waiver was in place, allowing double occupancy in the 155 square foot double rooms versus the regulation of 160 square feet in double occupancy rooms. Resident's residing in those rooms did not offer	F 458	See Attached	12/16/16

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F 458	Continued From page 44 complaints regarding the size of the rooms.	F 458		

Cerenity
SENIOR CARE
Humboldt

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

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

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

November 16, 2016

MN Department of Health
Attn: Susanne Reuss, RN Unit Supervisor
1645 Energy Park Drive, Suite 300
St. Paul, MN 55108-2970

Susanne,

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

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

Please contact me with any questions or concerns at 651-220-1742 or michael.syltie@bhshealth.org

Sincerely,

Michael Syltie
Administrator/ CEO
Cerenity Care Center- Humboldt

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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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 11/3/16, (Cerenity Care on Humboldt) was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 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: Health Care Fire Inspections State Fire Marshal Division	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/18/2016

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 1 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@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 on Humboldt) is a 4-story building . 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, addition was constructed was determined to be of Type II(222) construction. Because the original building and the 1 addition are of the same type of construction and meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 125 beds and had a	K 000		

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K 000	Continued From page 2 census of 117 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 211 SS=D	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This STANDARD is not met as evidenced by: Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 On facility tour between 12:0 AM and 04:30 PM on 11/3/16, based on observation and interview revealed that the findings include: Based on observation during inspection, it was found that the second means of egress out of the boiler room was locked with a key. Door was unlocked at time of inspection and will remain until new locking arrangement is completed. This deficient practice could affect the safety of all the staff and visitors within this compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 211	Door will remain unlocked. The lock has been removed from the door. Date Completed: 11-4-16	11/4/16

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K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1)	K 351	Sprinkler head on 3rd floor was cleaned on November 4, 2016. Cleaning of sprinkler heads will be added to the PM schedule and be cleaned on a quarterly or as-needed basis. Completed 11-4-16	11/4/16

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K 351	Continued From page 4 On facility tour between 12:30 AM and 4:30 PM on 11/3/16, based on observation and interview revealed that the findings include: Dust build-up around fire sprinkler head was found on 3rd floor dining room kitchen area. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the Facility Maintenance Director at the time of discovery.	K 351		
K 920 SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4.	K 920		11/4/16

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

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K 920	Continued From page 5 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 On facility tour between 12:30 AM and 4:30 PM on 11/3/16, based on observation and interview revealed that the findings include: An extension cord was found in office 102 being used as permanent power. This deficient practice could affect the safety of all the residents, staff and visitors within the smoke compartment. This deficient practice was confirmed by the	K 920	Extension cord was removed from office 102 on November 7, 2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245255	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/03/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 920	Continued From page 6 Facility Maintenance Director at the time of discovery.	K 920		

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically submitted
November 18, 2016

Mr. Michael Syltie, Administrator
Cerenity Care Center On Humboldt
512 Humboldt Avenue
Saint Paul, MN 55107

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5255026

Dear Mr. Syltie:

The above facility was surveyed on October 31, 2016 through November 3, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us**.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Please note it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00538	A. BUILDING: _____ B. WING _____	11/03/2016

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On October 31, November 1, 2 and 3, 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement the care plan for 1 of 3 residents (R75) with identified dental needs; for 1 of 3 residents (R63) who required staff assistance with oral care, and for 2 of 5 residents (R31, R24) who required assistance with incontinent care; and Findings include: R75 on 11/01/6, at 12:09 p.m., was observed to have missing teeth. The care plan revised 8/29/16, identified R75 as having broken and missing teeth and indicated R75 was to see the dentist as needed. On 11/02/16, at 1:39 p.m. health unit coordinator (HUC)-G reviewed R75's record and found R75 had been to the dentist on 3/31/15, and the dentist had recommended a return visit six	2 565	See above.	12/16/16

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2 565	Continued From page 3 months later. No return visit to the dentist was found in the record and this was confirmed at this time by HUC-G. R63, document review of the form titled, Care Plan, dated, 3/20/15, read, total assistance with oral cares. The document titled, Care Area Assessment (CAA) dated 3/10/16, read, "Resident is NPO (nothing per oral) and receives TF (tube feeding) Staff assist with oral cares-mouth swabs Q2H (every 2 hours). Thick white/yellow coating over tongue, had been treated with nystatin but no effect-does not appear to be thrush. Resident denies any discomfort, no bleeding, or open areas present, and coating is only on tongue-not sides of cheeks. Per wife has been present since he started TF. Staff to continue to assist with oral cares and will refer to dental prn." Document review of the form titled, Care Sheet, directed nursing staff for mouth swabs every two hours. During observation on 11/1/16, at 3:00 p.m. R63 was observed to have a white moist substance on the lips and tongue. R63 was observed with a heavy coating on the tongue and did complain that it was bothersome. Family member (F)-B is present and stated the facility is suppose to provide oral care every two hours using the pre-moistened swabs but there are none in the drawers currently and F-B verified frequently having to ask for more swabs because F-B did not think the oral cares were being provided every two hours. During continuous observations of R63's care on 11/2/16, from 7:30 a.m. through 12:15 p.m.: R63 was observed to be lying in bed and there were no offers to provide oral care.	2 565		

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2 565	Continued From page 4 On 11/2/16, at 1:21 p.m. registered nurse (RN)-A, nursing assistants (NA)-A and NA-B were in the room with R63 providing care, and when interviewed, verified no oral care had been provided to R63 yet today but they would provide the oral care now. Document review of the policy titled, Mouth Care, dated revised October 2010, directed, to review the resident's care plan to assess for any special needs of the resident. During an interview with RN-A on 11/2/16, at 1:30 p.m. verified the facility expectation was to provide oral care every two hours. R31's urinary incontinence care plan, last updated 10/10/16, indicated R31 was continent of bladder and bowel. The long term goal listed in the care plan was for R31 to maintain current level of bladder and bowel continence. To meet this goal, the care plan directed staff to provide toileting every two hours with extensive assist of one. R31's nursing assistant care card, dated 11/03/16, directed care staff to provide toileting every two hours with extensive assist of one. During continuous observation on 11/03/16 from 8:22 a.m. until 11:24 a.m., R31 was first seen leaving bedroom using rolling walker to reach a reclining chair in front of the nurses' station. R31 was observed moving back and forth between sitting in the reclining chair, and sitting at a table in the dining room. R31 remained sitting either in the reclining chair or the dining room for three hours. At 11:24 a.m. R31 got up from the table and walked down the hall toward bedroom using	2 565		

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2 565	Continued From page 5	2 565		

the rolling walker. The back of R31's dress had a dark marking on it. R31 got to bedroom, took off brief and dress and seemed distraught saying, "I wet my pants, I wet my pants. Can you put this in the laundry?" At this time the nurse had come down to R31's bedroom to give medications. The nurse helped R31 put on a clean brief and dress, and gave the medications. When asked whether staff helped with toileting, R31 replied "Sometimes."

In interview on 11/03/16 at 11:02 a.m. registered nurse (RN-E) said R31 was independent but staff encouraged toileting, and that R31 was assist of one with activities of daily living.

On 11/03/16 at 12:14 p.m., trained medication administrator (TMA-A) said that R31 goes to the bathroom independently, but wets brief once in a while. TMA-A said that staff were supposed to ask R31 every two hours to go to the bathroom, but the resident might not want to go.

In an interview on 11/03/16 at 11:40 a.m., registered nurse (RN-B) said R31 was continent so she does toilet herself at times too, but staff should be prompting R31 to go to the bathroom. RN-B confirmed R31 needed extensive assist with the briefs, and said the nursing aid care card probably needed to be reworded in regards to toileting, as the toileting program was not clear as written.

R24's self-care care plan dated as edited on 8/8/16, directed staff that R24 does not use the toilet due to inability to sit on the toilet safely and that R24 required, "Check and change q [every] 2 hours. Total dependence of 1-2 staff to check, change, and provide good peri care after each

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2 565	Continued From page 6 incontinent episodes." R24's skin integrity care plan dated as edited on 8/8/16, identified R24 had "PROBLEM: Resident is at risk for skin impairments and pressure ulcers AEB incontinence, immobility, totally dependent for ADL's [assist of daily livings], and mobility, APPROACH: Check and change Q 2 hours and PRN, provide Peri care after incontinence. Report redness and breakdown to nurse. Per turning and repositioning observation resident tolerates 2 hours of positioning without redness noted. Reposition Q 2 hours as resident allows." Undated nursing assistant assignment sheet reads, "... 2 staff present for cares Toileting: TA2 [total assist of two] Change every 2 hours and per request. Repositioning: TA2 every 2 hours Heels up on pillows when in bed". On 11/1/16 at 3:44 p.m., during observations of care, R24 was incontinent of bowel and bladder when the incontinence pad was checked and changed. NA-Z verified R24 was incontinent with bowel and bladder. On 11/2/16, from 7:57 a.m., until 10:44 a.m., R24 was observed to be in the bed, lying on back with bed in a low position and eyes closed. At 10:44 a.m. NA-A started to perform morning cares including turn, check and change of R24's incontinence brief. Upon removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and the skin was intact. At 10:59 a.m. a NA-A confirmed R24 was last repositioned and checked and changed around 7:30 a.m. NA-A added, R24 was wet because R24 is a heavy wetter.	2 565		

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2 565	Continued From page 7 On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A replied that the expectation was for all nursing staff to follow the care plan. RN-A verified R24 should have been repositioned, and checked and changed. SUGGESTED METHOD OF CORRECTION: Staff education could be provided to all staff responsible for the provision of resident care to ensure staff know how to care for the resident. The director of nurses or designee could randomly observe resident cares to ensure care plans are being implemented as written. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to update the	2 570	See above.	12/16/16

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2 570	Continued From page 8 comprehensive care plan to include interventions for reducing risk of falls for 1 of 4 residents (R102) reviewed for falls with injury. Findings include: R102 had diagnoses that included shortness of breath, generalized muscle weakness, congestive heart failure, acute respiratory failure, low blood pressure, anemia (lowered ability of the red blood cells to carry oxygen), and type II diabetes. The care area assessment dated 2/24/16 revealed R102 required limited assist with ambulating, supervision with toileting, and was unsteady when ambulating, moving from seated to standing, turning around, moving on and off the toilet, and transferring from surface to surface. The assessment identified R102 at risk for falls. Event reports indicated R102 had five falls during the month of October on 10/8/16, 10/13/16, 10/17/16, 10/25/16, and 10/27/16. Three of these falls happened when R102 attempted to use the bathroom alone in room, and one fall resulted in a broken finger. Progress notes highlighted interventions reviewed by the interdisciplinary team. R102 broke the right fourth finger on 10/8/16 at 4:45 a.m., when R102 got out of bed to go to the bathroom and fell. Progress notes dated 10/13/16 instructed R102 to wear a splint on the injured right hand most of the time (splint could be removed for bathing, washing, and gentle range of motion). On 10/13/16 at 11:30 p.m., R102 was using the bathroom in room just before falling. Progress notes dated 10/14/16 indicated R102 was	2 570		

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2 570	Continued From page 9	2 570		

provided a spill proof urinal to use at night instead of getting up to go to the bathroom. Staff also discussed proper footwear when walking to the bathroom, and supplied R102 with a new pair of non-skid socks.

On 10/17/16 at approximately 5:00 a.m., R102 slipped off wheelchair. Progress notes dated 10/18/16 indicated a physical therapy evaluation had been completed, and the rehabilitation nursing program for transfers included stand pivot, limited assist of one, and use of a gait belt.

On 10/25/16 at approximately 6:45 a.m., staff found R102 lying on right side, on the scale in the lounge. R102 explained that before falling, was trying to weigh self. In progress notes dated 10/25/16, staff noted the scale was in the lounge next to R102's room, out of sight of the nurses' station. According to the notes, R102 had previous falls related to weighing self without staff present. Staff reminded R102 not to use the scale alone, and decided to move the scale to the opposite lounge so the resident would have to walk past the nurses' station to get to the scale. Staff also discontinued an order for daily weights, and started weekly weights.

On 10/27/16 at approximately 3:30 a.m., R102 was turning to use the toilet and lost balance. Progress notes from 10/27/16 explained the resident was able to reach both the call light and urinal from bed, but neither had been used. Staff documented re-education to use call lights and urinal at night to avoid having to get out of bed.

Nursing assistants used Care Cards to quickly access up to date information about how to take care of each resident. Care cards included information about special needs, wake-up time

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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) COMPLETE DATE
2 570	Continued From page 10 and bed time, dietary information, toileting and repositioning, activities of daily living, ambulation, transfers, rehabilitation programs, scheduled items (bath, weights, etc.), and special interventions. R102's care card, dated 11/03/16, directed staff to keep the resident's right hand in a splint at all times (remove for hygiene), supervise toileting, keep a spill proof urinal at the bedside and encourage the resident to use it, remind resident to use call light, limited assist of one for transfer, use of pivot transfers and gait belt, and to use non-skid socks when possible. The falls care plan was last edited 8/21/16, and mentioned R102 was at risk for falls due to unsteadiness when moving from sitting to standing, moving on and off the toilet, and transferring from surface to surface. The care plan did not mention that R102 fell five times in October and broke a finger. The long term goal, dated 8/21/16, was to keep R102 free from fall related injuries through 11/30/16. The facility last updated the approaches used to meet this goal on 12/15/14. Approaches listed: analyze R102's falls to determine patterns, avoid restraint use, keep the call light in reach, obtain a physical therapy consult, orient R102 when there are changes in furniture placement or environment, keep the environment clutter free, and use a wanderguard at all times. The activities of daily living/rehabilitation care plan was last edited 11/02/16, and highlighted deficits in R102's mobility. This care plan included the current rehabilitation program for transfers (stand pivot, limited assist of one, use gait belt), but did not include the assessment that R102 required supervision with toileting. Although nursing assistant care cards provided	2 570		

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2 570	Continued From page 11 current interventions used to reduce risk of falls, the facility did not update R102's comprehensive care plan after recent falls to include the following treatment and interventions determined by clinical staff and reviewed by the interdisciplinary team: Wear a splint on injured right hand most of the time, use a spill proof urinal at night to avoid getting up to go to the bathroom, wear non-skid socks when appropriate, and supervise toileting. The facility policy titled, Fall Event and Post Fall Assessment, last updated 12/15, instructed the charge of building, clinical manager, or designee to ensure the newly implemented intervention(s) is documented in all necessary places (Care Card, Care Plan, etc.). In an interview on 11/03/16 at 2:37 p.m., when asked about whether R102's fracture and interventions for recent falls should be in the care plan, Registered Nurse (RN-B) said, "The fracture and history of fracture should be put in the fall care plan. I will need to update that. I should have put all that in the care plan. I put it in the care card so that the staff knows, but I need to put it into the care plan." SUGGESTED METHOD OF CORRECTION: A resident's care plan should be revised as necessary with any changes which affect the overall provision of care to a resident to ensure the appropriate care, services and treatments are provide to maximize a resident's potential for improvement. Care plans should be reviewed and revised, at a minimum on a quarterly basis. A member of the care planning team could review care plans at the time of the care conference to ensure revisions are completed timely.	2 570		

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2 570	Continued From page 12 TIME PERIOD FOR CORRECTION: Seven (7) days.	2 570		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's	2 840		12/16/16

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2 840	Continued From page 13 comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral care for 1 of 1 resident's (R63) dependent upon staff for personal cares; and failed to check and change 1 of 1 resident (R24) dependent on staff for incontinent care. Findings include: Resident (R24) was incontinent of bowel and bladder, and did not receive assistance with incontinence care every two hours on 11/1/16 and on 11/2/16 from 7:57 a.m., until 10:44 a.m., (two hours and 47 minutes).. On 11/1/16 at 3:44 p.m., R24's was observed to be incontinent with bowel and bladder during check and change of the incontinent pad. NA-Z verified R24 was incontinent with bowel and bladder. On 11/2/16, during continous observations. from 7:57 a.m., until 10:44 a.m., R24 was not checked for incontinence. The following was observed: - Between 7:57 a.m. and 8:31 a.m. R24 was observed to be in the bed, lying on back with eyes closed. The bed was in low position and R24 was covered with bed spread sheet and blue blanket	2 840	See above.	

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2 840	Continued From page 14 and had a pillow on abdomen area. - At 8:31 a.m. nursing assistant (NA)-A entered R24's room, looked at R24 and stepped out of the room without providing cares and/or speaking to R24. - From 8:32 a.m. until 9:08 a.m. R24 was lying on back in bed with eyes closed. The bed was in low position. R24 covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:08 a.m. NA-A entered R24's room, looked at R24, opened R24's closet, closed it, and stepped out of the room without providing cares and/or speaking to R24. - Between 9:12 a.m. and 9:42 a.m. R24 was observed lying on back in bed with eyes closed. The bed was in low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - From 9:12 a.m. until 9:42 a.m. no staff provided positioning or checked R24 for incontinence. - At 9:43 a.m. NA-A. walked past R24's room, looked at the room but never entered. - Between 9:43 a.m. and 9:49 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in low position. R24 was covered with a bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:49 a.m. NA-A entered R24's room, looked at R24 and stepped out of the room without providing cares, such as check, change, repositioning and/or speaking to R24. - From 9:49 a.m. to 10:41 a.m. R24 was observed in bed, lying on back with eyes closed and bed in low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 10:41 a.m. NA-A entered R24's room with mechanical Hoyer lift. NA-A started to perform morning cares which included, turn, check and change of R24's incontinence brief. Upon	2 840		

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2 840	Continued From page 15 removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and skin was intact. NA-A confirmed R24 was last repositioned and checked and changed around 7:30 a.m. and added, is a heavy wetter. The quarterly Minimum Data Set (MDS) dated 8/8/16, indicated R24 was always incontinent of bladder and bowel, required total assistance of two staff for bed mobility, transfers and toileting. Care Area Assessment for Urinary incontinence dated 5/12/16, reads, "[R24] triggers Urinary Incontinence D/T [due to] her requiring total assistance with toileting. [R24] is always incontinent of bladder and bowel... Staff will continue to check and change every 2 hours and PRN [as needed]". R24's self-care care plan dated as edited on 8/8/16, identified R24 had a self care deficit in toileting, does not use toilet due to inability to sit on toilet safely and requires check and change every 2 hours. The plan directed staff that R24 required total dependence of 1-2 staff to check, change, and provide good peri care after each incontinent episode. R24's skin integrity care plan dated as edited on 8/8/16, identified, "GOAL: Resident's skin will remain intact through the next review date. APPROACH: Check and change Q 2 hours and PRN, provide. Peri care after incontinence. Report redness and breakdown to nurse." Undated nursing assistant assignment sheet reads, "... 2 staff present for cares Toileting: TA2 [total assist of two] Change every 2 hours and per	2 840		

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2 840	Continued From page 16 request." On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A indicated the expectation was for all staff to follow the care plan and verified R24 should have been checked every two hours for incontinence. Policy and procedure title URINARY CONTINENCE AND INCONTINENCE - ASSESSMENT AND MANAGEMENT, revised September 2010, directed staff, "19. The staff will document the results of the toileting trial in the resident's medical record. C. A 'check and change' strategy involves checking the resident's continence status at regular intervals and using incontinence devices or garments. The primary goals are to maintain dignity and comfort and to protect the skin." SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could retrain staff about providing in a timely manner the appropriate care and services to residents who are incontinent or urine. A member of the nursing staff could randomly audit/observe residents identified as incontinent of urine to ensure timely incontinent care is provided. TIME PERIOD FOR CORRECTION: Seven (7) days.	2 840		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 855		12/16/16

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2 855	Continued From page 17 E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide oral care for 1 of 1 resident's (R63) dependent upon staff for personal cares; and failed to check and change 1 of 1 resident (R24) dependent on staff for incontinent care. Findings include: R63 was observed 11/1/16, at 3:00 p.m. to have a white moist substance on the lips and tongue. R63 was observed with a heavy coating on the tongue and did complain that it was bothersome. Family member (F)-B was present and stated the facility is supposed to provide oral care every two hours using the pre-moistened swabs but there are none in the drawers currently and F-B verified frequently having to ask for more swabs. F-B questioned if oral cares were being provided every two hours. During continuous observations of R63's care on 11/2/16, from 7:30 a.m. through 12:15 p.m., R63 was observed to be lying in bed and there were no offers to provide oral care. On 11/2/16, at 1:21 p.m. registered nurse (RN)-A, nursing assistants (NA)-A and NA-B were in the room with R63 providing care, and when interviewed, verified no oral care had been provided to R63 yet today but they would provide the oral care now.	2 855	See above.	

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2 855	Continued From page 18 R63's quarterly Minimum Data Set (MDS) dated 3/9/16, indicated R63 had intact cognition and was dependent with activities of daily living (ADL's). Document review of the form titled, Care Plan, dated, 3/20/15, read, total assistance with oral cares. The document titled, Care Area Assessment (CAA) dated. 3/10/16, read, "Resident is NPO (nothing per oral) and receives TF (tube feeding) Staff assist with oral cares-mouth swabs Q2H (every 2 hours). Thick white/yellow coating over tongue, had been treated with nystatin but no effect-does not appear to be thrush. Resident denies any discomfort, no bleeding, or open areas present, and coating is only on tongue-not sides of cheeks. Per wife has been present since he started TF. Staff to continue to assist with oral cares and will refer to dental prn." Document review of the form titled, Care Sheet, directed nursing staff for mouth swabs every two hours. Document review of the policy titled, Mouth Care, dated revised October 2010, directed, to review the resident's care plan to assess for any special needs of the resident. During an interview with RN-A on 11/2/16, at 1:30 p.m. verified the facility expectation was to provide oral care every two hours. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could observe the provision of morning cares to ensure staff are providing oral cares to those residents identified as dependent on staff for completion of oral care.	2 855		

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2 855	Continued From page 19 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on document review,observation and interview, the facility failed to ensure 2 of 3 residents (R63, R24) identified at risk for pressure ulcers (PU) received timely repositioning. Findings include: R63 who was at risk of developing pressure ulcers did not receive a position change for 4 hours. Document review of the Care Area Assessment (CAA) dated 3/9/16, indicated R63 was cognitively intact and able to make needs known. R63 was assessed as being moderately at risk for pressure ulcers, and directed, unable to off load independently, assist with turning and repositioning every two hours, staff monitor skin daily with cares and licensed staff assess every week with bath body audit. The plan of care dated	2 905	See above.	12/16/16

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2 905	Continued From page 20 9/6/16, directed at risk for pressure ulcer development and to reposition every 2 hours lying and sitting. During continuous observation of R63's care on 11/2/16, from 7:30 a.m. through 10:00 a.m. R63 remained positioned to the right side while lying in bed without an offer to change position. When interviewed on 11/2/16 at 10:00 a.m. nursing assistant (NA)-B was not aware of what time the night shift would have completed a position change for R63. NA-B was not aware of how long R63 was positioned to the right side. NA-B verified R63 did not have a position change until 10:00 a.m.. NA-A came to the room to assist with cares. R63 was turned to the left side at 10:05 a.m. and an open area to the right hip was observed. There was a white substance on the right hip open area that NA-A and NA-B said was the protective barrier the facility used. NA-A expressed taking care of R63 the day prior and the open area was not present to the right hip. R63 expressed pain to the right hip but also was experiencing pain to the left hip and did not want to remain on the right hip. NA-A and NA-B positioned R63 to the right hip after applying barrier cream to the open area right hip. NA-A and NA-B placed a chux, folded draw sheet and a thick soaker pad under R63 and on top of the pressure relieving mattress. When interviewed on 11/2/16, at 10:31 a.m. registered nurse (RN)-A was not aware of the open area to the right hip region. Furthermore, RN-A was not aware of when the night shift would have last changed the position for R63 but would find out. Currently the facility did not have a system to communicate change of shift position	2 905		

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2 905	Continued From page 21 time changes for residents who have been assessed at risk for skin breakdown. R63 was administered pain medication on 11/2/16, at 11:04 a.m. and at 11:50 a.m. RN-A assessed the right hip as a stage 2 pressure ulcer, and measurements length 1.5 cm (centimeter) width 0.5 cm and depth 0.2 cm. Document review of the facility form titled, Weekly Bath Day Body Audit Form, dated, 10/9/16, indicated no open areas or skin conditions for R63. There were no other completed weekly body audits for October or November to review. When interviewed on 11/3/16, at 9:30 a.m. verified speaking with the night shift who affirmed changing R63's position at 6 a.m. and NA-A verified a position change did not occur until after 10:00 am resulting in a 4 hour time span without a position change. Furthermore, RN-A verified the weekly bath audit was not documented since 10/9/16, but would investigate further. RN-A verified R63 did not have a position change for 4 hours and the facility had assessed R63 to require an every two hour position change. RN-A verified the pressure relieving mattress was not effective due to the soaker pad, chux and draw sheet being used over the pressure relieving mattress. R24 was at risk for skin breakdown and was not repositioned every two hours on 11/2/16, from 7:57 a.m., until 10:44 a.m., (two hours and 47 minutes). During continuous observations 11/2/16, from 7:57 a.m., until 10:44 a.m., the following was	2 905		

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2 905	Continued From page 22 observed: - Between 7:57 a.m. and 8:31 a.m. R24 was observed to be in the bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with a bed spread sheet and blue blanket and had a pillow on abdomen area. - At 8:31 a.m. nursing assistant (NA)-A entered R24's room, looked at R24 and stepped out without providing care and/or speaking to R24. - From 8:32 a.m. until 9:08 a.m. R24 was in bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:08 a.m. NA-A entered R24's room, looked at the R24, opened and shut R24's closet and left the room without providing cares and/ or speaking to R24. - Between 9:12 a.m. and 9:42 a.m. R24 was observed in the bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - From 9:12 a.m. until 9:42 a.m. no staff entered R24's to reposistion R24. - At 9:43 a.m. NA-A. walked past R24's room, looked at the room but never entered. - Between 9:43 a.m. and 9:49 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area. - At 9:49 a.m. NA-A entered R24's room, looked at R24 and stepped out of the room without providing cares such as repositioning R24. - From 9:49 a.m. to 10:41 a.m. R24 was observed to be in bed, lying on back with eyes closed. The bed was in a low position. R24 was covered with bed spread sheet and blue blanket and had a pillow on abdomen area.	2 905		

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2 905	Continued From page 23 - At 10:41 a.m. NA-A entered R24's room with mechanical Hoyer lift. NA-A started to perform morning cares including turn, check and change of R24's incontinence brief. Upon removal of the wet brief, R24's buttocks and thighs had numerous reddened areas and crevices from the wrinkling of the brief. The areas were blanchable at the time and the skin was intact. - At 10:59 a.m. a NA-A confirmed R24 was last repositioned around 7:30 a.m. and stated, R24 gets dressed and is left in bed until now. Skin assessment summary dated 8/8/16, reads, "Resident has a Braden scale score of 12 and is at risk for pressure ulcers. Risk factors include: diplegic CP [cerebral palsy], decreased ROM [range of motion] to all extremities, contractures, incontinence of B/B [bowel/bladder], PVD [Peripheral vascular disease], obesity, HX [history] of pressure ulcers and need for assistance with all mobility... Staff reposition Q2H [every two hours] and observe skin daily with cares, skin assessed by licensed staff with bath body audit..." The quarterly Minimum Data Set (MDS) dated 8/8/16, indicated R24 required total assistance of two staff for bed mobility, transfers and toileting, and R24 was at risk for developing pressure ulcers. R24's skin integrity care plan dated as edited on 8/8/16, identified R24 at risk for skin impairments and pressure ulcers and indicated R24 was totally dependent on staff for cares and mobility. The goal was for R24's skin to remain intact through the next review date. "APPROACH: Check and change Q 2 hours and PRN, provide. Peri care after incontinence. Report redness and breakdown to nurse. Per turning and	2 905		

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2 905	Continued From page 24 repositioning observation resident tolerates 2 hours of positioning without redness noted. Reposition Q 2 hours as resident allows." Undated nursing assistant assignment sheet reads, "Repositioning: TA2 every 2 hours Heels up on pillows when in bed". On 11/2/16, at 11:09 a.m. the registered nurse (RN)-A explained that the expectation is for all nursing staff to follow the care plan and verified R24 should have been repositioned every two hours. Policy and procedure title REPOSITIONING, revised May 2013, directed staff, "3. Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning. Interventions 3. Residents who are in bed should be on at least an every two hour (q2h) repositioning schedule." SUGGESTED METHOD OF CORRECTION: The director or nurses or designee should retrain staff regarding the importance of changing the position of high pressure risk resident's as frequently as assessed, in order to minimize the development of pressure ulcers. A member of the nursing staff could randomly observe and audit repositioning or residents to ensure residents are being positioned with enough frequency to minimize the potential for developing pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status	2 965		12/16/16

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2 965	Continued From page 25 Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview and record review, the facility failed to minimize the potential for weight loss for 1 of 3 residents (R130) identified with a weight loss of greater than 10% in a sixty day period. Findings include: On 11/2/16, at 11:29 a.m. R130 was observed being served three glasses of milk, a bowl of cereal and two slices of toast. At 11:30 a.m. the wellness director stated the meal served R130 was all the resident wanted to eat. At 11:42 a.m. R130 was observed to have consumed 1/2 a bowl of cereal, two glasses of milk and a few bites of toast before leaving the dining room. R130 was not offered any nutritional supplement and was observed to decline further food. At 10:44 a.m. R130 stated not being hungry. R130 was asked about the morning snack and replied, did not want any. A review of recorded weights during the time period dated 8/26-10/26/16, revealed R130 had gone from 158 pounds to 142 pounds, which was a 10% weight loss in 60 days. Although there	2 965	See above.	

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2 965	Continued From page 26	2 965		

were physician orders for R130 to receive a nutritional supplement three times a day, when necessary, the facility had not provided this to R130.

A nutrition assessment dated 8/22/16, noted R130 as having a significant weight loss in the last 60 days prior to admission, which was 8/19/16. The assessment indicated R130 was at high nutrition risk for weight loss and was to receive a Mighty Shake nutritional supplement.

A registered dietician (RD) note dated 9/7/16, indicated the RD was alerted to 10.4 pound weight loss over the past 20 days; the resident verbalized a dislike for meals served as they made her sick; and the resident requested a change in nutritional supplement to Ensure versus Mighty Shake.

A RD note dated 9/13/16, revealed the following: a 10 pound weight loss in less than a month; Ensure was being offered three times a day, with 3 of 17 refusals; and the resident was complaining of nausea and not feeling well.

A RD note 9/16/16, revealed R130 was taking a daily probiotic yogurt daily, had frequent loose stools and weight loss noted at 11.4 pounds.

A RD note dated 9/29/16, indicated R130 recently returned from the hospital after a bout with pneumonia and that R130 had told the RD eating was much better and loose stools had improved.

On 10/7/16, the physician ordered a nutritional supplement called Boost Glucose Control. The physician ordered the supplement to be administered three times a day, when necessary. However, the physician did not identify any

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2 965	Continued From page 27 parameters on when the supplement was to be administered and the facility did not get clarification on parameters of use. A RD note dated 10/25/16, noted the resident's weight loss and the the order for three times a day, when necessary, nutritional supplement. The RD note also identified that R130 had not received the nutritional supplement since the date the physician had ordered it. On 11/2/16, at 12:01 p.m. trained medication aide (TMA)-D was asked how it was determined when to give R130 the nutritional supplement. TMA-D explained that the nurse would tell the TMA-D when to give the supplement. TMA-D stated she had not offered the supplement to R130. On 11/2/16, at 12:07 HUC--G stated being responsible for ordering nutritional supplements for the facility and had never ordered Boost Glucose Control supplement for R130. On 11/2/16, at 12:10 p.m. RD-A, who had completed the 10/25/16, RD note was interviewed explained being at the facility for a week and verified there were no parameters for staff to know when to administer the "when necessary" nutritional supplement to R130. RD-A also verified R130 had not received the supplement that was ordered by the physician on 10/7/16. SUGGESTED METHOD OF CORRECTION: A physician's order should be obtained specifiying the parameters for when to give an as necessary nutritional supplement. The dietary staff should continue to monitor the resident's weight to ensure weight maintenance is achieved.	2 965		

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2 965	Continued From page 28 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure dentist recommendations were implemented for 1 of 3 residents (R75) with identified dental needs. Findings include: On 11/01/6, at 12:09 p.m. R75 was observed to have missing teeth. A review of R75's record failed to reveal the resident had been seen by a dentist since admission on 1/22/15. On 11/02/16, at 1:39 p.m. health unit coordinator (HUC)-G reviewed R75's record and found R75 had been to the dentist on 3/31/15, and the dentist had recommended a return visit six months later. HUC-G stated at this time they were not able to find any other dentist visit in R75's record. HUC-G showed the surveyor a dental	21325	See above.	12/16/16

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21325	Continued From page 29 consent signed by R75 on 1/23/15. HUC-G stated the dental visit and consent form were from a dental service the facility stopped using in 5/15. HUC-G stated they were not able to find a dental consent for the facility's current dental provider. On 11/03/16, 10:23 a.m., the director of health information services (HIS) stated R75 had not had a new dental visit scheduled to follow up on the dentist's 3/31/15 recommendations. The director of HIS stated R75 had "slipped through" and a new dental consent had not been obtained. The facility's 11/30/10, revised policy titled Dental Services revealed residents were to receive quality dental services upon admission, yearly and as needed. SUGGESTED METHOD OF CORRECTION: The director or nurses or designee could review all resident consent forms to ensure the resident, family member or rep-payee has indicated whether or not dental services are requested. Consents should be obtained for those residents requiring dental services and dental appointments scheduled as needed. A member of the nursing staff or designee could randomly review resident consents to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21325		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and	21375		12/16/16

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21375	Continued From page 30 sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 4 of 4 residents (R10, R56, R63, R54) observed for blood glucose monitoring; for handwashing during cares for 3 of 3 residents (R57, R63 R54) reviewed for activities of daily living; and for 2 of 7 residents (R96, R62) observed during medication administration. Findings include: On 11/3/16, at 9:56 a.m. during a blood glucose monitoring observation, registered nurse (RN)-G was observed to wash hands with hand sanitizer, remove a basket of blood glucose monitoring supplies from the medication cart and walk down the hall to R10's room. RN-G knocked on the door, walked into R10's room, obtained and applied gloves. RN-G placed the glucometer supply basket on table next to R10. RN-G placed test strip into glucometer, alcohol wiped R10's finger and obtained blood sample. RN-G tossed gloves into garbage, left room, placed glucometer basket on top of medication cart, tossed lancet (a sharp pointed medical instrument) into sharps container, tossed remaining garbage, and placed glucometer basket in bottom drawer of medication cart. RN-G washed her hands with hand sanitizer. RN-G was observed to not sanitize glucometer. On 11/3/16, at 10:01 a.m. when asked RN-G indicated the same glucometer was used on residents who required blood glucose readings	21375	See above.	

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21375	Continued From page 31	21375		

and confirmed it had not been sanitized after use. RN-G stated the glucometer was supposed to be sanitized between each resident. RN-G then walked into nurse's station to obtain green top Clorox hydrogen peroxide container of sanitizing wipes. Container was observed to have non-bleach statement printed on the front. RN-G then indicated to sanitize glucometer she would obtain one cloth, cover the glucometer and wipe it clean for 10 to 30 seconds.

On 11/3/16, at 10:20 a.m. after doing a glucometer check for R56, RN-E wiped the glucometer with a product titled Clorox Hydrogen Peroxide. After quickly wiping the glucometer RN-E placed the glucometer in a container and placed the container in the medication cart. When asked about the facility's glucometer cleansing procedure, RN-E stated not knowing and looked at the Clorox bottle container. RN-E read the product information and stated it was to remain wet for 30 seconds.

On 11/3/16, at 10:50 a.m. the administrator verified the Clorox Hydrogen Peroxide was a non-bleach product.

Facility Assure Platinum Blood Glucose Monitoring System Policy/Procedure dated September 22, 2014 revealed: "B. Cleaning and Disinfecting of the Assure Platinum Blood Glucose Monitoring System... Steps in the Procedure 1. Apply hand sanitizer or wash hands. 2. Apply gloves to hands. 3. Remove wipe from container and wipe entire meter, avoid getting liquid into the test strip port of the meter. 4. If meter is visibly soiled with blood, two wipes should be should be used. 5. Allow to sit for 1 minute. 6. Discard wipe(s) into designated container. 7. Place meter on barrier after

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21375	Continued From page 32 disinfection. 8. Remove gloves. 9. Apply hand sanitizer or wash hands." Assure Brilliance Comprehensive Service & Support Program Cleaning and Disinfecting your Assure Platinum Blood Glucose Meter dated May 2014 revealed: "Option 1 Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. Many wipes act as both a cleaner and disinfectant. If blood is visibly present on the meter, two wipes must be used, one wipe to clean and a second wipe to disinfect... Step 2 Remove wipe from package or container. Follow instructions on package. If wipe is very wet, gently wring wipe to remove excess liquid. Step 3 Wipe down meter on front, back, and sides. DO NOT WRAP THE METER IN A WIPE. Take extreme care not to get liquid in the test strip and key code ports of the meter. Step 4 Let meter dry per wipe manufacturer's instructions. Dispose of wipe... CMS guidelines read that blood glucose meters need to be cleaned and disinfected after each use. It is our interpretation that individually assigned meters need to be cleaned and disinfected... Disinfecting can be accomplished with an EPA registered disinfectant detergent or germicide that is approved for healthcare settings... It is important than an LTC facility establish a program for infection control... The program should include addressing the cleaning and disinfection of blood glucose meters." During observation of R57's morning cares on 11/3/16, at 8:31 a.m. nursing assistant (NA)-F walked into bathroom, turned on water, washed hands for 10 seconds, wiped hands, turned off water and applied gloves. NA-F asked R57 what she wanted to wear today and removed clothes	21375		

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21375	Continued From page 33 from closet. NA-F looked for cleansing wipes, was unable to find any, removed gloves, tossed in garbage and left room. On 11/3/16, at 8:39 a.m. NA-F walked into room, applied clean gloves, checked R57's pad and indicated it was not wet. NA-F applied R57's leg protectors, informed R57 she would get her dressed, then washed R57's face with wash cloth. NA-F applied R57's socks, pants, removed pad, rolled R57 toward window, wiped away small amount bowel movement, tossed pad into garbage and applied clean pad. NA-F pulled R57's pant legs up and pulled wheelchair over toward resident. NA-F assisted R57 to sit up, elevated head of bed, removed R57's shoes from walker seat and put them on R57. NA-F sat up R57, put transfer belt on, transferred R57 back into bed, strapped belt, laid R57 back down, lowered bed and sat R57 up again. NA-F transferred R57 to sitting position in wheelchair and removed transfer belt. NA-F walked into bathroom, flushed toilet, removed gloves, washed hands for 10 seconds, wiped hands, applied clean gloves, walked back into room, removed R57's nightgown, applied shirt, sweater and eyeglasses. NA-F twisted shut garbage bag with dirty linens. NA-F walked into bathroom to clean R57's dentures. R57 asked for a drink of water. NA-F removed gloves and left room. NA-F knocked on door, entered room and gave R57 a drink of water. NA-F applied clean gloves and put dentures in R57's mouth. NA-F picked up bagged linens and held bag as NA-F wheeled R57 from room. About five feet down the hall NA-F removed her gloves and held them while wheeling R57 down the hall. NA-F tossed linen bag and gloves in utility room and washed hands with sanitizing gel for 10 seconds.	21375		

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21375	Continued From page 34 On 11/3/16, at 9:14 a.m. NA-F stated she washed her hands after peri-care. When asked how long she washed her hands after removing gloves in the bathroom, NA-F stated she "could not remember" and indicated did not know proper handwashing time was 20 seconds. On 11/03/16, at 2:12 p.m. assistant director of nursing (ADON) stated her expectation was nursing assistant should remove gloves and wash hands after peri-care before continuing with cares and dressing the resident. ADON stated expectation was to wash hands for 20 seconds. Facility Standard Precautions policy dated December 2007 revealed: "Standard precautions include the following practices:... d. Wash hands after removing gloves (see below). e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one)." Facility Handwashing/Hand Hygiene policy dated August 2014 revealed: "7. Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... h. Before moving from a contaminated body site to a clean body site during resident care;... j. After contact with blood or bodily fluids;... Washing Hands 1. Vigorously lather hands with soap and rub them together, creating friction to all surfaces, for a minimum of 15 seconds (or longer) under a moderate stream of running water, at a comfortable temperature." During observation of R63's morning cares on	21375		

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21375	Continued From page 35 11/2/16, at 9:55 a.m. nursing assistant (NA)-A came to the room, went into the bathroom to wash hands, turned on the water with bare hands, put hands under the water stream, after 2 seconds, NA-A turned off the water with bare hands, dried hands with a paper towel and donned a pair of gloves. NA-B came into the room at the same time and did not wash hands or use hand sanitizer before donning a pair of gloves. R63 was incontinent of a large loose bowel movement which NA-A and NA-B used wipes to cleanse away the bowel movement and to provide perineal cleansing. NA-A and NA-B were handing back and forth a tube of protective barrier cream wearing contaminated gloves, further contaminating the tube of protective barrier cream which then was put back into R63's bedside drawer without being sanitized. NA-A and NA-B removed the contaminated gloves but did not wash or sanitize hands before donning another pair of gloves. After completing cares, NA-A was observed to wash hands for 5 seconds. NA-B used the hand sanitizer in the room and then left. When interviewed on 11/2/16, at 10:13 a.m. NA-A thought the handwashing policy was to wash hands for 30 seconds or while singing the ABC's. On 11/2/16, at 10:14 a.m. trained medication assistant (TMA-A) came into the room to do a blood glucose monitor for R63. TMA-A did not wash or sanitize hands and donned a pair of gloves. TMA-A obtained the sample of blood, removed the gloves and left the room without washing or sanitizing hands. TMA-A did not sanitize the glucometer and took the glucometer to TMA-B on another wing. TMA-B sanitized the	21375		

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21375	Continued From page 36 glucometer using a wipe from a purple topped bin. TMA-B wiped the glucometer for 15 seconds with the sanitizing wipes. On 11/2/16, at 10:23 a.m. TMA-B took the glucometer and supplies to R54's room and donned a pair of gloves without hand sanitizing. After the blood was drawn, TMA-B removed the gloves and proceeded to wash hands with soap and running water for 12 seconds. When interviewed at 10:26 a.m. TMA-B thought the facility handwashing policy was for 30 seconds or while singing happy birthday. Back at the med cart, TMA-B proceeded to sanitize the glucometer and wiped off the glucometer for 10 seconds and left the glucometer to air dry on the top of the medication cart. On 11/2/16, at 3:55 p.m. during observation of a medication administration, RN-D placed the antipsychotic medication Haldol 0.25 mg (milligrams) into their hand from the blister pack and then into the medication cup for R96. The meds were then administered to R96. Without washing hands RN-D returned to the medication cart and began setting up medications for R62. RN-D punched out 25 mg of the antihypertensive medication metoprolol from the blister pack into their hand and placed the medication into the med cup. The medication was administered to R62 and afterwards RN-D washed hands. Interview at 4:00 p.m. with RN-D explained that hands were washed before starting the medication pass and no residents had been touched. Facility Handwashing/Hand Hygiene policy dated August 2014 revealed: Use an alcohol-based	21375		

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21375	Continued From page 37 hand rub cdntaining at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:... c. Before preparing or handling medications;." SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee should review and revise the facility's policy on the cleansing/disinfecting of multi-use glucometers. Staff could then be educated on the revised policy and a member of the nursing staff could randomly observe staff during glucometer use. Staff should also be educated the appropriateness of handwashing during medication administrations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home.	21426		12/16/16

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21426	Continued From page 38 This MN Requirement is not met as evidenced by: Based on interview and document review, facility failed to document complete results of the tuberculosis (TB) skin (TST) that was given for 1 of 5 residents (R52) reviewed for TB screening; failed to document complete results of the TST given for 2 of 5 employees (E1, E3) reviewed for TB screening; and failed to document medical evaluation results for 2 of 5 employees (E4, E5) reviewed for TB screening. Findings include: R52 was admitted to the facility on 9/6/16, per R52's admission Minimum Data Set (MDS). R52's immunization record revealed R52 was given the first step TST on 6/9/16, with 0 millimeters (mm) and negative results. The second step TST was given on 6/26/16, with negative results, but did not indicate mm read. E1's start date was 8/10/16. E1's immunization record revealed E1 was given the first step TST on 8/10/16, with 0 mm and negative results. The second step TST was not given. E3's start date was 8/8/16. E3's immunization record revealed E3 was given the first step TST on 8/24/16, with 0 mm and negative results. The second step TST was given on 9/28/16, but was not read. E4's start date was 7/27/16. E4's immunization	21426	MN St. Statute 144.04 Subd.3 Tuberculosis Prevention and Control A Nursing Home provider must establish and maintain a comprehensive Tuberculosis Infection Control Program according to the most current tuberculosis infection control guidelines. The Policy and Procedure titled Facility Tuberculosis Screening-Administration and Interpretation of Tuberculin Skin Tests has been reviewed and deemed appropriate. The policy and procedure titled Facility Tuberculosis, Employee Screening has been reviewed and updated to include Health Care Workers with newly identified TST or IGRA require a medical evaluation to rule out a diagnosis of active TB disease prior to any direct resident contact. R52 has had a second step TST. E4 and E5 both received medical evaluations. Mandatory education for all licensed nursing staff will be provided on December 6th and 7th, 2016. Education will include	

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21426	Continued From page 39 record revealed E4 was given the second TST on 8/8/16, with 18mm and positive results. E4 received a chest x-ray on 8/10/16, with negative results. E4 did not receive a medical evaluation. E5's start date was 9/21/16. E5's immunization record revealed E5's 9/21/16, Quantiferon TB-gold test results were positive. E5 received a chest x-ray 9/22/16, with negative results. E5 did not receive a medical evaluation. On 11/3/16, at 11:58 a.m. interview was completed with assistant director of nursing (ADON) who confirmed missing TB information. ADON stated she expected facility to follow policy for TB immunizations. ADON further indicated the facility had interpreted the need for a medical evaluation differently, regarding TB, page 12, item 4, which directs facility: Health Care Worker (HCW) with newly identified TST or IGRA; Before the HCW has direct patient contact, the following should be documented in their record: 4. Medical evaluation to rule out a diagnosis of infectious TB disease. Facility Tuberculosis Screening - Administration and Interpretation of Tuberculin Skin Tests policy dated August 2013 revealed: "5. All test results must be read in mm." Facility Tuberculosis, Employee Screening for policy dated July 2010 revealed: "b. If the employee's chest x-ray is negative and he/she is free of symptoms of active TB, the employee will be considered free of active tuberculosis." It did not address the need for a medical evaluation following negative chest x-ray results. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could	21426	the review of the policies Facility Tuberculosis Screening- Administration and Interpretation of Tuberculin Skin Tests and Facility Tuberculosis, Employee Screening. Audits will be completed to assure all current residents have had a two-step TST and that results are reflected in mm read. Audits will be completed through January 24, 2017 on all new admissions to assure the two step process reflects results are reflected in mm read. New employee audits will be completed through January 24, 2017 to verify any need for medical evaluations have been completed prior to any direct resident contact. All audits will be reported to the Quality Council in January and the Quality Council shall determine if ongoing audit schedule is required. The Infection Control Coordinator/designee is responsible for monitoring compliance. Date of Completion: December 16, 2016	

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21426	Continued From page 40 review/revise policies on resident and employee Tuberculosis screening and perform audits to ensure the policy was being followed. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
21545	MN Rule 4658.1320 A.B.C Medication Errors A nursing home must ensure that: A. Its medication error rate is less than five percent as described in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (m), found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, which is incorporated by reference in part 4658.1315. For purposes of this part, a medication error means: (1) a discrepancy between what was prescribed and what medications are actually administered to residents in the nursing home; or (2) the administration of expired medications. B. It is free of any significant medication error. A significant medication error is: (1) an error which causes the resident discomfort or jeopardizes the resident's health or safety; or (2) medication from a category that usually requires the medication in the resident's blood to be titrated to a specific blood level and a single medication error could alter that level and precipitate a reoccurrence of symptoms or toxicity. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the	21545		12/16/16

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21545	Continued From page 41 resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. C. All medications are administered as prescribed. An incident report or medication error report must be filed for any medication error that occurs. Any significant medication errors or resident reactions must be reported to the physician or the physician's designee and the resident or the resident's legal guardian or designated representative and an explanation must be made in the resident's clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were administered to 3 of 7 (R96, R82, R111) residents observed during medication administraiton times. This resulted in an 11.11% med error rate. Findings include: During observation of a medication administration on 11/2/16, from 3:50 to 5:10 p.m., registered nurse (RN)-D was observed to administer medications to four residents and the following medication errors were observed: On 11/2/16, at 3:55 p.m. RN-D was observed to administer R96 one tablet of 500 mg (milligram) calcium carbonate. A review of the physician orders dated 11/1-11/30/16, revealed the resident was to receive 1250 mg of calcium carbonate. At 4:05 p.m. RN-D was observed to administer R82 one tablet of the laxative senna plus. A	21545	See above.	

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21545	Continued From page 42 review of physician orders dated 11/1-11/30/16, revealed the resident was to receive two tablets of senna plus. At 5:07 p.m. RN-D removed from the medication cart a bottle of Tylenol Extra Strength 500 mg tables. RN-D stated R111 did not receive that dosage, replaced the bottle in the cart and removed a bottle of Tylenol 325 mg tablets. RN-D stated R111 received the 325 mg dose. RN-D then placed two tablets of Tylenol 325 mg into the medication cup and administered the medication to R111. A review of the physician orders dated 11/1-11/30/16, revealed the resident was to receive Tylenol 500 mg, two tablets for a total of 1000 mg. The facility's 12/12 revised policy titled Administering Medications, indicated medications were to "be administered in accordance with orders." SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee should retrain the staff person who had committed the medication erros. The DON or designee or consulting pharmacist could observe random staff to ensure medications were administered without error. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21545		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300.	21620		12/16/16

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21620	Continued From page 43 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure medications were properly labeled for 2 of 8 residents (R69 and R102) using inhalers on the third floor, and 1 of 9 residents (R7) using insulin on the second floor west wing. Findings include: R69 had a discontinued physician order for a Ventolin inhaler to be used as needed, in place of a nebulizer, when on leave of absence from the facility. Although the order was discontinued, observation on 11/02/16 revealed the facility kept R69's inhaler in the third floor east medication cart. It was stored inside a plastic bag, and labeled in marker with the resident's name. The inhaler and bag lacked a pharmacy label to indicate medication name, strength, expiration date, resident's name, route of administration, and any applicable instructions and precautions. In an interview on 11/02/16 at 10:40 a.m., registered nurse (RN-B) said that R69's inhaler should have had a pharmacy label attached. In an interview on 11/03/16 at 2:19 p.m., the director of nursing (DON) confirmed that all inhalers should have a pharmacy label. R102 had a current physician order for the Advair Diskus inhaler. Observation on 11/02/16 revealed that the facility stored R102's Advair Diskus in the third floor west medication cart. The inhaler was stored inside a plastic bag, and labeled in marker with the resident's name. The dose indicator on top of the diskus indicated that the medication had been used, but the inhaler lacked a date indicating when the medication was removed	21620	See above.	

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21620	Continued From page 44 from the foil storage pouch. The inhaler also lacked a pharmacy label. When asked about R102's unlabeled inhaler on 11/02/16 at 10:59 a.m., trained medication assistant (TMA-C) said they should throw the unlabeled Advair away and order a new one. In an interview on 11/02/16 at 11:11 a.m., licensed practical nurse (LPN-B) confirmed that R102's Advair needed to have a pharmacy label. On 11/03/16 at 2:19 p.m., the DON said that the Advair Diskus needed to be dated for disposal 30 days after opening. The document titled Guidelines For Use Of Advair Diskus directed users to discard Advair Diskus 1 month after you remove it from the foil pouch. R7 had a current physician order for Novolog insulin on a sliding scale. Observation on 11/02/16 revealed the facility stored R7's insulin in the second floor west medication cart. The insulin lacked a date that indicated when it was opened. There was not much insulin left in the vial, indicating that the medication had been used. When asked about the missing open date in an interview on 11/02/16 at 12:28 p.m., RN-A said that normally the date opened was written on a sticker on the insulin vial. On 11/03/16 at 2:19 p.m., the DON confirmed that the facility policy required staff to date insulin after it was opened. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper storage of medications. Nursing staff could be educated as necessary to the importance of labeling medications properly and discarding expired	21620		

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21620	Continued From page 45 medications. The DON or designee, along with the pharmacist, could audit medications on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21620		